REPORT OF THE

COMMISSION ON THE NEEDS OF ELDERLY VIRGINIANS

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 32

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF PURCHASES AND SUPPLY
RICHMOND

1978

MEMBERS OF THE COMMISSION

Mary A. Marshall, Chairman
Orby L. Cantrell, Vice Chairman
John C. Buchanan
Howard C. Cobbs
J. Marshall Coleman
Franklin P. Hall
George H. Heilig, Jr.
Edward M. Holland
Thomas J. Michie, Jr.
Bernard R. Mullady
Frank M. Slayton
C. Jefferson Stafford
T. Preston Turner
Stanley C. Walker
Edwin L. Wood, Ex Officio

STAFF

DIVISION OF LEGISLATIVE SERVICES

John A. Banks, Jr., Director
Elizabeth H. Neale, Consultant
Lelia B. Hopper, Staff Attorney

TABLE OF CONTENTS

Report of the

Commission on the Needs of Elderly Virginians

Richmond, Virginia

January 16, 1978

TO: The Honorable John N. Dalton, Governor of Virginia

and

The General Assembly of Virginia

INTRODUCTION

The Commission on the Needs of Elderly Virginians was created in 1973, pursuant to the provisions of House Joint Resolution No. 175, which expressed the concern of the General Assembly for "... the availability of needed services, facilities and other benefits so that elderly residents of the Commonwealth may maintain themselves in dignity and have adequate care." It has been the purpose of the Commission to identify and study the existing needs and potential problems facing Virginia's elderly citizens and to advocate and support, when deemed in the best interests of the elderly and the Commonwealth, proposals to meet these needs and assist in solving the problems. This year, the Commission has concentrated its efforts in the area of health care and has sought to recommend the most appropriate and least restrictive atmospheres for provision of health care services and related home services to the frail elderly. Wherever feasible, the Commission has recommended non-institutional alternatives as preferable to institutional placement, believing that such alternative placement represents the desires of the majority of the elderly and that it is the most cost beneficial placement, which benefits would necessarily be passed along to the individual taxpayer.

During the past three and one-half years, the Commission has held ten public hearings throughout the State, meeting with approximately two thousand interested citizens and hearing testimony from over two hundred persons. The information received at these meetings assisted the Commission greatly in identifying the most critical needs of the elderly in Virginia. Transportation, home care and tax relief figured most often in the areas of need mentioned at the hearings. Underlying these and many other problem situations faced by the elderly are the basic factors of low income and inadequate housing. An estimated 621,683 persons aged sixty and over reside in Virginia.[1] By 1980, an estimated 685,395 persons over the age of sixty will be living in Virginia, which will amount to approximately 13 percent of the State's total population.[2] Twenty-nine percent of persons over the age of sixty-five have incomes below the established poverty level,

which is approximately $2,800 annually, and ten percent of the elderly have incomes just barely above the poverty level.[3]

Since its creation in 1973, the Commission has sponsored and supported several proposals, aimed at meeting the needs of the elderly, which it feels have been significant. Foremost among these proposals was that which resulted in the creation of the Virginia Office on Aging in 1974. The Office on Aging is the officially recognized State agency to administer programs and services under the Older Americans Act. Under the most able direction of Edwin L. Wood, the Office on Aging has grown to represent professionalism in the field of aging and has proven a very effective advocate for Virginia's aging population. The most extensive and detailed aging reports in this and many other states have been researched and published by this Office and reflect the expertise and professional ability represented in its staff.

Transportation for the elderly is a major concern of the Commission and was among those needs mentioned most often by speakers at the Commission's public hearings. As a result of the Commission's desire to increase the mobility of the elderly, Senate Bill No. 888 was proposed and subsequently passed by the 1975 General Assembly. This bill allowed for the public use of school busses for non-school purposes, when not being used for the transportation of school children. Also, Commission members were responsible for the proposal of House Joint Resolution No. 208, which was passed by the 1977 General Assembly, requesting the Governor's Council on Transportation to study the transportation needs of the elderly.

Aware of skyrocketing property taxes and the acute effects on the elderly with low and fixed incomes, the Commission undertook a study of property tax relief for the elderly in 1975. Due to the fiscal problems facing the State at the time, it was impossible for such relief to be considered by the 1976 General Assembly. It is the feeling of the Commission that some form of tax relief should be initiated in the Commonwealth.

The Commission has sponsored legislation which would have increased taxable income deductions for spouses of federal retirees. While this specific bill did not pass in 1975, such deductions were granted the following year. A State Center on Aging at Virginia Commonwealth University was proposed by the Commission in 1975, but did not pass at that time as it was felt that such a proposal should be studied first by the State Council on Higher Education and the higher educational community as a whole. This year, satisfied that proper study has been made, the Commission is again recommending that a State Center on Aging be established.

In 1976, the Commission sponsored a bill which would have established a retirement review board, amending Virginia's compulsory retirement laws, and supported legislation which succeeded in removing some restrictions pertaining to the advertisement of prices for eyeglasses and prescription drugs.

While the Commission is concerned about the major housing problems facing the elderly, time constraints did not permit the Commission to delve into a housing study. The Commission is aware of the work of the Office on Housing and the Virginia Housing Developmental Authority and recommends to the General Assembly that any recommendations in this area be considered and expanded upon where necessary in an effort to solve the problems represented by inadequate housing.

OBJECTIVES AND CONSIDERATIONS

Throughout this year, the Commission has been concerned primarily with seeking the means of providing the least restrictive and most appropriate care for the frail elderly. Non-institutional alternatives for the provision of such care have been explored as they appear to the Commission to offer settings which are most desirable for the elderly and which are most cost beneficial to the taxpayer. Presently, 91.9 percent of the State's aging budget goes toward costly institutional care with the remaining 8.1 percent going toward administration (2.5 percent) and community services (5.5 percent). [See Appendix C.]

Prevention of the situations which lead to the need for increased care should be the main consideration in any care and treatment program, and the Commission is concerned that more and more federal and State dollars are being spent on acute treatment programs and less on the prevention of situations which lead to the need for institutionalization and irreversible long-term care.

As in most programs, it is important that incentives be built in to insure effective utilization; unfortunately, our present system is geared toward institutionalization and provides incentives for its perpetuation. A 1976 Michigan report entitled Alternatives to Institutionalization cited a recent report of the House Select Committee on Aging which charged that "federal health policy is institutionally biased and deprives hundreds of thousands of elderly of home care by encouraging more expensive nursing home usage."[4]

Under the Medicare program, a person must have been hospitalized for at least three days before qualifying for home health care or qualifying to receive heavy equipment such as wheel chairs, hospital beds and exercise equipment. Such home health coverage is limited to 100 annual visits. After one qualifies for Medicaid coverage in an institution, there is no such limit to the number of days covered. Approximately 70 percent of institutional beds are covered by Medicaid funds. Neither Medicare nor Medicaid provide coverage for preventive services, such as annual physicals. Domiciliary care facilities do not qualify for reimbursement under these programs.

The Commission recognizes the need for institutional care in many acute and chronic health cases but disagrees strongly with a system which lacks more appropriate alternatives and which actually has built-in disincentives to such programs.

The following Commission recommendations are proposed in an effort to assure quality care for the elderly which is best suited to their individual needs. It is the Commission's belief that these recommendations will demonstrate the need for viable alternatives to institutionalization and will provide the necessary initial incentives for development and expansion of such alternatives.

RECOMMENDATIONS

Supplemental Security Income

The Commission recommends that the Department of Welfare submit a report to the General Assembly on the status of the SSI recipient in Virginia to include the number of persons receiving such payment, the number of new recipients expected to be added to the rolls, and the average standard of living of Virginia's SSI recipient. The Commission also requests that this report include a recommendation, supported by sufficient cost data, for State assistance to recipients of SSI.

The federal SSI assistance program supplements the incomes of aged, blind and disabled persons, whose incomes are below the guaranteed income floor level of $177.80 per month for an individual and $266.70 per month for a couple. The average monthly participation in the SSI program in Virginia is approximately 87,800, of which cases 55 percent are elderly and 45 percent blind or disabled. The average federal SSI payment in Virginia to an elderly person is $72.00. The State presently provides additional supplementation only for previous Old Age Assistance recipients who would have received less under SSI than they were receiving from the Old Age Assistance program, and for SSI recipients in domiciliary care. Computed annually, these SSI payments put individuals and couples in the program well below the poverty level.

Twenty-three states currently supplement SSI payments to individuals and couples and the Commission, recognizing that many existing problems of the elderly and the blind and disabled are compounded when they are forced to live on such low incomes, believes that it is time that Virginia take a step toward relieving a small part of the burden on these citizens. [See Appendices D and E.]

General Medical Clinics

To promote better health care and an early diagnosis of potential health problems, the Commission recommends that the Health Department set up a task force to conduct a feasibility and cost study relative to the establishment of a system of statewide general medical clinics for the elderly.

According to the Health Department, a number of simple screening tests for such conditions as glaucoma, diabetes, hypertension, cancer of the cervix and breast, deafness and dental conditions could easily and quickly be performed. Diabetes and hypertension represent one-half of the chronic

conditions in the country today.

Often the elderly are forced to seek treatment after development of an acute condition, as payment assistance is severely lacking for preventive health care.

The present cost of operating a community clinic is approximately $29.00 per hour. Although screening would not be considered a complete physical examination, the number of conditions which could be diagnosed would certainly be significant in terms of prevention and early care, eliminating some of the need for many elderly to be housed in costly and restrictive institutions.

Geriatric Training

Geriatric training in medical schools has traditionally been lacking, although the elderly comprise approximately 13 percent of the total population and have unique problems directly related to age which justify the need for specialized training of health care and related personnel.

The University of Virginia Medical School, as of July 1, 1977, has established a Division of Geriatrics within its Department of Internal Medicine and sees the Division as growing to include training for all geriatric workers as well as the residents and interns who receive instruction in the present program. The Commissin applauds this innovative effort at the University of Virginia in geriatric training.

According to a Medical College of Virginia spokesman, the study of medical problems associated with aging is integrated into all fields rather than one particular field of medical study at the Medical College of Virginia.

The Eastern Virginia Medical School has no plans for a specific geriatric program and informed the Commission that the study of medical problems of the elderly is integrated into all the fields of medical study.

Home Health Care

The Commission recommends that an additional one million dollars be added to the Health Department's budget for the upcoming biennium for the delivery of home health services.

One of the most basic desires of an elderly person is to be able to maintain himself or herself in his or her own home. Often a person is forced to leave home because it has become too much of a burden to perform the small tasks required in home maintenance or because limited health assistance is required. According to a statement from the United States Senate Special Committee on Aging "... Medicare and Medicaid have actually fashioned serious roadblocks to the development of such [home health] services."[5] As previously noted, Medicare limits the number of days of home health care one may receive and also only reimburses for services provided by a licensed agency. Home services for full-time nursing

care, drugs and homemaker services are not covered.

