REPORT ON

THE FEASIBILITY OF CREATING

A JOINT HOMEMAKER-HOME HEALTH AID POSITION

REPORTED TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 10

COMMONWEALTH OF VIRGINIA
DIVISION OF PURCHASES AND SUPPLY
RICHMOND
1979

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December 1,1978

TO: House of Delegates Committee on Health, Welfare and Institutions
and
Senate Committee on Education and Health

The report contained herein is being submitted pursuant to House Joint Resolution No. 33, passed by the 1978 Session of the General Assembly. The State Department of Welfare and the State Department of Health were "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 was also requested to investigate potential reimbursement sources for the services provided by a homemaker-home health aide.

This report identifies alternative approaches which can be utilized to provide and fund the joint service. We agree with the contents of this report and support efforts necessary to implement its findings.

Respectfully submitted,

William L. Lukhard
Commissioner
Department of Welfare

HJR 33 REPORT SUMMARY

House Joint Resolution No. 33 was passed by the 1978 session of the General Assembly. It requested the State Department of Health and the State Department of Welfare to establish a joint task force to study the feasibility of creating a joint homemaker-home health aide position and to investigate potential reimbursement sources for the services provided by the position.

The Departments of Health and Welfare carried out the required study with the assistance of an Advisory Task Force, whose members included central, regional and local health and welfare personnel, staff members of related State and advocacy agencies, and representatives of proprietary and private non-profit agencies.

The study determined that significant growth in the provision of joint homemaker-home health aide services had occurred through the country during the past twenty years. Encouraged by the National Council for Homemaker-Home Health Aide Services, Inc. and funding mechanisms such as Titles XVIII, XIX and XX of the Social Security Act, the number of aides has increased from 1,500 in 1958 to 82,000 in 1978. While local home health and social services in Virginia have increased dramatically in recent years, the availability of joint homemaker-home health aide services remain limited.

The Medicaid and Medicare programs are funded by Titles XIX and XVIII of the Social Security Act, respectively. For the categorically needy, those who receive public assistance, and the medically needy, those whose income exceeds public assistance eligibility but is insufficient to meet medical costs, the Medicaid program in Virginia includes home health care. By law Medicare home health care benefits are skilled care or rehabilitation oriented. To be eligible for such benefits, a person must be homebound, under the care of a physician and need part-time or intermittent skilled nursing service and/or physical or speech therapy. In contrast, Medicaid home health care benefits do not require skilled nursing care or physical or speech therapy. Home health aide services funded through either program include personal care duties (exercise, medications, bathing) and incidental household services (light cleaning and laundry, food preparation) which do not substantially increase the time spent by the home health aide.

Title XX of the Social Security Act also funds the provision of many social services related to homemaker-home health aides. In Virginia, Title XX funds are allocated to 117 geographic areas which, based upon local needs assessment, determine the social services to be provided the citizens. The twenty-nine potential services may be delivered directly through local departments of public welfare or purchased from other agencies. One purchased service, through a contract between the State Health and Welfare Departments, is home health services, including home health aide services, provided by local departments of public health to homebound patients who are Title XX eligible but not Medicare or Medicaid eligible. Other home

based services funded through Title XX which relate to the types of services provided by a homemaker-home health aide are homemaker, chore and companion services. They are optional services which are delivered by local welfare agencies as well as purchased from voluntary non-profit and private providers.

Homemaker-home health aide services assist the aged, the chronically ill, the person convalescing at home, the physically handicapped, the mentally ill and those who are socially incapacitated to sustain, attain or regain maximum self reliance in his own home and to enhance the quality of daily life. Duties under the supervision of a nurse or other appropriate professional person include both home management and personal care, such as bathing, rehabilitative services, meal planning and preparation, assistance with oral medications and essential household tasks. When combined, the joint services of a homemaker-home health aide can prevent individuals and families receiving the two separate services from different individuals and can save significant costs to the agencies involved through the elimination of duplication of effort.

The provision of homemaker-home health aide services is dependent upon the availability of individuals trained to provide the service and funding mechanisms to pay for it. The study determined that such services can be provided through many types of agencies -- public, voluntary non-profit, proprietary, private non-profit and other combinations -- some of which have staff currently capable of providing the service in Virginia. Training of staff is important and the State Department of Health recently received approval of a federal grant to develop an operational model for statewide home health aide education. The basic national standards for homemaker-home health aide services developed by the National Council are designed to provide adequate safeguards for consumers, third-party payers and service providers.

Funding mechanisms available for homemaker-home health aide services depend upon the agency providing the service, client resources and program eligibility, and the level of service needed. Depending upon these factors, the joint service can be funded partially or entirely by the client, private insurance, Medicaid, Medicare and Title XX, or combinations thereof.

To facilitate the development and utilization of homemaker-home health aides in the Commonwealth, the Department of Health and the Department of Welfare make the following recommendations:

1. The position of homemaker-home health aide should be created to provide personal care and household services essential to health care and health-related services to homebound individuals.

2. The State Department of Personnel and Training, working cooperatively with staff of the State Departments of Health and Welfare and other appropriate persons, including the private sector, should develop a job description, job requirements and training for the position of homemaker-home health aide.

3 The Virginia Office on Aging should take the lead in coordinating Virginia's efforts in support of the development of a sound State and national policy which would consolidate home health and in-home service programs.

4. Local welfare departments, which provide homemaker services, and local health departments, which provide home health aide services, should work closely together to ensure that cases requiring both homemaker and home health care receive homemaker-home health aide services from a single individual whenever possible.

5. Staff of local welfare departments who provide direct homemaker services and who meet the job requirements of the position of homemaker-home health aide should be given priority to participate in the nursing project for the training of homemaker-home health aides.

6. In the Virginia Title XX Comprehensive Social Service Plan for the fiscal year ending June 30, 1981, homemaker service should be expanded to include home health services and homemaker-home health aide services and consideration should be given to make such service mandatory in all localities.

7. Non-profit, voluntary and public certified home health agencies should consider subcontracting with proprietary home health agencies as one alternative means of expanding services without hiring additonal staff.

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Department of Welfare

and The

Department of Health

To

The House of Delegates Committee on Health, Welfare and Institutions

and

The Senate Committee on Education and Health

SECTION I -- INTRODUCTION AND METHODOLOGY

House Joint Resolution No. 33 of the 1978 Session of the General Assembly requested the Department of Welfare and the Department of Health to establish a joint task force to study the feasibility of creating the position of homemaker-home health aide and investigate the potential funding sources for the services provided by such a position.