Old Folks at Homes , a 1976 Joint Information Services Report, points out that, to some extent, placement in an institution is determined by ambulation and continence [of bowl and bladder], and notes that persons in this category, although they could be assisted by unskilled and semi-skilled personnel, must often be placed in a skilled facility in order to receive reimbursements.[6]

As has been shown, reimbursement for institutional care is much more readily available than it is for home care, even though the cost for care in a skilled nursing facility in Virginia, for example, is $1,290 per month per patient and $870 per month per patient in an intermediate care facility. The State, as of October 1, 1977, will be responsible for 43 percent of such costs, which will amount to $554.70 per month per patient in a SNF and $374.10 per month per patient in an ICF.

The Health Department currently operates a home health care program which they estimate meets approximately 35 percent of the State's needs in this area. The average cost per home health visit is $22.00, 85 percent of which is reimbursible from Medicare, Medicaid, Title XX and other third party payments. The total cost of providing home health services in the fiscal year 1976-1977 is estimated to be $3,753,600, with revenues estimated at $3,264,000. The State-local cooperative budget is then responsible for the difference which is $489,000 (60 percent State share, 40 percent local share).

A 1974 report by the Bureau of Home Health Services of the Department of Health revealed that over a three month period in 1974, the home health program saved an estimated 5,977 hospital days and an estimated 6,043 nursing home days. Computing a hospital bed to be $100 per day and a nursing home bed to be $30 per day, the study showed that a total of $781,990 was saved. The cost of providing the home health services to the 552 patients served was $253,920 resulting in a net saving of $528,070. [See Appendix F.]

The Commission feels strongly that expansion of Virginia's home health program is justified and important not only for elderly citizens but for the individual taxpayer as well. For the purpose of expanding home health services the Commission recommends that one-half million dollars be allocated to the Health Department in each year of the biennium. Currently, the Department of Health requires additional personnel in order to step up the home health services program. Each home health patient requires on the average 56.8 hours of nursing time per year for treatment, records assessment, and committee meetings to determine patient care procedure. Annually, one nurse can handle approximately 31 patients. If the one-half million were used to hire an additional 43 nurses throughout the State, an additional 1,300 new patients could be served in home health care. Since administration and oversight of such a program is a large and time consuming responsibility, the Commission recommends that a certain portion of the allocation be spent in this area. Also, in view of the fact that the State presently employs only one nurse consultant in geriatrics who

is responsible for the entire State in this field, the Commission recommends that another such position be created with these funds.

The allocation of the one-half million for each year of the biennium should be as a special project grant to the Health Department from which it will flow directly to localities based on need and accountability. It is recommended that the funds be used for expansion of personnel positions. Once the personnel positions are built up to an appropriate level, it is recommended that reassessment of the areas of need in the home health program for future funds be undertaken. It is the Commission's feeling that such an allocation for expansion of home health services be one in which continued funding could be anticipated by the Health Department.

The Commission also recommends that the Department of Health submit quarterly reports to the legislature accounting for the allocated funds in terms of expansion of the home health program.

Homemaker - Home Health Aide Program

The Commission recommends that a joint task force of the Department of Health and the Department of Welfare be established to study the feasibility of creating the position of homemaker - home health aide in order to allow one person to perform both light homemaker services and limited health related services. Reimbursement sources for such a position, such as Medicare and Medicaid, should be thoroughly investigated.

Since many elderly persons in their own homes require both homemaker and simple health related services, it appears that it would be more economically feasible to have both services performed by one person.

Optional Uniform Licensure Standards

The Commission briefly looked at the need for optional licensing and regulation of home health delivery agencies. Since a subcommittee of the House Committee on Health, Welfare and Institutions is currently involved in a more detailed study of such licensure, the Commission has no specific legislative requests to offer in this area.

Presently, the State does not license non-institutionally based private health care delivery agencies. Many such organizations, realizing the importance of professional delivery of home health services, have requested such licensure and would have to be licensed to qualify for Medicare-Medicaid reimbursement. The Commission believes that the licensing of health care delivery agencies would serve to promote professional and cost accountable delivery of home health services to the citizens of the Commonwealth.

Day Care

The Commission recommends that a study be made by the Health Department to determine the feasibility of providing Medicaid reimbursement for day care operations in nursing homes. Day care for

those elderly requiring some daily supervision while living alone or with working relatives or friends would allow many elderly to remain in a home situation. Since nursing homes have existing capabilities to provide medical back-up and food preparation sites, among many other services, it appears to the Commission that a day care component in nursing homes would be the most practical and economical.

Due to the lack of third party payment sources for such day care components in nursing homes, few such facilities have been established. According to the Department of Health, the Medical Assistance Program has been unable to consider such additional services due to budget limitations but is prepared to consider reimbursement for the medical and nursing components of day care facilities associated with nursing homes.

The Virginia Health Care Association endorses a program of day care in combination with nursing home operations. The Commission feels that Virginia is fortunate that our nursing homes realize the importance of day care to the elderly and are not so institutionally biased as to oppose such a non-institutional alternative program.

Homes for Adults

The Commission endorses and recommends passage of that part of the biennial budget request of the Department of Welfare which would increase payments to eligible recipients in homes for adults from the present maximum of $230 per month to a maximum of $336 per month. As is the present policy in the Department of Welfare, domiciliary care facilities would be required to justify their costs, and payments to the individual residents would be made on that basis. Individual payments at the maximum allowable would compute to $10.30 per day. When contrasted with the 1978 projected SNF and ICF costs per patient day, $42.33 and $28.70, respectively, the obvious cost benefits are quite significant.

In order to supplement payments up to $336 per month to the approximately 1,200 recipients qualifying for assistance, the Department of Welfare has requested the sum of $4,713,500.00, with the funding responsibility being shared 62 1/2 percent State and 37 1/2 percent local. The federal program contributes an amount which would bring the individual's income up to $177.80; the maximum State responsibility per individual would be $98.88 and the maximum local responsibility would be $59.32 if supplementation is increased up to $336.00 per month.

Many homes for adults, which house approximately 9,000 elderly, are unable to maintain recipients at the present low reimbursement rate of $230 per month maximum, as their costs far exceed such payments. Without this justified increase, more and more homes will be forced to turn people away and may face the possibility of closing. This has already occurred in several instances. Homes for adults meet a very specific need for those elderly not requiring extensive and expensive health care, and it is the recommendation of the Commission that this less costly alternative to nursing home care be supported and realistically funded.

Pre-Screening

The Commission recommends that pre-screening be continued to be required for Medicaid nursing home admissions and that it further be expanded to include those admissions from State hospitals. Such pre-screening should also be available to non-Medicaid patients. A recent publication of the American Psychiatric Institute and the National Association for Mental Health revealed the importance of screening patients in health care facilities, stating that, "... we were inclined to feel that some proportion of the people we saw both in nursing homes and in board-and-care homes would have done well at one lesser level of placement."[7]

The Health Department now operates a new and innovative pre-screening program in which Medicaid and potential Medicaid nursing home admissions are screened by a team, consisting of a public health nurse, a physician, and a social worker. Each local team reviews the potential patient's records and family associations and recommends appropriate placement. All cases in this program are subject to close follow-up. Those Medicaid admissions presently screened do not include admissions directly from hospitals, although the Department plans to expand the program to include screening of such admissions. The Commission recommends that hospital admission screening be included in the mandatory screening process as soon as possible.

The pre-screening program in the Department of Health began as a pilot project conducted in four areas of the State--Loudoun - 4 screened, all approved for nursing home placement; Alexandria - 11 screened, 10 approved, 1 diverted to alternative placement; Roanoke - 30 screened, 24 approved, 6 diverted; Richmond - 122 screened, 85 approved, 37 diverted. Review of these statistics led the Department of Health to project that if such a program were undertaken throughout the State, over five million dollars, approximately two million of which would be State funds, could be saved in diverting approximately 25 percent of possible nursing home admissions to alternative placements such as homes for adults, mental health facilities, alcohol treatment centers, day care centers, and home health and chore programs.

Since the program has been expanded statewide, the Department of Health has documented very favorable results. [See Appendix G.] From May to August of 1977, 439 possible admissions were screened; 338 were approved for nursing home admission, 101 were recommended for alternative placement, resulting in an overall 23 percent diversion rate. This quarterly screening resulted in an overall savings of $200,000.00 and the Department of Health estimates that the program could save the State over two million dollars annually if further expanded. Without such pre-screening all of the 439 possible admissions would have been approved for placement in a nursing home.

Not only has the pre-screening program documented the savings which can and do result from such screening but it has also revealed that a number of institutional placements are inappropriate.

The Commission wishes to recognize the excellent work of the Health Department in their pre-screening program and believes that the initial findings revealed in the study more than justify expansion of the program.

Geriatric Facilities in State Hospitals

The Commission encourages the Department of Mental Health and Mental Retardation to continue full use of geriatric services units in their hospitals. In this era of "de-institutionalization" it is easy to lose sight of the fact that some elderly persons receive the most appropriate, least restrictive care in an institutional setting. It is the Commission's hope that the careful patient screening for entrance of patients by the Department of Mental Health and Mental Retardation will continue and that those elderly who need the special services offered in the institution will be allowed to remain.

The Commission is concerned that follow-up on discharged patients is not as complete as it should be and recommends that the Department's follow-up program be expanded. As previously stated in the report, the Commission has recommended that patients going from State hospitals to nursing homes be carefully screened.

Mental Health Services in Nursing Homes

The Commission recommends that more mental health services be made available in nursing homes.

The most recent report of the Office on Aging revealed that the elderly are definitely an "at risk" group for mental health problems which are most often brought on by conditions such as death of a loved one, loss of employment through retirement, changes in bodily appearance, loss of sensory abilities and a lowered standard of living.[8]

It has been brought to the attention of the Commission that, in order to recognize and treat those patients in need of mental health counseling, nursing homes should employ geriatric social workers to work with the residents and should make more professional psychiatric services available. The report Old Folks at Homes revealed that, "The heavy use of major tranquilizers in nursing homes was manifest [56% of patients in SNF, 39% in ICF] ... and used mainly for their tranquilizing properties. A much smaller percentage of nursing home residents receive anti-depressant medication [12% SNF; 19% ICF] ... and anti-depressant medication is being underutilized ...."[9]

The Commission recommends that nursing homes and local mental health services organizations form contractual arrangements for the delivery of mental health services in nursing homes. Presently only two percent of mental health services offered in communities go toward treatment for the elderly, although they require such services greatly, having a 15 percent prevalence rate for mental illness (as established by the Department of Mental Health and Mental Retardation).[10]

State Center for Aging

The Commission recommends that a State Center on Aging be established at Virginia Commonwealth University. A budget of $211,045 for the upcoming biennium has been requested by Virginia Commonwealth University for staffing and support services for such a Center. The Commission supports this budget request and recommends that it be accepted.

The State Center on Aging would be an information and knowledge source which would be available to all who needed it. Currently, information about the aged population is available based only on national census data and estimates. There is little accurate and relevant data available which directly relates to the elderly in Virginia. Such a Center would provide this and other vitally necessary information.

The Commission recommends that an Advisory Board be established for the Center and include representatives from the various public agencies involved with research and services to the elderly, and representatives from each of the six regional Higher Educational Consortia. Also, at least five representatives from the general public should be members of the Board.

The Advisory Board for the State Center on Aging should meet at least three times a year to review the budget and program development of the Center and report directly to the Office on Aging and the General Assembly.

Office on Aging

The Commission commends the excellent work of the Office on Aging both for the elderly of Virginia and the State as a whole, and is most appreciative of the assistance the Office has given the Commission in its study of the needs of elderly Virginians.

Since its inception in 1974, the program responsibilities of the Office on Aging have greatly increased and the amount of funds it is responsible for administering has doubled. For fiscal year 1978, the total budget for the Office will be over eight million dollars, $7,177,585 of which is federal, $799,782 of which is local and $138,315 of which is State. [See Appendix I.] The Office on Aging has twenty-one full-time staff positions, the same number of positions established when the Office was created.

Since 1975 the budget of the Office has increased from $3,476,489 to $8,115,692 for 1978. With increased funding, responsibilities in planning, delivery and administration have grown. The Commission, realizing the importance of the work of the Office and its escalating responsibilities, is concerned that monetary incentives for personnel to remain with such a State office are lacking. Virginia's personnel system determines agency salaries according to the number of personnel supervised. With twenty-one people on staff, the Office on Aging is considered a small agency, although it carries aging responsibilities across many lines and handles a large

amount of aging funds. Since those on staff are only credited with those working directly under them, their "number of personnel supervised" is necessarily small. Unfortunately, this results in salaries that are inconsistently low in comparison with the responsibilities and professional ability required for the jobs. Along with the Office, the Commission is concerned that valuable personnel will be lost, as is presently the case to some extent; and, therefore, recommends that the personnel system in Virginia be examined and changed to reflect a more equitable and representative salary structure.

Beginning in 1978, the Office on Aging will be responsible for submitting a Proposed State Plan for Services every two years. In order to prepare this plan, the Office on Aging must study and investigate and evaluate services and facilities provided for the elderly citizens in Virginia and those services not provided for but needed by the elderly. Currently, twenty-five departments, councils, commissions or other units have responsibilities for some aging program. [See Appendix H.]

It is the Commission's recommendation that the Office on Aging be granted, legislatively, the power to review and comment upon the proposed aging budgets of all agencies responsible for any aging programs. Since the Office on Aging must report on the overall plan of the State toward aging services, it would be in the best position to make recommendations concerning the entire State aging budget. The Office is now charged with making such recommendations in regard to the expenditure of State funds for aging, and it should have access beforehand to the entire proposed aging budget. The Commission feels that allowing the Office on Aging such budget review and comment would be of great benefit to the State.

Legislative Oversight

The Commission believes that legislative oversight of aging proposals is imperative and, therefore, recommends that a legislative Subcommittee on Aging be established by the General Assembly. The Subcommittee should be comprised of members of the House of Delegates Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and should review and make recommendations concerning all aging legislation. The Subcommittee should also receive and study reports of the Office on Aging, and all other reports from task forces and special boards and commissions requested by the legislature to conduct studies which would affect the elderly.

Legislative oversight and review are essential components in the process of assuring the elderly of having the best programs made available to them, and assuring the public of accountability for such programs by its elected representatives.

Respectfully submitted,

Mary A. Marshall, Chairman

Orby L. Cantrell, Vice Chairman

John C. Buchanan

Howard C. Cobbs

*J. Marshall Coleman

Franklin P. Hall

George H. Heilig, Jr.

Edward M. Holland

Thomas J. Michie, Jr.

Bernard R. Mullady

**Frank M. Slayton

**C. Jefferson Stafford

T. Preston Turner

Stanley C. Walker

*Mr. Coleman did not participate in the formulation of this report and has not endorsed its contents.

**Dissents of Mr. Slayton and Mr. Stafford can be found in Appendix A.

FOOTNOTES

1. Virginia's Direction in Aging ... A Timely Matter , Virginia Office on Aging, 1976, p. 31.

2. Ibid., p. 31.

3. Ibid., p. 220.

4. Alternatives to Institutionalization , Michigan Office of Services to the Aging, 1976, p. 4.

5. Ibid., p. 4.

6. Old Folks at Homes , 1976, Joint Information Services of the American Psychiatric Institute and the National Association for Mental Health, p. 76.

7. Ibid., p. 69.

8. Virginia's Direction in Aging ... A Timely Matter , Virginia Office on Aging, 1976, p. 18.

9. Old Folks at Homes , 1976, Joint Information Services of the American Psychiatric Institute and the National Association for Mental Health, p. 74.

10. Virginia's Direction in Aging ... A Timely Matter , Virginia Office on Aging, 1976, p. 118.

APPENDICES

APPENDIX A

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

October 4, 1977

Mrs. Bet H. Neale, Consultant
Commission on the Needs of
Elderly Virginians
Division of Legislative Services
P. O. Box 3-AG
Richmond, Virginia 23208

Dear Bet:

I have read the report and the various attachments very carefully and commend you for a job well done.

It seems to me that you have successfully put together a report which reflects accurately the requests made of you by various members of the Commission and, although some of the requests were detached in some part from the deliberations of the Commission, you have succeeded in compiling a document that reads smoothly, although the requests to you were perhaps at times disjointed.

Having made those observations, however, it does not follow that I can support the recommendations which the report is making on behalf of the Commission. Although I am reluctant to state those objections I feel that my position as a member of the Committee on Health, Welfare and Institutions, as well as Appropriations, causes me to make certain comments reserving judgment in some instances, until the legislative package has been drawn, and, in a few instances, to raise certain objections which I find fundamental to the proposals contained in the draft.

These comments are not intended to be critical of the overall efforts of the Commission, because my experience has been such as to convince me that this Commission is composed of outstanding citizens of the Commonwealth, all of whom are dedicated to arriving at recommendations which, if adopted by the General Assembly, would result in the overall improvement of the lot of senior citizens of the Commonwealth.

I should also like to observe that the experience which I have personnaly gained from service on this Commission has caused me to have an entirely different perspective with regard to this group of

our citizens and has made me realize that any effort on the part of any governmental agency to deal with elderly Virginians as a group tends to stigmatize all senior citizens. This is certainly an undesirable result and one which serves no useful purpose.

The study has pointed out that as in all other age groups a general statement with regard to that particular group does not apply to all of the individuals within that category.

It is within that context that I have attempted to formulate my position with regard to this final report by the Commission on the Needs of Elderly Virginians.

I subscribe to the principle that if at all possible we should do more to support the participants in the SSI programs in Virginia, but I feel that it would be cruel to offer the false hopes that additional funds would be forthcoming until we know for certain that those funds would be available.

Home Health Care - Inasmuch as certain data has come to my attention which indicates to me that the Health Department has not performed the various tasks assigned to it by the General Assembly in an appropriate manner, I am at this time reluctant to concur in any recommendation which will add any additional funds such as the $1 million suggested appropriation to the Department's budget. It is my personal feeling that the General Assembly should take a detailed and in-depth look into the State Health Department before conferring any additional responsibilities or appropriating substantial additional funds to its progroms and operations.

Homemaker - Home Health Aide Program - I concur with the comments made in this paragraph regarding a thorough investigation and study into the feasibility of these two agencies performing homemaker services as needed to our senior citizens.

Day Care, Home for Adults, Pre-Screening, Geriatric Facilities in State Hospitals, Mental Health Services in Nursing Homes are all subjects which have been addressed by this Commission and touch on programs that have been conducted by the Health Department in various areas of the State at different times. They do not reflect any continuum of treatment or expansion of existing programs, but rather reflect an idea that seems to have caught on in the minds of a few people.

While these comments are not intended to be critical of any particular individuals or group, it does seem to me that a repetition of observations of this kind only encourage expectations which the federal, state and local governments are not prepared to fulfill.

Virginia Center on Aging - I generally support the creation of a Virginia Center on Aging, and the concept that it would function for the purpose of gathering information and serving as a resource as well as a research center for the institutions of higher learning throughout the Commonwealth.

The Advisory Board suggested on Pages 19 and 20 would, I am afraid, result in the destruction of this center as I had initially conceived it.

It would appear to me that it would be more appropriate if the Advisory Board consisted of faculty members from the medical schools and the colleges and universities from around the State.

I do not believe that personnel from State agencies. i.e.; Health and Mental Health, should serve on this Board because it was my feeling that this center was to be oriented toward education and research and that it would not be in the business of providing services to the average citizen in the community.

I also feel that membership on the Advisory Board from the colleges and universities should not be limited to the state-supported institutions but should include representation from the private sector as well.

Legislative Oversight - The Committee on Health, Welfare and Institutions has within its jurisdiction the responsibility for programs which directly affect the needs of the senior citizens of Virginia. In my judgment no useful purpose would be served by establishing a joint subcommittee on a permanent basis from both Houses to carry out the function of legislative oversight.

With best wishes and kindest regards, I am

Yours very truly,

Frank M. Slayton

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

October 4, 1977

Mrs. Bet H. Neale, Consultant
Commission on the Needs of
Elderly Virginians
Division of Legislative Services
P. O. Box 3-AG
Richmond, Virginia 23208

Dear Bet:

I concur with the basic premises of the report dealing with the need for less costly and more appropriate alternatives to institutionalization; however, regarding a $1 million appropriation to the Health Department for expansion of home health care, I feel compelled to cite several reservations. I feel that the budgetary operations of the Health Department should be scrutinized carefully before additional funds are added to the existing budget. Also, it is doubtful to me how much $1 million could enhance the existing home health program.

Sincerely,

C. Jefferson Stafford

C. Jefferson Stafford

APPENDIX B

HOUSE JOINT RESOLUTION NO. 29

Requesting the Department of Welfare to submit a report to the General Assembly on the status of the Supplemental Security Income recipient in Virginia.