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.

Patrons-Marshall, Stafford, Cantrell, Michie, and Slayton

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-home 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.

The study in response to House Joint Resolution No. 33 was initiated by the Departments of Welfare and Health beginning in May, 1978, when a meeting was held with the key individuals of both agencies. At that time, lead responsibilities for the agencies were assigned to Ben Greenberg of the Department of Welfare and Betty Jo Wright of the Department of Health. Subsequent to that initial meeting, core groups of agency staff persons were established to begin the tasks of acquisition and assessment of all available information concerning homemaker-home health aides. Contacts were initiated and information gathered from the National Council of Homemaker-Home Health Aides, Inc., the Department of Health, Education and Welfare, other states and pertinent literature.

This initial phase was followed by preparations for and creation of the Advisory Task Force, the membership of which is indicated above. The Task Force was composed of State and local welfare and health staff involved in the previously mentioned core groups, as well as representatives of other State and local public and private agencies either involved in the provision of related services or acting as spokespersons for potential client groups who were expected to be recipients of the service. The Advisory Task Force met three times during the months of August, September and October to consider relevant issues and identify alternative approaches to delivering the needed homemaker-home health aide services. Special attention was paid to aspects of service delivery and funding considerations.

This report represents the concensus opinion of the members of the Advisory Task Force and the Departments of Health and Welfare.

SECTION II -- BACKGROUND INFORMATION

National Perspectives

In recent years, the health care and social services fields have experienced a significant trend in service delivery away from institutionalization and toward assisting individuals and families in their own homes. However, in-home services actually had their beginnings in the early twentieth century when agencies assisting families began to use women in homes to substitute for hospitalized mothers or to care for a sick mother and children. Such care often provided an alternative to foster care placement for children. The first recognized homemaker service was established in 1923 by the Jewish Family Welfare Society of Philadelphia. Other voluntary family and children's agencies in large cities soon began to offer similar substitute parental care to families with children.

Homemaker services expanded significantly during the 1930's and the depression. The Work Progress Administration, with the goal of hiring needy women, employed housekeeping aides to provide short-term services to families whose members were acutely ill. This service represented two significant steps in the delivery of homemaker services, in that public funds were used and services were provided to aged individuals.

The expansion of homemaker services was curtailed during World War II, when women were needed by industry and industry wages exceeded those paid to homemakers. However, homemaker and health-based aide services expanded again at the conclusion of World War II and during the 1950's. This expansion is illustrated by the existence of 208 agencies in the United States delivering services in 1961. These agencies were located in forty states, the District of Columbia and Puerto Rico.

The use of homemaker-home health aides expanded tremendously during the 1960's and 1970's. In 1958, homemaker-home health aides in the United states numbered 1,500. In 1972, there were 43,000 aides employed, and in 1978 82,000 aides. The expansion in programs is illustrated by the increase from 300 programs providing services in 1958 to 3,700 programs in 1978.

Many factors have led to this documented surge. National agencies such as the U.S. Children's Bureau, Public Health Service, the Child Welfare League of America, the Family Service Association of America, and, especially, the National Council for Homemaker-Home Health Aide Services, which was established in 1962, have encouraged the development of these services. This development has paralleled the movement away from unnecessary institutionalization and the availability of increased funding from federal sources. For example, the 1961 White House Conference on Aging stated that "the need to expand institutional facilities should not discourage non-institutional alternatives, particularly treating the individual in his own home".

The inclusion of home health aide services in the Medicare and Medicaid programs created in 1965, specifically stimulated the expansion of services to the aged.

The role of the National Council for Homemaker-Home Health Aide Services cannot be overstressed in this history of service expansion. It was incorporated in 1962 as the National Council for Homemaker Services, with its headquarters in New York City. Its name was changed in 1971, as part of its efforts to recognize the generic services needed in the health and social service fields. It has established standards for the delivery of homemaker-home health aide services, developed training and educational manuals and materials, and assisted in establishing national social policy through legislative efforts.

Further developments in the expansion of homemaker-home health aide services on the national level are anticipated in the future with changes in the federal requirements for the Medicare and Medicaid programs. A mammoth report on these programs has been made to Congress during the Fall, 1978, and the recommendations, if enacted by legislation, are expected to resolve some of the limitations currently restricting the use of Medicare and Medicaid funds for in-home health care services.

Virginia Perspectives

Virginia's experience with the delivery of homemaker-home health aide services has paralleled that of the nation, as described above. The discussion below will concentrate upon recent events.

The Commission on the Needs of Elderly Virginians was established in response to a legislative resolution passed by the General Assembly in 1973. During its five-year history, it studied the needs of the aged throughout the Commonwealth and services to meet those needs. On the issue of institutionalization, the Commission stated in its 1977 report to the General Assembly:

> "Whenever feasible, the Commission has recommended non-institutional alternatives as preferable to institution placement, believing 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".

That same 1977 report to the General Assembly called for the joint efforts of the Department of Health and the Department of Welfare to study the possibility of creating the joint position of homemaker-home health aide.

Efforts in Virginia to reduce institutionalization can be documented in several ways. During the 1970's, the State Department of Mental Health and Mental Retardation has intensified its deinstitutionalization efforts, returning many patients in State hospitals to communities

throughout the State, while at the same time increasing local mental health services to these individuals and others to prevent their institutionalization.

The State Department of Health has made similar intensive efforts to prevent institutionalization and improve home health services. On July 1, 1976, the Virginia Medical Assistance Program (Medicaid) instituted a pilot program to screen all nursing home admissions to prevent those which are inappropriate and to provide alternative services when available and practical. This pilot effort has been determined successful (see attached Appendix A) and was expanded on May 15, 1977 to include screening of all nursing home applications other than those of patients transferring from hospitals or other nursing homes or those cases in which applicants will not become eligible for Medicaid within 90 days. Further expansion of the pre-screening program to include nursing home admissions from hospitals is currently under study. This program has provided a specific mechanism for documenting the need for and availability of community services necessary to prevent nursing home institutionalization.

During the past several years, local home health services and social services to individuals and families in their own homes have expanded to meet many needs heretofore unmet. These services provided by local departments of public health, local departments of public welfare and voluntary and private agencies will be explained in detail, elsewhere in this document. As a result of such efforts, individuals are increasingly able to remain in their own homes and families are increasingly able to remain together during times of severe stress. Without the increased local welfare and health efforts, deinstitutionalization and the prevention of institutionalization would be mere slogans and not the realities which now benefit the citizens of the Commonwealth.

References

Violet M. Sieder, Ph.D. and Charlotte J. Califf, MSS, "Homemaker-Home Health Aide Services to the Mentally Ill and Emotionally Disturbed: A Monograph" National Council for Homemaker-Home Health Aide Services, Inc., New York, 1976, pp. 8-15

Eugene B. Shinn and Nancy Day Robinson, "Trends: In Homemaker-Home Health Aide Services, Abstracts for Social Workers, Vol. 10, No. 3, Fall, 1974

Mrs. Gilbert W. Humphrey: "Shaping the Future of Homemaker-Home Health Aide Services", presented at the Regional Institute of the National Council for Homemaker-Home Health Aide Services, Inc., New Orleans, March 7, 1978

SECTION III - MEDICARE/MEDICAID AND HOME HEALTH SERVICES

Medicare and Medicaid

The Department of Health, Education, and Welfare (HEW) administers the principal Federal programs which provide home health care. The main home health care programs that are medically oriented are Medicare and Medicaid. HEW is also responsible for administering various home care or in-home services programs which are authorized under the Social Security Act and the Older American Act.

Title XVIII and Title XIX of the Social Security Act established the Medicare and Medicaid programs respectively to help eligible persons meet the costs of health care services.

Under Medicare, eligible persons, generally aged 65 and over or disabled, may receive two basic forms of protection:

> Part A, hospital insurance benefits, generally financed by special social security taxes, covers inpatient hospital services and certain posthospital care in skilled nursing facilities and patients' homes.
>
> Part B, supplementary medical insurance benefits, is a voluntary program, financed by premiums of enrollees and Federal contributions covering physician services and many other medical and health benefits.

During the 1976 fiscal year the Medicare program paid $16.6 billion nationwide on behalf of eligible beneficiaries ($12 billion was paid under Part A and $4.6 billion under Part B).

Under Medicaid, a grant-in-aid program, the federal government and the states share the costs of providing medical assistance to specific persons whose income and resources are inadequate to pay for health care. Medicaid (Federal and State) paid approximately $15 billion for about 24 million recipients nationwide in fiscal year 1976. In Virginia, the Virginia Medicaid Program expended $245,161,055 for medical services between July 1, 1977 and June 30, 1978 for 317,506 program eligibles.

Two groups of people can be covered by Medicaid. The first group, known as the categorically needy, are people who can or do receive public assistance under one of the cash assistance programs. The categorically needy, with the exception of certain SSI recipients, must be covered by the State's Medicaid Program. In addition, States may elect to pay for medical care to medically needy persons and their families, those whose income exceeds the standard under the appropriate cash assistance plan but is insufficient to meet their medical costs. Virginia provides for both the categorically needy and the medically needy who are categorically related.

The Medicare home health care benefits are, by law, skilled care or rehabilitation riented. They do not address custodial care related to helping with activities of daily living, unless the patient required skilled nursing care or physical or speech therapy.

Home health services, as defined by the Social Security Act, include:

> Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
>
> Physical, occupational, or speech therapy;
>
> Medical social services under the direction of a physician;
>
> To the extent permitted in regulations, part-time or intermittent services of a home health aide; and
>
> Medical supplies (other than drugs and medications including serums and vaccines), and the use of medical appliances.

To be eligible for home health care under Medicare, a person must be confined to his/her residence (essentially homebound), be under the care of a physician, and need part-time or intermittent skilled nursing service and/or physical or speech therapy. A physician must prescribe the need for such care. If these requirements are met, a person is eligible to receive other covered home health services.

Medicare home health care outlays in the United States were, or were estimated to be, $433 million for fiscal year 1977, and $563 million for fiscal year 1978. In fiscal year 1978, it is estimated that home health care costs will exceed the Medicare costs for skilled nursing facilities by $100 million, primarily due to the expansion of Medicare to the disabled under the age of sixty-vied implemented in July, 1977.

Home health care became a required service for the categorically needy under Medicaid on July 1, 1970. In Virginia, services provided by the Medicaid program are equally available to the categorically needy and the medically needy.

The Medicaid home health care benefits differ from Medicare benefits because they do not require skilled nursing care or physical or speech therapy for a person. Also, they do not provide for medical social services.

For fiscal year 1977 total State expenditures were, or were estimated to be, approximately $154 million, for home health care benefits under their Medicaid programs. The Federal share was about $87 million. In contrast, total federal and State Medicaid expenditures for institutionalized care in skilled nursing and intermediate care facilities were $5.8 billion.

Home Health Aide

The primary function of a home health aide in both the Medicare and Medicaid programs is the personal care of the patient. The services of a home health aide are given under the supervision of a registered professional nurse, or other appropriate person, such as a physical therapist. The assignment of a home health aide to a particular case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Personal care duties which may be performed by a home health aide include assistance in the activities of daily living, for example helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise, to take medications specifically ordered by his physician which are ordinarily self-administered, and to retrain the patient in the necessary self-help skills.

While the primary need of the patient for home health services furnished in the course of a particular visit may be for personal care services furnished by the aide, the home health aide may also perform certain household services which are designated to the home health aide in order to prevent or postpone the patient's institutionalization. These services may include keeping a safe and hygienic environment in areas of the home used for the patient, e.g. changing the bed, light cleaning, rearrangements to assure that the individual can safely reach necessary supplies or medication, laundrying essential to the comfort and pleasantness of the patient, etc., seeing that nutrition needs which may include the purchase of food and assistance in the preparation of meals of the patient are met, and washing utensils used in the course of the visit. If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimburseable.

Housekeeping services, which would materially increase the amount of time required to be spent by the home health aide to make the visit above the amount of time necessitated by the care for the patient, are not reimburseable. Where another member of the household is an equally aged and feeble or ill person, such as an aged spouse or parent of the beneficiary, certain services performed by the home health aide may be advantageous to both members of the household but would nevertheless be reimburseable if the amount of time spent by the aide is not materially increased in order to service the non-beneficiary member.

H.R. 3

Under the provisions of Section 18 of Public Law 95-142, the Department of Health, Education, and Welfare has prepared for the Congress an indepth home health report, known as H.R. 3. This report analyzes certain aspects of federally assisted home health care programs and provides information and an evaluation of the cost impact of possible changes in the Medicare and Medicaid programs. These changes would

increase the probability of services being delivered to clients in need and help to provide services not currently covered by the program.