WHEREAS, aged, blind and disabled persons generally are unemployable and rarely possess any income producing assets; and

WHEREAS, the cost of living has risen dramatically in the last decade and costs are rising continually, particularly in the areas in which low-income persons spend the major portions of their incomes; and

WHEREAS, current federal Supplemental Security Income levels fall short of assuring even a "poverty level" income to many of Virginia's aged, blind and disabled citizens, and the pressures of existing on such a limited income often compound the problems of such persons; and

WHEREAS, Virginia currently provided no supplementation to federal Supplemental Security Income payments with only two minor exceptions: payments to previous Old Age Assistance recipients who would have received less money under the Supplemental Security Income program and payments to Supplemental Security Income recipients in domiciliary care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Welfare is requested to prepare and submit a report to the House of Delegates Committee on Health, Welfare and Institutions and to the Senate Committee on Education and Health detailing the status of the Supplemental Security Income recipient in Virginia.

The report shall include the number of persons receiving Supplemental Security Income payments, the number of new recipients expected to be added to the rolls during the 1978-1980 biennium and the average standard of living of recipients in Virginia.

In addition, the report shall include a recommendation, supported by sufficient cost data, for State assistance to recipients of Supplemental Security Income.

The Department of Welfare shall submit its report no later than December one, nineteen hundred seventy-eight.

HOUSE JOINT RESOLUTION NO. 33

Requesting the Department of Health and the Department of Welfare to establish a joint task force to study the feasibility of creating a homemaker-home health aide position.

WHEREAS, one of the most basic desires of an elderly person is to be able to maintain himself or herself in his or her own home; and

WHEREAS, often elderly persons are forced to leave home because they are unable to perform the small tasks required in home maintenance or because limited health assistance is required; and

WHEREAS, frequently, elderly persons who could be assisted by unskilled and semi-skilled personnel must be placed in a skilled nursing facility in order to receive financial assistance for such services; and

WHEREAS, many elderly persons in their own homes require both homemaker and simple health-related services, and one person could perform such services thereby maintaining the elderly person at home and providing a viable alternative to institutionalization; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health and the Department of Welfare are requested to establish a joint task force to study the feasibility of creating the position of homemaker-home health aide to allow one person to perform both light homemaker services and limited health-related services for the elderly person who wishes to remain at home. The task force shall investigate potential reimbursement sources, such as Medicare and Medicaid, for the position of homemaker-health aide.

The task force shall report its findings and recommendations to the House of Delegates Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health no later than December one, nineteen hundred seventy-eight.

HOUSE BILL NO. 503

A BILL to create a Virginia Center on Aging at Virginia Commonwealth University.

Be it enacted by the General Assembly of Virginia:

1. *§ 1. There is hereby created a Virginia Center on Aging to be located at Virginia Commonwealth University, hereinafter referred to as the Center, provided funds are appropriated by the General Assembly for this purpose.*

§ 2. The Center shall be an interdisciplinary study, research, information and resource facility for the Commonwealth of Virginia utilizing the full capabilities of faculty, staff, libraries, laboratories and clinics for the benefit of older Virginians and the expansion of knowledge pertaining to the aged and to the aging process.

§ 3. The Center shall be subject to the control and supervision of the board of visitors of Virginia Commonwealth University.

§ 4. The board of visitors of Virginia Commonwealth University shall appoint an executive director for the Center and a Central Advisory Committee.

§ 5. The executive director with the approval of the board of visitors of Virginia Commonwealth University shall have the following powers and duties:

A. Exercise all powers and perform all duties imposed upon him by law;

B. Carry out the specific duties imposed upon him by the board of visitors of Virginia Commonwealth University; and

C. Employ such personnel and contract for such services as may be required to carry out the purposes of this act.

§ 6. The Center, under the direction of the executive director, shall have the following powers and duties:

A. To develop and promote programs of continuing education and in-service training for persons who work with or provide services to the elderly;

B. To develop educational and training programs for persons sixty years of age and older to assist them in adjusting to the aging process to include, but not be limited to, the areas of retirement planning, health maintenance, employment opportunities, recreation and self-development;

C. To foster development of educational courses for students of higher education in disciplines other than gerontology to increase their

understanding of the process of aging in humans;

D. To conduct research in the field of gerontology and to make available the findings of such research to interested public and private agencies;

E. To collect and maintain data on the characteristics and conditions of persons over the age of sixty on a Statewide and regional basis and to make such data available to the State Office on Aging and to all organizations and State agencies involved in the planning for and delivery of services to such persons;

F. To coordinate the functions and services of the Center with those of the State Office on Aging in such a manner that the knowledge, education and research programs in the Center shall constitute a readily available resource for the planning and service implementation responsibilities of the State Office on Aging, and to do so in such a manner as to prevent any duplication of effort;

G. To apply for and accept grants from the United States government and the State government and agencies and instrumentalities thereof and from any other source in carrying out the purposes of this act. To these ends, the Center shall have the power to comply with conditions and execute such agreements as may be necessary;

H. To accept gifts, bequests and any other thing of value to be used for carrying out the purposes of this act;

I. To receive, administer and expend all funds and other assistance made available to the Center for the purposes of carrying out this act;

J. To do all other things necessary or convenient for the proper administration of this act.

HOUSE BILL NO. 259

A BILL to amend and reenact § 2.1-373 of the Code of Virginia, relating to duties of the Office on Aging.

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-373 of the Code of Virginia is amended and reenacted as follows:

§ 2.1-373. Powers and duties of Office with respect to aging persons; area agencies on aging; advisory board.—(a) The Office shall have the following duties with respect to the following:

(1) To study the economic and physical condition of the residents in the Commonwealth whose age qualifies them for coverage under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, hereinafter referred to as the aging, and the employment, medical, educational, recreational and housing facilities available to them, with the view of determining the needs and problems of such persons;

(2) To determine the services and facilities, private and governmental and State and local, provided for and available to the aging and to recommend to the appropriate person or persons such coordination of and changes in such services and facilities as will make them of greater benefit to the aging and more responsive to their needs;

(3) To act as the single State agency, under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, and as the sole agency for administering or supervising the administration of such plans as may be adopted in accordance with the provisions of such law or laws. As such agency, the Office shall have authority to prepare, submit and carry out State plans and shall be the agency primarily responsible for coordinating State programs and activities related to the purposes of, or undertaken under, such plans or laws;

(4) With the approval of the Governor, to apply for and expend such grants, gifts or bequests from any source as may become available in connection with its duties under this section, and is authorized to comply with such conditions and requirements as may be imposed in connection therewith;

(5) To hold such hearings and conduct such investigations as are necessary to pass upon applications for approval of a project under the plans and laws set out in (3) hereof, and shall make such reports to the Secretary of the United States Department of Health, Education and Welfare as may be required;

(6) All agencies of the State shall assist the Office in effectuating its functions in accordance with its designation as the single State agency

under the laws set out in (3) and (8) hereof;

(7) To designate area agencies on aging pursuant to Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States and to promulgate rules and regulations for the composition and operation of such area agencies on aging;

(8) To develop biennially a proposed State plan for the services provided by State agencies to the elderly of the Commonwealth and to report on such plan to the Governor and General Assembly commencing on September one, nineteen hundred seventy-eight ;

(9) To review, in conjunction with the Department of Planning and Budget, the proposed programs and budgets of State agencies delivering services to the aging and to make recommendations to the appropriate agencies and Secretaries of the Governor and to the Governor concerning those items which affect the aging .

(b) The governing body of any county, city or town may appropriate funds for support of area agencies on aging designated pursuant to subsection (a) (7) hereof.

(c) The Governor is authorized to select such persons as may be qualified, as an advisory board, to assist the Office in the performance of the duties imposed upon it herein.

SENATE JOINT RESOLUTION NO. 81

Requesting the Senate Committee on Education and Health and the House of Delegates Committee on Health, Welfare and Institutions to appoint a Joint Subcommittee on Aging.

WHEREAS, the Commission on the Needs of Elderly Virginians was created in nineteen hundred seventy-three to identify and study the existing needs and potential problems facing Virginia's elderly citizens; and

WHEREAS, the Commission concluded its study in nineteen hundred seventy-seven stipulating that legislative oversight of all proposals affecting elderly Virginians is imperative to assure the progressive availability of optimum quality programs for the elderly and to assure the public accountability for such programs by the elected representatives; and

WHEREAS, the Commission has recommended that a subcommittee be established to review and to make recommendations concerning all legislation affecting elderly Virginians and that, in addition, the Subcommittee should receive and study reports of the Office on Aging and all other reports from task forces and special boards and commissions requested by the legislature to study issues affecting the elderly; now, therefore, be it

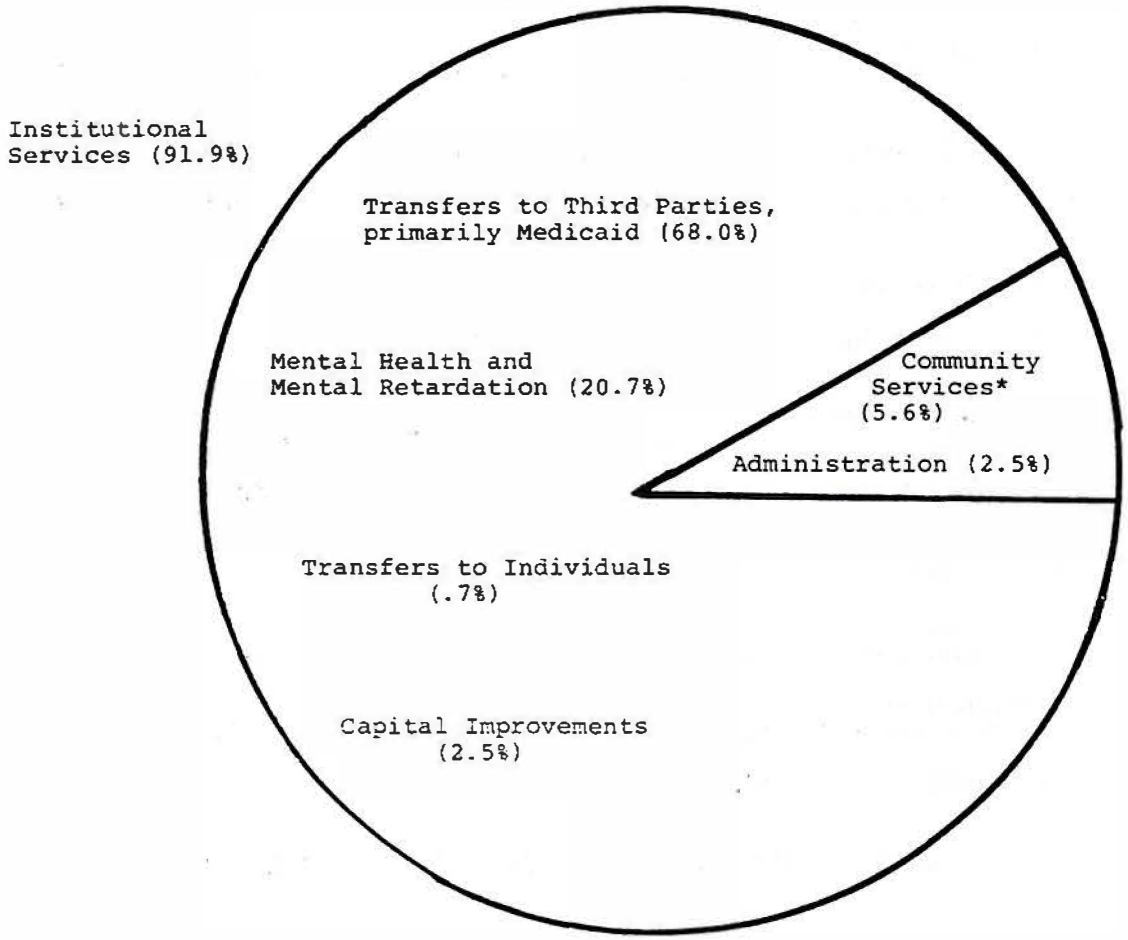
RESOLVED by the Senate, the House of Delegates concurring, That the chairman of the Senate Committee on Education and Health and the chairman of the House of Delegates Committee on Health, Welfare and Institutions are requested to appoint from the membership thereof, a joint subcommittee to be known as the Joint Subcommittee on Aging.