Some of the key recommendations included in H.R. 3 are:

Change the term "home health aide" under Medicare to homemaker-home health aide", permitting reimbursement for homemaker services.

Combine part A and B of Medicare into a single benefit of 200 visits, deleting the prior hospitalization requirement. Reimburse skilled evaluation and nutritional visits as direct services, not as administrative costs.

Clarify for intermediaries that terminal conditions are covered if other requirements are met. Clarify and revise the homebound requirement.

Mandate under Medicaid minimums on amount, duration and scope of home health services and enforce requirements that all states implement home health care.

Strengthen under Medicare the conditions of participation to include home health aide training, utilization review, improved planning of treatment and care, requiring bonding for home health agencies.

Delete the requirement that proprietaries be licensed by the State in order to be certified for Medicare and Medicaid.

Issues for the Future

A workable and coherent national policy on in-home care services will involve reaching agreement on the definition and ranges of such services. Home health services have generally been understood to include nursing; medical assistance; medical social work; physical, occupation, and speech therapy; and medical supplies and equipment. Home health care is also included under Medicaid. An issue is whether or not support services such as the homemaker aspect of homemaker-home health aide services, meals on wheels, friendly visiting, telephone assurance, escort and more services are to be funded as a part of home health care or, at the very least, funded and administered so that they can be closely coordinated within home health care. Wherever strictly medical services shade over into social areas, difficulties in funding, coordination and administration occur. Yet, health practitioners and social workers know that it is often these support services which make all the difference. Aside from simplifying administration and coordination issues, broadening the current definition could be cost effective, allowing appropriate needed in-home supports, contrasting with inappropriate, costly institutionalization in many cases. When the patient receives services, the service to the consumer is often fragmented and frequently inadequate to the need. Obtaining these desperate funds, putting them together like a jigsaw puzzle to provide comprehensive service for the consumer, and accounting for them to

various sources can become a nightmare to the agency administrator. Some agencies do not even try, and so needs go unment. While no one is opposed to determining costs or to measuring effectiveness, there is little agreement about what is included in cost, and effectiveness must be measured against the expensive alternatives.

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

1. Recruitment and screening of home health aides;

2. Orientation and in-service training of all staff;

3. Supervision of patients and home health aides by appropriate professionals;

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

5. Travel time expense of staff;

6. Overhead cost; and

7. Administrative expenses

In many states, including Virginia, Medicaid uses the same data and rules for determining costs that are used by Medicare.

The in-home service field appears finally to have been recognized as an important part of the health and social service delivery system by significant groups of providers, consumers' organizations, third party payers, federal legislatives, and administrative agencies, especially HEW. The general interest in its expansion is most encouraging.

A sound national policy for the guidance of official agencies and others is urgently needed to give direction to the in-home services movement. The policy should be developed by the federal government in concert with the voluntary sector. It should include approaches for coordinating, if not actually improving, the current fragmented sources of Federal funding, for assuring quality service, and for coordinating the delivery of services to the consumer at the community level.

Reference

"Report to the Congress by the Comptroller General of the United States", HRD-78-19, published Dec. 30, 1977.

Florence M. Moore, "New Issues for In-Home Services", Public Welfare, Vol. 35, No. 2, Spring, 1977, pp. 26-37.

SECTION IV -- TITLE XX SOCIAL SERVICES

Title XX

On January 4, 1975, Public Law 93-647 was signed by the President, establishing Title XX of the Social Security Act. This law replaced the social service provisions of Titles IV-A and VI and created a new federal legislative base for the provision of social services. Title XX was implemented nationwide on October 1, 1975. In Virginia, the Governor designated the Department of Welfare and the Commission for the Visually Handicapped as the agencies to administer Title XX for the Commonwealth.

Title XX significantly changed the provision of social services. Its impacts include:

The expansion of social services for the non-welfare poor.

Increased public participation in planning for and delivery of social services.

Greater autonomy and flexibility in service planning and delivery for states and localities.

Persons eligible for social services funded by Title XX can be classified in three groupings:

1. All persons are eligible for Universal Access Services, which in Virginia are adoption services, court services, emergency shelter for children, family planning, foster care services for children, information and referral, protective services for adults and protective services for children.

2. Other persons are eligible for social services on the basis of their membership in an income maintenance group, including recipients of financial assistance through the Aid to Dependent Children program and the Supplemental Security Income program.

3. The Income Eligible Group includes those persons who have financial resources at or less than 50% of the State median income or 70% of State median income if such persons are deaf, visually handicapped, mentally retarded, cerebral palsied, epileptic or autistic.

For the purpose of planning and administering Title XX social services, localities in Virginia are grouped into 117 geographic areas. Each geographic area is allocated a portion of federal and state Title XX funds based upon a formula which currently includes as equal factors raw population in each juristiction and the average number of open service cases reported for certain months. Based upon its allocation and a local needs assessment, a geographic area then determines how it plans to provide social services to its residents. It should be noted that

services may be delivered in each locality directly by the department of public welfare or by local welfare agency purchase from other public, voluntary or private agencies.

The 1978-79 Comprehensive Annual Plan for Social Services includes twenty-nine social services which may be made available in any geographic area. Of these twenty-nine services, the Department of Welfare and the Commission for the Visually Handicapped have mandated each area to offer nine of the services based upon requirements in State or federal law or the decision that certain services best foster the national goals for Title XX. Appendix B identifies each of the services, the total number of persons to be served by each service, and the projected expenditures for each service statewide for the 1978-79 fiscal year. Those services which are mandated statewide are footnoted accordingly. Appendix C identifies the actual services offered during the 1977-78 fiscal year and the persons served and expenditures for each service.

Purchased Home Health Services

In addition to services provided as a result of locally determined plans, certain social services are provided through purchase contracts between the State Department of Welfare and a variety of other organizations. One service which is in its third year of purchase and which is important to note in relation to the provision of homemaker-home health aide services is the home health service purchased from the State Department of Health. This service is provided by local health departments to home-bound patients referred by physicians. Services delivered by home health services include those of a visiting nurse, a home health aide, a physical therapist, an occupational therapist, a speech therapist, a social worker or a combination of these individuals. The service is funded by the appropriate resource, which includes Medicaid and Medicare; however, the State Title XX contract permits federal social services funds to be used for home health services delivered to individuals otherwise eligible for Title XX but determined to be ineligible for either Medicaid or Medicare reimbursement. Eligibility for the services is determined by local welfare staff. During the 1976-77 fiscal year, the Title XX contract for home health services allocated $225,000 in federal funds, while approximately 27% or $61,000 was expended. The utilization rate increased dramatically during 1977-78, when $199,965 in federal funds was allocated and approximately $187,367 or 93.7% was expended. The current contract for the 1978-79 fiscal year allocates $219,962 in federal funds to the State Department of Health for home health services.