The Joint Subcommittee on Aging shall be primarily responsible for legislative oversight of all proposals affecting Virginia's elderly citizens. The Joint Subcommittee shall receive and study all reports of the Office on Aging. The Joint Subcommittee shall monitor other programs affecting the elderly including the pre-screening program for hospital and institutional admissions, transportation for the elderly, assuring adequate matching funds for federal programs to benefit the elderly and assuring the availability of educational opportunities for elderly Virginians.

The Joint Subcommittee shall make such recommendations as it deems appropriate to the Governor and the nineteen hundred seventy-nine and nineteen hundred eighty Sessions of the General Assembly.

APPENDIX C

AGING BUDGET ALLOCATION, 1976-1978



*Excludes Title XX funds subsequently estimated at $20,000,000 biennium or an additional 5% of revised aging budget. "Community Services" therefore would be 10-11% of actual cost.

TABLE 1. AGING BUDGET

CATEGORY	GENERAL FUND	SPECIAL FUND	TOTAL AMOUNT	% OF TOTAL AMOUNT
I. DIRECT SERVICES				
Community Services	$ 4,453,022	$ 11,452,677	$ 15,905,699	5.6%
Institutional Services	29,739,632	29,269,295	59,008,927	20.7%
Capital Improvements	7,264,330	0	7,264,330	2.5%
TOTAL DIRECT SERVICES	41,456,984	40,721,972	82,178,956	28.8%
II. ADMINISTRATION				
Full-time on Aging Services	222,800	518,410	741,210	.3%
Part-time on Aging Services	3,089,147	3,194,061	6,283,208	2.2%
TOTAL ADMINISTRATION	3,311,947	3,712,471	7,024,418	2.5%
II . TRANSFERS				
Transfers to Individuals	2,085,736	0	2,085,736	.7%
Transfers to Third Parties	86,136,642	107,976,174	194,112,816	68.0%
TOTAL TRANSFERS	88,222,378	107,976,174	196,198,552	68.7%
TOTAL AGING BUDGET	$132,991,309	$152,410,617	$285,401,926	100.0%

TABLE 2. AGING BUDGET BY AGENCY

AGENCY	GENERAL FUND	(% OF TOTAL GENERAL FUND)	SPECIAL FUND	(% OF TOTAL SPECIAL FUND)	TOTAL	(% OF TOTA AGING BUDG
Department of Health	$ 88,485,062	(66.5%)	$107,976,176	(70.8%)	$196,461,238	(68.8%)
Department of Mental Health and Mental Retardation	39,482,985	(29.7%)	29,804,915	(19.6%)	69,287,900	(24.3%)
Virginia Office on Aging	272,800	(.2%)	10,765,625	(7.1%)	11,038,425	(3.9%)
Department of Welfare	2,422,443	(1.8%)	2,437,461	(1.6%)	4,859,904	(1.7%)
Division of War Veteran's Claims	1,232,704	(.9%)	0	(0)	1,232,704	(.4%)
Commission for the Visually Handicapped	481,768	(.4%)	479,806	(.3%)	961,574	(.3%)
Virginia Employment Commission	0	(0)	756,600	(.5%)	756,600	(.3%)
Department of Accounts	358,785	(.3%)	0	(0)	358,785	(.1%)
Home for Needy Confederate Women	250,000	(.2%)	0	(0)	250,000	(.1%)
Board of Education	4,762	(0)	190,036	(.1%)	194,798	(.1%)
TOTAL	$132,991,309	(100.0%)	$152,410,619	(100.0%)	$285,401,928	(100.0%)

APPENDIX D

ALTERNATIVE PROPOSALS FOR SSI SUPPLEMENTATION TO AGED, BLIND, DISABLED

Presented to

Economic Security Resource Allocation Panel

April 8, 1977

Prepared by

Virginia Office on Aging

Contents

I. The Problem

General. Aged, blind and disabled persons generally do not have adequate access to the major income producing resource--employment. Further, for many of them their income producing assets are few, if existing at all.

At the same time, costs of living are rising--particularly in the areas in which low-income persons spend the major portions of their incomes.

Current SSI levels for these groups fall well short of assuring even a "poverty level" income. Virginia provides no supplementation to federal SSI payments with two minor exceptions--"holdover" Old Age Assistance recipients who would otherwise have received diminished payments when SSI was begun in January, 1974, and SSI participants who reside in domiciliary care.

Target Population. An estimated 109,500 elderly persons (65+) are living with below poverty level incomes. Similar estimates for disabled and blind persons were not obtained.

For purposes of this report, the target population was estimated by increasing current SSI cases by 800 cases per month without allocating these cases to the aged blind and disabled categories.

Cost of Living. The cost of living has risen dramatically in the last ten years--and particularly in those areas which account for most of the disposable income available to low-income groups.

Table 1 identifies consumer price index rises and the allocation of a retired couple's income to certain expenditures. Note that the areas of housing, food, and health are critical spending areas, and also the same areas with most rapid cost increases.

II. Current Economic Security Program in Virginia - Supplemental Security Income (SSI)

Eligibility. Aged, blind and disabled Virginians are eligible for federal SSI payments if they qualify according to the definitions and limitations established by the federal government. There are limits on income and resources. Table 2 summarizes Basic Eligibility Conditions.

Current Participation and Projections for 1978-80. Current (September, 1976) participation of Virginians in the SSI program is as follows:

Category	SSI Participants
Aged	42,393
Blind	1,421
Disabled	34,469
TOTAL	78,283

Table 1. Consumer Price Index and Use of Disposable Income By a Retired Couple on a Lower Budget

	Type of Expenditure									
	All Items	Medical Care	Food	Apparel & Upkeep	Housing	Transportation	Personal Care	Reading & Recreation	Other	All Services
Consumer Price Index, 3/77 (1967=100)	174.3	192.3	181.7	151.8	181.6	171.4	165.2	154.4	155.1	185.8
% of Disposable Income Used By Retired Couple on Lower Budget	-	13	32	5	33	6	3	-	8	-

Sources: U.S. Department of Health, Education and Welfare, Social Security Bulletin, March, 1977.

U.S. Department of Labor, Bureau of Labor Statistics, Monthly Labor Review, October, 1975.

Table 2. Basic Eligibility Conditions

Aged	65 or over
Blind	Vision no better than 20/200 even with glasses or tunnel vision (limited visual field of 20 degrees or less)
Disabled	A physical or mental impairment which prevents a person from doing any substantial work and which is expected to last at least 12 months or result in death
Income	Below $167.70 a month for an individual $251.80 for a couple

(A person may have income above these levels and possibly be eligible for a State supplement only, but the income levels vary with each State.)

(Not counting $20 a month of unearned income and $65 plus half of remainder of earned income)

Resources	$1,500 for an individual $2,250 for a couple

(Not counting a home, car, personal effects, household goods of reasonable value)

Source: U.S. Department of Health, Education and Welfare, Social Security Administration, A Guide to Supplemental Security Income, DHEW Publication No. 75-11015, July, 1975.

Assuming an increase of 800 persons per month in the program (in all categories combined) we can estimate an average monthly participation in the 1978-80 biennium to be 87,883 persons with total enrollment at the end of the biennium to be 97,483.

Payment Levels.

Federal. Current federal payment levels (April, 1977) guarantee a floor of $167.80 for individuals and $251.80 for couples. Annualized, the figures represent $2,013.60 for individuals and $3,021.60 for couples.

These annual figures may be compared with poverty levels established by the Community Services Administration in December, 1975 of $2,640.00 for an individual and $3,475.00 for a couple. More current poverty levels would obviously result in an even greater discrepancy between federal income floors and incomes needed to enable persons to live at even the poverty income line.

While the federally established "floors" are $167.80 and $251.80, actual average monthly payments to individuals and couples are much lower (approximately $92.00 per person).

State. State payments are of two types: 1) payments to keep former Old Age Assistance and Disability recipients at their pre-1974 levels (these payments are mandatory) and 2) supplementary payments for SSI recipients who are in domiciliary care (these payments are optional).

In January, 1977, 1,887 people were in these two categories with approximately 1,707 of them in the second category. The Department of Welfare and the Virginia Commission for the Visually Handicapped combined budgets in these categories for the current biennium is approximately $3 million (entitled "Auxiliary Grants" in budget).

Because the numbers of "holdovers" are so small, and will decrease further, they receive no special budget consideration in this report.

Supplementary payments for residents of domiciliary care facilities are discussed in Section V.

III. SSI Supplementation in Other States

As of August, 1976, twenty-three (23) states provided some supplement to SSI recipients who lived independently. Table 3 identifies those states and the payment level to which they supplement. The amount of supplementation varies from $2.20 per month per individual (New Hampshire) to $114.61 per month per individual (Massachusetts).

Several states offer different payment levels for aged, blind, and disabled; some (like Virginia) supplement only for persons not living independently; and at least two have supplements which vary by region of the state.

Table 3. State Payment Levels and State Supplementation for Aged,* Effective July 1, 1976**

State	State Payment Level		State Supplemental Payments	
	Individual	Couple	Individual	Couple
Alaska	270.00	405.00	102.20	153.20
California	276.00	522.00	108.20	270.20
Colorado	201.00	402.00	33.20	150.20
Connecticut	256.00		88.20	60.20
Hawaii	183.00	276.00	15.20	24.20
Idaho	231.00	302.00	63.20	50.20
Illinois	175.00	251.80	7.20	None
Maine	177.80	266.80	10.00	15.00
Massachusetts	282.41	430.00	114.61	178.20
Michigan	192.10	288.20	24.30	36.40
Minnesota	196.00	289.00	28.20	37.20
Nebraska	233.00	326.00	65.20	74.20
Nevada	202.75	323.00	34.95	71.20
New Hampshire	170.00	251.80	2.20	None
New Jersey	190.00	262.00	22.20	10.20
New York	228.65	327.74	60.85	75.94
Oklahoma	189.70	300.60	21.90	48.80
Oregon	179.80	261.80	12.00	10.00
Pennsylvania	200.20	300.50	32.40	48.70
Rhode Island	199.24	311.12	31.44	59.32
Vermont	(varies from place to place, but al areas have supplement)			

*Payment levels for blind and disabled are the same in all states except Alabama, California, Colorado, Delaware, Indiana, Iowa, Massachusetts, Nevada, Nor h Carolina, Ohio, Oregon, South Carolina, Utah, and Wisconsin

**For persons or individuals living independently. Many states offer different supplements to residents of nursing homes, domiciliary care, foster homes, etc.

Table 3. (Conto.)

State	State Payment Level		State Supplemental Payments	
	Individual	Couple	Individual	Couple
Washington	(varies from place to place, but all areas have supplement)			
Wisconsin	234.00	351.00	66.20	99.20
All States Without Supplementation	167.80	251.80		

IV. Alternative Proposals for SSI Supplementation in Virginia

Three (3) proposals are presented in this section. Each raises the income floor to aged, blind, and disabled Virginians, by supplementing SSI payments.

The proposals make several assumptions:

1) SSI participation will increase by 800 persons per month

2) Non-SSI eligibles will receive no state benefits

3) "Holdover" SSI recipients (former Old Age Assistance and Aid to the Blind and Disabled recipients) will be zero in 1978-80

4) Auxiliary payments for domiciliary care residents will be a separate budget concern (see Section V)

5) The state will bear full cost of the supplementation (NOTE: General Relief (GR) is shared by state and localities at 62.5%/37.5% ratio)

6) SSI payments from the federal level will increase $8.40 per month for individuals and $12.40 per month for couples from the current levels in July, 1977 so that a payment rate of $176.20 per month for individuals and $264.20 per month for couples will be in effect in the next biennium.

7) Participation rates of couples vs. individuals and of individuals in the three (3) Aid to Dependent Children (ADC) "regions" will remain constant with increases in participation spread proportionately among these groups

Tables 4, 5, and 6 present proposals aimed at supplementing SSI payments to each of three (3) levels:

1) ADC-GR actual current levels (1973 level)

2) ADC-GR expanded to reflect cost of living increases since 1973

3) 1975 poverty income cutoffs

Total costs for the biennium, for each alternative is as follows:

Alternative 1 (current ADC-GR)	$ 9,772,723
Alternative 2 (adjusted ADC-GR)	20,515,070
Alternative 3 (1975 poverty level)	87,826,737

Table 4. Cost of State Supplementation of SSI to Bring Payment Level to Current AOC-GR Level (Alternative 1)

(1)	(2) Estimated Average Monthly Participants		(3)	(4) SSI Federal Payment		(5) Target Level		(6) State Supplementation Required (Per Month)		Stat Cost Bienni (2ax3x + (2bx3x
Region	(a) Individual	(b) Couple	Number of Months	(a) Individual	(b) Couple	(a) Individual	(b) Couple	(a) Individual (5a-4a)	(b) Couple (5b-4b)	
I (59% of all eligibles)	45,629	6,222	24	176.20	264.20	146	228	0	0	0
II (34% of all eligibles)	26,295	3,586	24	176.20	264.20	173	256	0	0	0
III (7% of all eligibles)	5,413	738	24	176.20	264.20	243	326	66.80	61.80	9,77?
State	77,337	10,546	24	176.20						9,77?

*"One member eligible" are considered as single individuals for this computation. Individuals account for 88% of all cases currently and this percentage is used in this computation.

Table 5. Cost of State Supplement of SSI to Bring Payment Level to ADC-GR Level Adjust to Reflect Cost of Living Since 1973 (Alternative 2)

(1)	(2) Estimated Average Monthly Participants		(3)	(4) SSI Federal Payment		(5) Target Level		(6) State Supplementation Required (Per Month)		State Cost/ Biennium (2ax3x6a + 2bx3x6b
Region	(a) Individual	(b) Couple	Number of Months	(a) Individual	(b) Couple	(a) Individual	(b) Couple	(a) Individual (5a-4a)	(b) Couple (5b-4b)	
I (59% of all eligibles)	45,629	6,222	24	176.20	264.20	157	246	0	0	0
II (34% of all eligibles)	26,295	3,586	24	176.20	264.20	187	276	10.80	11.80	7,831,219
III (7% of all eligibles)	5,413	738	24	176.20	264.20	262	351	85.80	86.80	12,683,851
State	77,337	10,546	24	176.20	264.20					20,515,070

*"One member eligible" are considered as single individuals for this computation. Individuals account for 88% of all cases currently and this percentage is used in this computation.

Table 6. Cost of State Supplement of SSI to Bring Payment Level to 1975 Poverty Level
(Alternative 3)

(1)	(2) Estimated Average Monthly Participants		(3)	(4) SSI Federal Payment		(5) Target Level		(6) State Supplementation Required (Per Month)		State Cost/ Biennium (2ax3x6a + (2bx3x6b
Region	(a) Individual	(b) Couple	Number of Months	(a) Individual	(b) Couple	(a) Individual	(b) Couple	(a) Individual (5a-4a)	(b) Couple (5b-4b)	
I (59% of all eligibles)	45,629	6,222	24	176.20	264.20	220	290	43.80	25.80	51,817,86
II (34% of all eligibles)	26,295	3,586	24	176.20	264.20	220	290	43.80	25.80	29,861,75
III (7% of all eligibles)	5,413	738	24	176.20	264.20	220	290	43.80	25.80	6,147,11
State	77,337	10,546	24	176.20	264.20	220	290			87,826,73

*"One member eligible" are considered as single individuals for this computation. Individuals account for 88% of all cases currently and this percentage is used in this computation.

V. Special Discussion: Supplementation for Residents of Homes for Adults

Current Situation. The Department of Welfare and the Virginia Commission for the Visually Handicapped currently supplement SSI recipients in domiciliary care, up to $215.00 per month ($167.80 of that amount is accounted for by federal payments). Approximately 1,700 persons are served under this program.

Homes for adults operators and the Department of Welfare have identified costs per month in the homes to be far higher than $215.00 per month per resident. Welfare estimates, in a 1975 study, shared costs ranging from $225.00 per month to $478.00 per month with a mean cost of $300.00 per month.

The participation in this program (in terms of SSI recipients) has been fairly stable with a recent slight rise in the numbers of disabled and slight decline in the number of aged.

Estimates for 1978-80 below reflect a modest increase (300 persons) based primarily on anticipated results of nursing home pre-screening which should result in additional home for adults placements.

Alternatives. Table 7 summarizes the cost of providing supplementation to 2,000 homes for adults residents in the biennium with three (3) levels of supplementation: 1) up to $230.00 per month; 2) up to $250.00 per month; and 3) up to $300.00 per month. Estimates assume full cost is borne by the state with no local participation.

Table 7. Cost of Providing State Supplementation to Residents of Homes for Adults Who Are SSI Participants in 1978-80 Biennium

(1) Alternative	(2) Number of Participants Estimated	(3) SSI Payment Federal	(4) Target Payment	(5) Number of Months	(6) Required State Supplementation	(7) Cost (2x5x6)
1	2,000	176.20	230	24	53.80	2,582,400
2	2,000	176.20	250	24	73.80	3,542,400
3	2,000	176.20	300	24	123.80	5,942,400
4	2,000	176.20	215 (Current)	24	38.80	1,862,400

APPENDIX E

ESTIMATED COSTS FOR CROSS-THE-BOARD STATE SUPPLEMENTS TO ALL SSI RECIPIENTS 1978-80 BIENNIUM

Number of Recipients

-Assuming monthly case rise of 800
-Average monthly participation will be 87,883 cases
  -55% are elderly
  -45% are blind/disabled

State Supplement		# Cases		# Months	Biennium Cost to State
$5.00/month for individuals	X	77,337	X	24	$11,178,720
$7.50/month for couples	X	10,546	X	24	
$10.00/month for individuals	X	77,337	X	24	$22,357,440
$15.00/month for couples	X	10,546	X	24	
$20.00/month for individuals	X	77,337	X	24	$44,714,880
$30.00/month for couples	X	10,546	X	24	

APPENDIX F

HOME HEALTH COST BENEFIT STUDY

During the last three months of 1974, the Bureau of Home Health Services, Virginia State Health Department, conducted a statewide study to determine if Home Health Services were cost beneficial. The study was based on the hypothesis that it would be less costly to maintain a patient at home and meeting certain criteria, than to maintain in a hospital or nursing home. The social benefits were not assessed. The criteria were as follows:

a) In need of intermittent nursing care that can be provided at home

b) Interval of care no more frequent than daily

c) Desire to remain at home

d) Family or other resources willing to support

e) Attending physician willing to regularly direct the care

Results of the study are recorded on the attached page. The essential information is that:

a) 941 patients referred to local health departments - 552 accepted for care

b) As determined by the public health nurse providing the care, 337 of the 552 patients were spared either some hospital or nursing home days.

c) 5977 nospital and 6143 nursing home days saved

Comment

As an average, 23 visits are required to serve one patient for the entire term of Home Health Services. In 1974-5, home health visits were costing $20 each. If a nospital day cost $100, and a nursing home day costs $30, we can conclude that nome health care is cost beneficial.

$100 X 5977 days = $597,700

30 X 6143 days = 184,290

$781,990 = total cost of days saved

552 patients accepted X 23 average number visits required = 12,696 visits

12,696 visits X $20 per visit = $253,920 = total cost of Home Health Services

HOME HEALTH REFERRALS

October 1, 1974 - December 31, 1974

Following are the results of a study done on all referrals to home health services from October 1, 1974 to December 31, 1974.

The purposes of the study were:

1. Obtain an estimate of hospital and nursing home[1] days saved as a result of providing home health services to patients.

2. Obtain information on referrals not admitted to service especially those that would indicate additional staff would be needed to provide the requested service.