Home Based Care Services

Many local departments of public welfare in Virginia, either directly or through purchased services, provide home based services to residents of their communities. These home based services are closely linked to the proposed joint homemaker-home health aide services studied in response to House Joint Resolution No. 33.

Home based care services include three types of services -- homemaker services, companion services and chore services. It is important to point out that the State Department of Welfare defines these services and the policies which govern how they can be provided; therefore, the State has a certain degree of flexibility in its authority to establish a framework for the provision of home based care services. With this flexibility permitted Virginia and other states, probably no two states provide homemaker, companion and chore services in the exact same manner. The description of these services below is only applicable to the State of Virginia.

Homemaker, chore and companion services are optional social services which can be provided by or through local departments of public welfare. That is, localities, as part of their Title XX planning process, can make the decisions as to whether they want to provide any or all of the services, to whom and how many persons or families they may wish to provide the services and the manner in which these services would be delivered; however, localities must provide homemaker and companion services to the former recipients of Old Age Assistance and Aid to the Permanently and Totally Disabled who had allowances for such services in their grant. As the following table indicates, there is significant variation in the extent to which these services are provided in Virginia.

Home Based Care Services in the
1978-79 Title XX Plan

Service	# Localities	# Clients	Expenditures
Homemaker	47	3,507	$ 1,348,879
Companion	116	8,164	$ 10,972,543
Chore	61	552	$ 266,705

The reasons for these variations in service delivery are many. The expenditures of Title XX funds in Virginia have increased dramatically during the past several years. During the 1977-78 fiscal year for the first time, Virginia essentially spent its entire federal Title XX allocation. As a result, the demands for all social services are continuing to increase dramatically while the federal allocation has only just been increased for the first time since the public law was established, and this increase has only been enacted by Congress for one year. This funding limitation coupled with increased state mandates and priorities for many services have placed localities in a difficult bind with respect to providing optional social services, such as home based care services. With limited funds available to provide social services, many localities have turned to greater utilization of companion services, which can be provided at a lower unit cost with fewer administrative controls. Furthermore, the definitions of chore and companion services have changed during the past several years to the extent that many services previously provided under chore are now being provided under companion. This helps to explain the significant

decreases in chore expenditures since 1976. The following table identifies the trends in the delivery of homemaker, chore and companion services by comparing the average monthly expenditure for each during the past several years:

Average Monthly Expenditure for Home Based Care Services by Calendar Year

Service	1976 Expenditures	1977 Expenditures	1978 Expenditures
Homemaker	$ 7,323	$ 17,154	$ 27,367
Companion	255,174	636,794	650,921
Chore	265,619	20,389	3,121

The variations in the delivery of homemaker, companion and chore service are also results of changes in the adult protective services programs in localities of the State. Adult protective services was a mandated service by State law until July 1, 1977, when a new adult protective services law became effective. Due to the increased responsibilities of localities for this program, a law enacted during the 1977 General Assembly session authorized localities to provide the service, but did not mandate the service. The Title XX Plans for 1977-78 and 1978-79 have reflected this change in including adult protective services as an optional service. All but five localities in 1977-78 and three localities in 1978-79 chose to offer the service in terms of the basic defined elements of receiving complaints and reports, investigating them, and initiating court action, when necessary.

The adult protective services program significantly impacts home based care services needed. Many of the identified and confirmed adult protective services clients are in need of home based assistance, such as that provided through the homemaker, companion and chore programs. As a result, new policy initiated by the State Department of Welfare effective March 1, 1978 for adult protective services specifically identified six optional ten-day components which may be offered to adult protective services recipients, and homemaker, companion and chore services are among these optional components. This new policy has been in effect for too short a period of time to determine its impact upon the provision of these home based care services, but an increase in the delivery of such services could be expected as the adult protective services program continues to identify more individuals in need of help and protection.

The delivery of home based care services should be specially noted. In general, those localities which offer the services do so by purchasing them from voluntary non-profit and private providers. Several of the larger local departments of public welfare in Virginia employ their own homemakers, such as in the City of Richmond, but even in these localities homemaker services may be purchased.

Below are general descriptions of each of the three home based care services funded through Title XX of the Social Security Act during the 1978-79 fiscal year. The more specific policies adopted by the State Board of Welfare which govern the provision of homemaker, companion and chore services can be found in Appendix D.

Homemaker Service

The definition of homemaker service, as stated in the 1978-79 Title XX Plan, is as follows:

> "Performance of or instruction in activities such as personal care, home management, household maintenance, nutrition, consumer education, hygiene and child rearing, by a person trained in homemaking skills who is an employee of a local welfare agency or by staff of an organized homemaker agency."

Several statements in the definition help to clarify the performance of homemaker service. For example, the homemaker

1. may actually perform the service or instruct household members in how to perform the service, whether it be house cleaning or child rearing;

2. must be trained;

3. may be a staff member of a local department of public welfare or of an independent homemaker agency, the latter case when homemaker services are purchased by the local department; and

4. carries out varied services to the individual or family depending upon his/her/their needs.

The homemaker services have four stated objectives:

> "To upgrade household, home management and child rearing skills of parents to enable them to attain economic independence."

> "To provide a means whereby an individual/family attains or maintains capacity to function responsibly and achieve a maximum level of independence and self-determination."

> "To provide care, guidance, and/or instruction to an individual/family at risk."

> "To supplement the capacity of an individual/family to function in his own living situation."

Homemaker services, like other Title XX social services, are funded in varying combinations of federal, state and local funds. Due to the limitation in state funding available to match federal monies, state funds are only available for services provided to adult recipients of Supplemental Security Income (SSI) and recipients of former financial assistance programs replaced by SSI who had an allowance for homemaker

services in the assistance grant. Federal funds must be matched totally by local or donated funds when homemaker services are provided to adults who are eligible on the basis of income level status.

Homemaker services may be provided to adults or families with children.