All Referrals	Admitted to HHS	Not admitted[2] to HHS
941	552	389

Admitted to HHS	Number with estimated Hosp. or Nurs. days saved	No hospital or Nurs. home days saved
552	337	215

Number with estimated Hosp. or Nurs. home days saved	Admitted from Hospital	Admitted without prior hospitalization
337	233	104

Hosp. days saved	Nursing Home days saved	Hosp. days saved	Nursing Home days saved
4,131	3,517	1,846	2,526

Total estimated hospital days saved were 5,977.
Total estimated Nursing home days saved were 6,043.

[1]Includes skilled and non-skilled nursing homes.

[2]Most frequent reasons for not admitting patients to services:
1. Admitted to hospital or nursing home before home health services could be started.
2. Continuous care required.
3. Home health services not necessary.
4. Family understands care-only one or two visits necessary.
5. Patient deceased before care started.
6. Admitted on Chronic Disease record.

The lack of staff was seldom given as a reason for not admitting the patient to home health services.

February 24, 1975

APPENDIX G

POTENTIAL PATIENTS SCREENED FOR NURSING HOMES
BETWEEN 5-15-77 AND 8-1-77

	HEALTH DISTRICT	NO. SCREENED
1.	Tidewater	39
2.	Central Shenandoah	36
3.	Central Virginia	32
4.	Richmond	32
5.	Peninsula	25
6.	Pittsylvania/Danville	22
7.	Crater	21
8.	Lord Fairfax	21
9.	Alleghany	18
10.	Fairfax	17
11.	Middle Peninsula	16
12.	Hampton	14
13.	Franklin	12
14.	Eastern Shore	10
15.	New River	10
16.	Roanoke City	10
17.	Mount Rogers	0
18.	Rappahannock	9
19.	Southside	9
20.	Thomas Jefferson	9
21.	Lenowisco	8
22.	Virginia Beach	8
23.	Henrico	7
24.	Northern Neck	7
25.	Prince William	7
26.	Piedmont	6
27.	Chesterfield	6
28.	Alexandria	5
29.	Arlington	4
30.	Cumberland Plateau	3
31.	Loudoun	3
32.	Charles City	2
33.	Rappahannock/Rapidan	2

Key to Appreviations:

NC = No change of domicile
NH = Nursing home
PD = Planning District

Localities	# Screened	Recommendation NH	NC	Other
Alleghany (PD #5)				
Alleghany	4	2	1	1
Clifton Forge	2			2
Botetourt	4	3	1	
Roanoke County	7	4	1	2
Craig	1		1	
TOTAL	18	9	4	5
		50%	22%	28%
Alexandria (PD #8)				
Alexandria	5	5		
TOTAL	5	5		
		100%		
Arlington (PD #8)				
Arlington	4	3	1	
TOTAL	4	3	1	
		75%	25%	
Central Shenandoah (PD #6)				
Augusta/Staunton	15	10	4	1
Bath	1	1		
Highland	1			1
Rockbridge/Lexington	3	3		
Rockingham/Harrisonburg	10	7	2	2
Buena Vista				
Waynesboro	6	5	1	
TOTAL	36	26	7	4
		70%	19%	11%
Central Virginia (PD #11)				
Amherst	4	3		1
Appomattox				
Bedford	1			1
Campbell	9	4	1	4
Lynchburg	18	10	6	2
TOTAL	32	17	7	8
		53%	22%	5%

Localities	# Screened	Recommendation NII	NC	Other
Charles City (PD #15)				
Hanover				
Charles City				
New Kent				
Goochland	2	2		
TOTAL	2	2		
		100%		
Chesterfield (PD #15)				
Chesterfield	6	6		
Powhatan				
Colonial Heights				
TOTAL	6	6		
		100%		
Crater (PD #19)				
Dinwiddie	2	1	1	
Emporia	1	1		
Greensville	1	1		
Hopewell	7	7		
Petersburg	8	7		1
Prince George	1	1		
Sussex	1	1		
Surry				
TOTAL	21	19	1	1
		90%	5%	5%
Cumberland Plateau (PD #2)				
Buchanan				
Dickenson	1	1		
Russell				
Tazewell	2	2		
TOTAL	3	3		
		100%		
Eastern Shore (PD #22)				
Accomac	8	4	2	2
Northampton	2		2	
TOTAL	10	4	4	2
		40%	40%	20%
Fairfax (PD #8)				
Fairfax County	17	13	2	2
TOTAL	17	13	2	2
		76%	12%	12%

Localities	# Screened	Recommendation NH	NC	Other
Franklin (PD #12)				
Henry-Martinsville	10	9		1
Franklin County	1			1
Patrick	1	1		
TOTAL	12	10		2
		83%		17%
Hampton (PD #21)				
Hampton	14	12		2
TOTAL	14	12		2
		86%		14%
Henrico (PD #15)				
Henrico	7	6	1	
TOTAL	7	6	1	
		86%	14%	
Lenowisco (PD #1)				
Lee				
Wise	6	4	1	1
Scott	2	2		
TOTAL	8	6	1	1
		75%	13%	13%
Lord Fairfax (PD #7)				
Clarke	3	3		
Frederick	5	5		
Winchester	5	4		1
Page	2	2		
Warren	3	3		
Shenandoah	3	3		
TOTAL	21	20		1
		95%		5%
Loudoun (PD #3)				
Loudoun	3	3		
TOTAL	3	3		
		100%		
Middle Peninsula (PD #18)				
Essex	4	4		
Gloucester	10	10		
King and Queen	2	2		
King William				
TOTAL	16	16		
		100%		

Localities	# Screened	Recommendation NH	NC	Other
Mount Rogers (PD #3)				
Bland				
Carroll				
Grayson	1	1		
Smyth	1	1		
Wythe	4	2	2	
Bristol	1	1		
Galax				
Washington	2	2		
TOTAL	9	7	2	
		78%	22%	
New River (PD #14)				
Floyd	3	2		1
Giles				
Montgomery	3	3		
Pulaski	2	2		
Radford	2	2		
TOTAL	10	9		1
		90%		10%
Northern Neck (PD #17)				
Lancaster	3	2	1	
Northumberland	2	2		
Richmond County	1	1		
Westmoreland	1	1		
TOTAL	7	6	1	
		86%	14%	
Peninsula (PD #21)				
James City-Williamsburg	6	5	1	
Newport News	19	14	3	2
York				
TOTAL	25	19	4	2
		76%	16%	8%
Piedmont (PD #14)				
Amelia				
Buckingham				
Charlotte	3	3		
Cumberland				
Lunenburg				
Nottaway	3	2	1	
TOTAL	6	5	1	
		83%	17%	
Pittsylvania/Danville (PD #12)				
Pittsylvania	14	10	2	2
Danville	8	5	1	2
TOTAL	22	15	3	4
		68%	14%	18%

Localities	# Screened	Recommendation NH	NC	Other
Prince William (PD #8)				
Manassas	2	2		
Prince William	1	1		
Garfield Branch	4	4		
TOTAL	7	7		
		100%		
Rappahannock (PD #16)				
Caroline	3	2	1	
King George				
Spotsylvania	1	1		
Stafford	2	2		
Fredericksburg	3	2	1	
TOTAL	9	7	2	
		78%	22%	
Rappahannock-Rapidan (PD #9)				
Fauquier	2	1		1
Orange				
Madison				
Rappahannock				
Culpepper				
TOTAL	2	1		1
		50%		50%
Richmond City (PD #15)				
Richmond City	32	25	3	4
TOTAL	32	25	3	4
		78%	9%	13%
Roanoke City (PD #5)				
Roanoke City	10	6	1	3
TOTAL	10	6	1	3
		60%	10%	30%
Southside (PD #13)				
Brunswick	4	2	1	1
Halifax	5	4	1	
Mecklenburg				
South Boston				
TOTAL	9	6	2	1
		67%	22%	11%
Thomas Jefferson (PD #10)				
Fluvanna				
Greene	1	1		
Louisa	1	1		

Localities	# Screened	Recommendation NH	NC	Other
Thomas Jefferson (cont'd.)				
Albermarle	1	1		
Nelson	1	1		
Charlottesville	4	3	1	
TOTAL	8	7	1	
		88%	12%	
Tidewater (PD #20)				
Isle of Wight	5	5		
Southampton	4	2		2
Chesapeake (Great Bridge)				
Franklin City	3	3		
Suffolk	2	2		
Portsmouth	11	9	1	1
Norfolk	14	11	2	1
TOTAL	39	32	3	4
		82%	8%	10%
Virginia Beach (PD #20)				
Virginia Beach	8	6	2	
TOTAL	8	6	2	
		75%	25%	
STATE TOTALS	439	338	53	48
		77%	12%	11%

APPENDIX H

Figure 11

Organization of the Virginia State Government - Agencies and Offices Associated With Aging Programs