Companion Services

Companion services are defined as follows:

> "Companion services are to be provided to an eligible adult who, because of advanced age, blindness, disability or infirmity, is unable to perform light housekeeping and personal tasks himself and there is no one available to provide these services without cost."

The objectives of companion services are:

> "To supplement the capacity of the adult maintaining or returning to his own home who is unable to assume total responsibility for personal and/or household tasks."
>
> "To reduce harm or neglect by self or others through supplemental task performance."
>
> "To provide a resource for the performance of personal tasks to the adult who is not maintaining his own home but living as a member of another household."

Funding of companion services is provided in the same manner as homemaker services with respect to the availability of state funds, with respect to the clients receiving the service or the required donated or local funds for other clients in need.

In many ways, the provision of companion services is more similar to the homemaker services aspect of homemaker-home health aide services, as explained more fully in Section V than are the homemaker services provided in accordance with its definition. Both the housekeeping and personal care components of companion services are aimed primarily toward the needs of the single individual who may be aged or disabled in such a way as to prevent them from taking adequate care of themselves.

The expanded utilization of companion services has been the target of some criticism, as localities have turned to this service as a less costly alternative to homemaker services. Companions receive compensation as low as the minimum wage and are the recipients of, in the opinions of many, too little training and supervision. Companions may even be self-employed, thereby requiring them to pay their own Social Security tax and fund their own benefits. While these potential problems are recognized, so also is recognized the fact that many more individuals in need can be served through the utilization of a less costly companion service, while homemaker services can be used for families and for individuals with more serious needs. Adequate assurance is needed, however, that companion services are only provided to persons with less serious and demanding needs.

Chore Services

The definition of chore services is:

> "Chore services are to be provided to an eligible adult who, because of advanced age, blindness, disability or infirmity, is unable to perform household and home maintenance tasks himself and there is no one available to provide these services without cost."

The objectives are as follows:

> "To provide safety and security for the adult in his own living situation."
>
> "To maintain independent home or living arrangements where age or disability diminishes capacity."

Funding requirements for chore services duplicate those of homemaker and companion services. Traditionally in Virginia, chore services involve more strenuous and difficult home and household maintenance tasks than those performed through the other services.

Health Related Services

Already mentioned above as one of the Title XX social services purchased on a statewide basis through an agreement with the Health Department are home health services. It is important to point out that home health services represent one component of a large service entitled "health related services", which also includes the Early and Periodic Screening, Diagnosis and Treatment Program and hospital social services.

Home health services are defined to "include provision of instruction and assistance in preventative/restorative health measures in caring for the ill or disabled individual in his home" and "provision of home health nursing service, rehabilitative service through use of physical or speech therapy and educational programs in caring for the individual in the community".

Three objectives are stated in the Title XX plan relating to home health services:

> "To promote, maintain or restore health through minimizing effects of illness and disability and to enable an individual to become self-sufficient."
>
> "To strengthen and safeguard health and health related needs of individuals when there is indication of neglect, abuse or exploitation."
>
> "To enable an individual to receive health care required for remaining in the home or community."

The home health program is a vital mechanism in the delivery of community health services to homebound and bedridden patients. The home health program provides services to any homebound person referred to it by a physician. The person may have required services of a visiting nurse, a home health aide, a physical therapist, a speech therapist, an occupational therapist, a social worker or a combination of these individuals.

A majority of the clients now served by local health departments are over the age of sixty-five years. Between July 1, 1977 and June 30, 1978, 5969 patients under active care were age 65 or older. This represents 68% of all home health patients. On an average, these patients received 22.6 visits each during this twelve month period. The most frequent patient problems handled are stroke and other cardiovascular diseases, muscular skeletal diseases, fractures, diabetes, arthritis and cancers.

Sections III and IV have thoroughly discussed the Medicaid, Medicare and Title XX programs as they relate to home health services. These programs are summarized and directly compared on the basis of significant criteria in Appendix E.

SECTION V HOMEMAKER-HOME HEALTH AIDE SERVICES

Introduction

As documented elsewhere in this report, the provision of homemaker-home health aide services has shown tremendous expansion throughout the United States, expecially during the past twenty years. However, Virginia is one of several states in which this expansion and growth has been limited. For example, on August 11, 1978, memorandum from the American Public Welfare Association identifies no agencies in Virginia which have demonstrated conformity with the basic standards of the service developed by the National Council for Homemaker-Home Health Aide Services. In recognition of the need for such services in Virginia, this Section defines homemaker-home health aide services and identifies essential elements which would facilitate their successful implementation in Virginia. The information included in this Section is consistent with policies and standards developed by the National Council for Homemaker-Home Health Aide Services, which also accredits and approves agencies which demonstrate conformity with its basic standards.

Definition

The Homemaker-home health aide assists the aged, the chronically ill, the person convalescing at home, the physically handicapped, the mentally ill and those who are socially incapacitated to sustain, attain, or regain maximum self reliance in his own home and to enhance the quality of daily life.

This individual's duties involve both home management and personal care. Assigned tasks in the individual's home are visually carried out under the supervision of a nurse, but may be under the supervision of another appropriate professional person, who assesses the need of the client for the service and implements the plan of care. Reports are made to the supervisor concerning changes in the person's condition. Often there is a training component of the service, so that through demonstration and practical suggestion the aide helps the individual make the necessary adjustment in his daily routine to become more self sufficient and to follow safety precautions. Appropriate records are kept as assigned and staff meetings and in-service training sessions are attended by the homemaker-home health aide.

Examples of duties characteristic of a homemaker-home health aide include:

1. Provides personal care of the patient and assists in activities of daily living; such as bathing, toileting, changing clothes, and care of mouth, hair and nails.

2. Provides rehabilitative services for the patient such as helping with prescribed exercise and activities, and assists

patient in ambulation; in moving from bed to chair and in walking. May assist patient as needed to and from and during outpatient clinic or physician visits.

3. Plans and prepares meals, including special diets, gives basic instructions on principles of nutrition, does marketing as needed. Washes or otherwise maintains utensils and equipment used in the course of the visit.

4. Assists with oral medications which can be self-administered; executes prescribed procedures such as hot and cold compresses; changes dressings and position of patient.

5. Performs essential household tasks such as bedmaking, light cleaning (dusting, vacuuming, dry mopping), light laundry (necessary to the comfort and pleasantness of the patient), keeping a safe environment, rearrangements to assure that the patient may safely reach necessary supplies and medications.