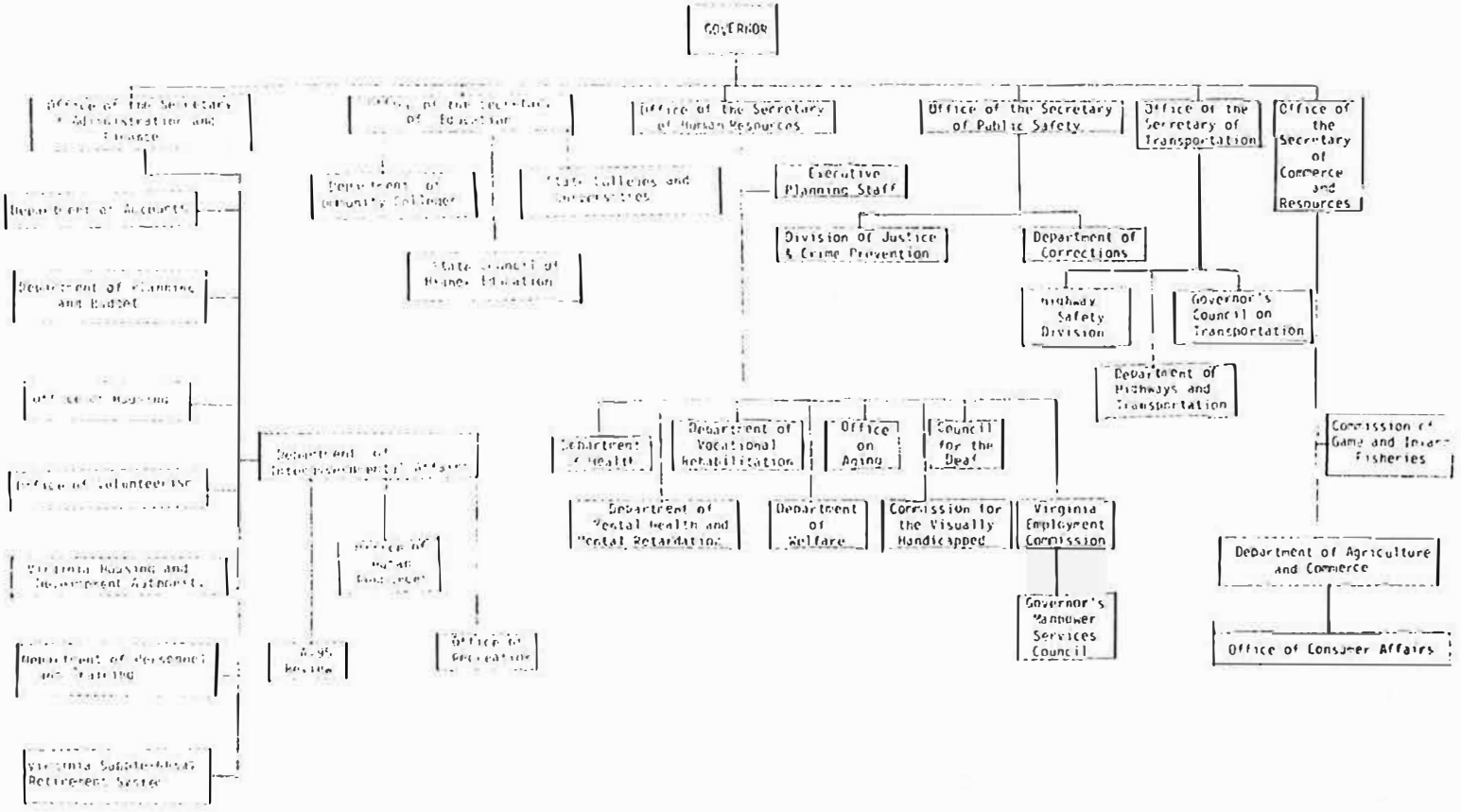
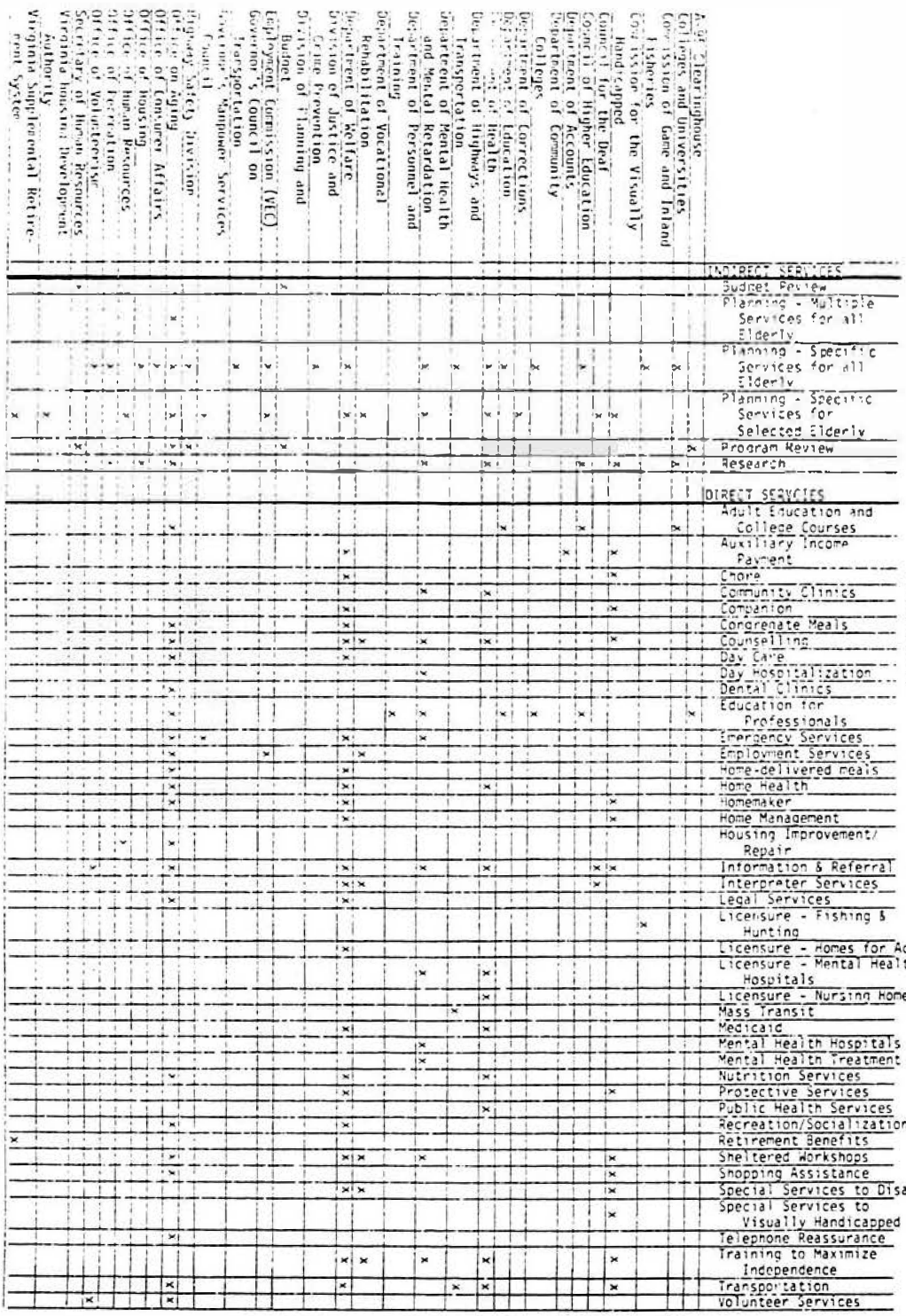


Table 47

Services Provided Through State Agencies
Virginia, 1977



APPENDIX I

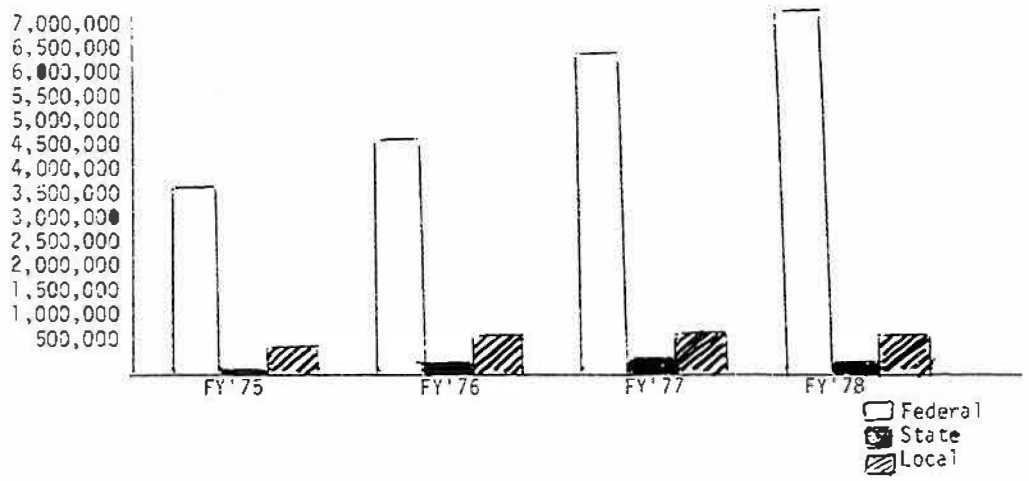
Office on Aging Budgets: Federal, State, Local - FY '75, '76, '77, '78

	Federal	State	Local	Total
FY'75	$3,065,981	$ 59,523	$350,985	$3,476,489
FY'76	4,556,834	130,763	530,878	5,218,475
FY'77	6,404,126	137,633	684,850	7,226,609
FY'78	7,177,595	138,315	799,782	8,115,692

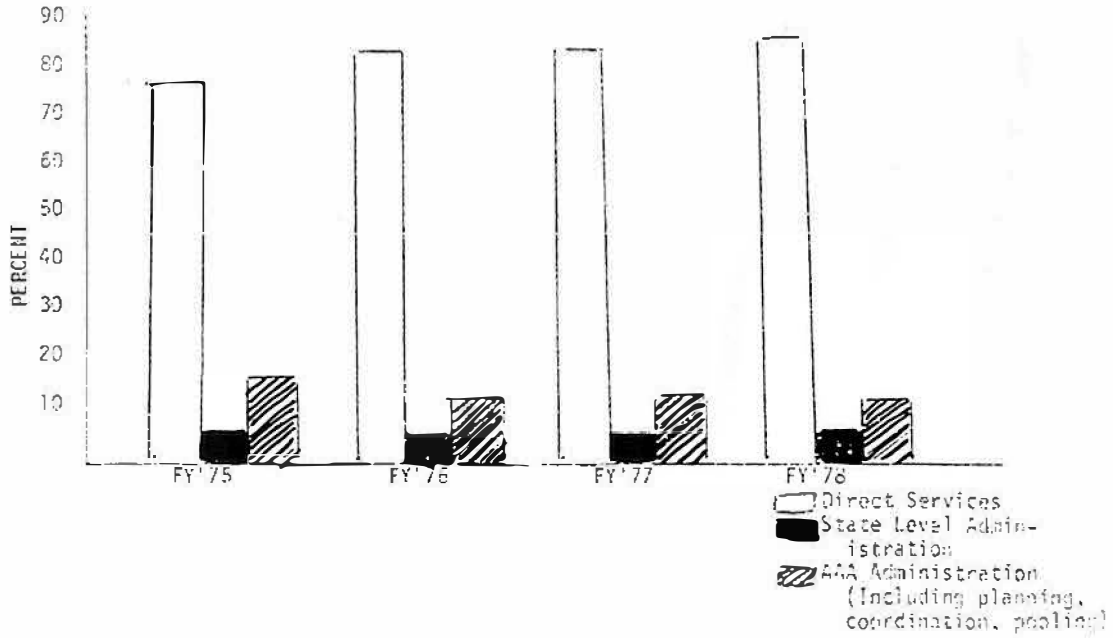
Office on Aging Budgets: Administrative and Direct Services - FY '75, '76, '77, '78

	Administrative (State)	Administrative (AAA)	Direct	Total
FY'75	226,092 (6.5)	520,443 (15.2)	2,731,953 (78.3)	3,476,489
FY'76	323,053 (6)	620,972 (12)	4,266,450 (82)	5,218,475
FY'77	432,289 (6)	832,280 (12)	5,962,040 (82)	7,226,609
FY'78	509,749 (6)	851,570 (10)	6,804,373 (84)	8,115,692

OFFICE ON AGING BUDGETS: FEDERAL, STATE, LOCAL - FY '75, '76, '77, '78



OFFICE ON AGING BUDGETS: ADMINISTRATIVE AND DIRECT SERVICES - FY '75, '76, '77, '78



Source: Annual State Plans on Aging submitted to Administration on Aging, DHEW