6. Does such errands as paying utility or other necessary bills when needed and banking.

To be able to perform such duties, it is appropriate that the homemaker-home health aide meet certain qualfication standards:

1. At least eighteen years of age;

2. Able to read, write and carry out directions;

3. Have knowledge of home management and basic principles in nursing practice; and

4. Possess a sympathetic attitude toward the care of the sick and maturity and ability to deal effectively with the demands of the job.

Training

The House Joint Resolution No. 33 Advisory Task Force was especially concerned about the projected expansion of homemaker-home health aides in Virginia without adequate training of the individuals carrying out the service. The Task Force agrees wholeheartedly with the emphases placed upon training of homemaker-home health aides by the National Council for Homemaker-Home Health Aide Services, Inc. and leaders in the field, who believe that appropriate training can help to protect both the consumers and the providers of the service and ensure that monies spent, whether they be public or private funds, are used effectively.

The Advisory Task Force and the Departments of Health and Welfare support the purpose and intent of the following training guidelines, which were adopted by the National Council in 1977:

1. Aides who receive training must be screened and sponsored by the agency which will employ them and assume responsibility

for their services. In no case should homemaker-home health aides be trained to become independent providers. The moral and legal implications of independently provided paraprofessional services are self-evident.

2. The training of the homemaker-home health aide, both initial and ongoing, is based on a "team concept," in which professionally educated persons assume the responsibility for training the aides as well as the responsibility for case assessment and reassessment, establishing a plan of care (case management) and providing supervision and direction of the aide.

3. Instructors for the course should be familiar with the homemaker-home health aide field and, wherever possible, should have had experience working with an approved homemaker-home health aide service. When possible, instructors should be selected who have had some experience in teaching adults.

4. Field experiences are essential to a good training program. Plans for providing aide trainees with these learning experiences should be worked out jointly by the employing agency and the training resource.

5. The employing agency should have the privilege of monitoring the entire course. The instructors should be given opportunities to observe the aides at work in the homes of the families they serve.

Virginia now has a unique opportunity to assist in the training of homemaker-home health aides as such services expand throughout the Commonwealth. This opportunity is the result of the recent approval of a grant for the State Department of of Health's Bureau of Public Health Nursing in the amount of $73,960. This grant will permit the Department to develop an operational model for Statewide home health aide education. This model will include eighty hours of training provided in the classroom and through clinical experiences. When completed, the model will be available for use in training homemaker-home health aides who provide the service through the public or private sectors. The operational model will be testing the recently developed "Model Curriculum and Teaching guide for Training Homemaker - Home Health Aides". This model training manual outlines the basic training components, including training resources and facilities, supervision and requirements of teachers, and a broad range of methods.

The Departments of Health and Welfare have visited one existing training program for Homemaker-home health aides, which is currently operating in York County. A brief description of this program can be found in Appendix F.

Recipients of the Service

House Joint Resolution No. 33 refers to the need of homemaker-home health aide services to assist aged persons to become self-sufficient. The need of these services for the aged is unquestionably great. Aging individuals, who frequently live alone, often have the combined health care and personal care needs for which agencies often must provide two services -- homemaker services and health care services. As stated in the Resolution, "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". The prevalent needs of the aged for such services is indicated by the data in Section III which identied 68% of the recipients of home health services as aged individuals.

Recognizing the intent of the Resolution, the Advisory Task Force feels it is important to point out the needs for homemaker-home health services among other client groups. There are many severely disabled individuals, adults and children whose needs can be met by homemaker-home health aides as a means of preventing institutionalization and providing support for the individual and relief from stress situations.

Disabled individuals in the United States include:

730,000 of 3.5 million persons with arthritis require assistance in their own homes.

200,000 persons are crippled from muscular disorders.

500,000 persons have multiple sclerosis and related diseases.

671,000 mentally retarded persons are severely disabled.

In Virginia, 2,500 children are recipients of SSI and are eligible for service under the Disabled Children Program of the Bureau of Crippled Children. Approximately 56% of these children receive medical service from the Bureau. The Department of Health's Bureau of Crippled Children treated 20,527 persons during the 1977 fiscal year, including 205 children with cystic fibrosis, 906 with cerebral palsy, 47 with rheunatoid arthritis, 69 hmophiliacs, 506 children with spina bifida, and 36 amputees.

The homemaker-home health aide, a trained, supervised person who works as a member of a team of professionals, is ideally suited to work cooperatively with the primary care provider, usually the parent in the case of a child. Assistance may be provided on a routine basis, as in the case of a child with cystic fibrosis who requires ongoing percussion and drainage treatments, or in time of crisis, such as when a child returns home following surgery and requires additional care. The parents, but more especially the single parent, need relief, particularly when other children in the family need attention. In a number of families, there are several handicapped children, which means there is an even greater need for supportive services. The resource of

volunteers usually available to families is limited due to their reluctance to care for the handicapped child needing semi-skilled care. For example, the child who has seizures, uses appliances, or has special feeding problems may be intimidating to extended family members or neighbors who would otherwise like to assist.

The homemaker-home health aide can serve a number of purposes within the framework of providing supportive services. Often there is a need for a training component when, through emotional support and understanding, demonstration and practical suggestion, the homemaker-home health aide helps the child and/or the parent make the necessary adjustment in his daily routine to become more self-sufficient, to raise the quality of home life, and to follow safety precautions. Education may focus on such areas as adapting meal preparation to a special diet or learning to use equipment correctly and safely. For the severely disabled child, contact with a helping person outside of the nuclear family provides an opportunity to gain independence and attain maximum self-sufficiency, while simultaneously serving as a form of respite care for the primary caretaker.

By observing and reporting changes in the child's condition, and the strengths and weaknesses in individual and family functioning, the homemaker-home health aide assists the professional member of the team in being better abled to develop an adequate care plan for the severely disabled child.

The severely disabled individual, child or adult, if he is to remain in his own home, may require the services of one person to perform both light home services and limited health related services and to be known as a homemaker-home health aide.

Benefits

There are two key areas of benefits to be derived from the availability of homemaker-home health aide services, in comparison to the separate availability of homemaker services and home health services services to the client and cost savings.

In terms of services to clients, the Advisory Task Force and the Departments have become aware of situations in the State in which individuals and families are receiving at the same time the two separate services. A homemaker, who is employed by or whose services are purchased by the local department of public welfare, may be providing housekeeping and home management services to an individual during his or her recovery from an illness at home. Rather then requiring the individual client to deal with two staff persons, who could conceivably be in the home at the same time or at different times duplicating the services of the other, a homemaker-home health aide could provide both services, facilitating the relationship to be established with the client. The more comprehensive the service, the greater the likelihood that a clients needs will be met and the less the likelihood that inefficiencies in service delivery will occur.

The other significant area of benefits involves potential cost savings to the agencies involved. An example, from Greenwich, Connecticut can illustrate this issue. Prior to 1970 in the City of Greenwich, homemaker services were provided by the Department of Social Services while the community hospital provided home care, including home health aide service. Between 1970 and 1975 these two services were gradually merged under the administration of the Department of Social Services with supervision of personal care provided by the Department of Health. The hospital entered into an agreement to purchase the services of the home health aides. The results of the change in service delivery were startling. In the year before the merging of services began, the Department had provided 16,132 hours of homemaker services and the hospital had provided 28,378 hours of home health aide services, for a total of 44,510 hours. During the first year of completing integrated service, a total of 32,952 hours of service were provided the same community, representing a reduction of 11,558 service hours or a saving of greater than 25%. The merger occurred as a result of the overlap and inefficient use of the aides.

It is also important to point out the qualitative benefits of home-based services in general to the patient. Appendix G identifies such benefits in a meaningful way, which can be easily contrasted to conditions of institutionalization.

References

Florence M. Moore, "New Issues for In-Home Services", Public Welfare, Vol. 35, No. 2, Spring, 1977, pp. 26-37

SECTION VI -- SERVICE DELIVERY

Agency Trends

Thusfar, this report has referred to homemaker - home health aide services in terms of the individual who actually provides the service. An important distinction which must be made in understanding homemaker - home health aide services and how they are delivered to the client relates to the auspice by which the service is delivered. Section V refers to the necessary supervision and training of homemaker - home health aides to insure adequate and appropriate service delivery. Such supervision and training is provided by the agency for whom the homemaker - home health aide is employed.

There are several types of agencies who employ homemaker - home health aides -- public, voluntary, proprietary (for profit), non-profit, and combinations thereof. Since the late 1950's, there have been dramatic shifts in the types of agencies providing the service. In 1958, approximately three-fourths of all homemaker programs were provided by voluntary agencies, with all the remaining programs under public auspices and none under proprietary ownership. However, in 1973, 56% of such agencies were operated under public auspices, 28% by voluntary agencies, 7% by combined public-voluntary agencies, and 9% by agencies with proprietary ownership. The National Council for Homemaker-Home Health Aide Services, Inc. has undertaken a new survey in 1977, from which data supports continued marked increases in the proprietary and government agencies and a recent phenomenon of private non-profit agencies, which did not exist in 1973. The actual configuration of the current service delivery network is as follows:

51% public
23% voluntary non-profit
15% proprietary
4% combined public voluntary
4% private non-profit
3% other or unable to be determined

The National Council believes these trends will continue, particularly in the growth of the proprietary sector. This growth is further encouraged by two developments in the Medicare program:

1. The program now allows reimbursement of proprietary agencies which subcontract with certified home health agencies.

2. Twenty-one states have now enacted licensing laws which permit proprietary agencies to participate in the Medicare program.

Agency Standards

As indicated elsewhere in this report, the National Council for Homemaker-Home Health Aide Services, Inc. is the national standard-setting organization. It has and continues to play an extremely significant role in the leadership for the provision of homemaker-home health aide

services and appropriate standards for the services. The basic standards are designed to safeguard the consumer, the third-party payer and the service provider. The basic national standards for homemaker-home health aide services are identified below (interpretive information developed by the National Council for each standard can be found in Appendix H):

1. The agency shall have legal authorization to operate.

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

3. There shall be no discriminatory practices based on race, color or national origin, and the agency either must have or be working toward an integrated board, advisory committee, homemaker-home health aide services staff, and clientele.

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

5. The service shall have written personnel policies, and a wage scale shall be established for each job category.

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

7. Every individual and/or family served shall be provided with these two essential components of the service:

   A. Service of a homemaker-home health aide and supervisor, and

   B. Service of a professional person responsible for assessment and implementation of a plan of care.

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

9. There shall be: a) initial generic training for homemaker-home health aides such as outlined in the National Council for Homemaker Services Training Manual, and b) an ongoing in-service training program for homemaker-home health aides.

10. There shall be a written statement of eligibility criteria for the service.

11. The service, as an integral part of the community's health and welfare delivery system, shall work toward assuming an active role in an ongoing assessment of community needs and in planning to meet these needs including making appropriate adaptations in the service.

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

13. The governing authority shall evaluate through regular systematic review all aspects of its organization and activities in relation to the service's purpose(s) and to community needs.

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

Accountability Procedures in Virginia

As indicated above, homemaker-home health aide services may be provided by many types of agencies and the Departments of Health and Welfare want to insure that such agencies do so with an appropriate degree of accountability. The ability of such agencies to meet the basic standards established by the National Council is one way of insuring accountability, but there are additional procedures which would require agencies to operate in prescribed ways.

The 1978 session of the General Assembly passed House Bill No. 159, enacting a new Chapter 29 of Title 32 of the Code of Virginia, establishing the Home Health Agency Licensing Law. The new Sections 32-439 through 32-448 of the Code of Virginia require all home health agencies to be licensed by the State Department of Health. A "home health agency" is defined as a "public or private agency or organization, whether operated for profit or not for profit, which provides skilled nursing services and at least one additional home health service at a patient's residence....". The State Board of Health has recently promulgated new rules and regulations governing the licensure of home health agencies, and these regulations shall be effective January 1, 1979.

These rules and regulations do not prescribe standards for homemaker-home health aide services; however, they do require licensure of agencies which might provide such services, and they specifically state minimum requirements for the home health aide position which currently exists. The requirements for this position, which can be found in Appendix I, include the following provisions which were stressed in Section V on homemaker-home health aid:

1. Training is required to the extent that the individual must satisfactorily complete at least forty-two hours of classroom instruction and eighteen hours of practical application;

2. Duties include, in addition to more specific health related services, the performance of incidental household services which are essential to patient health care; and

3. Supervision is provided by an appropriate professional staff person, to include supervisory visits to patients' residences at least every two weeks.

It is important to point out that the minimum standards set forth in the licensing regulations are consistent with federal regulations for the certification of home health agencies participating in the Medicare and Medicaid programs. Therefore, State licensure will permit for profit home health agencies to participate in the federal payment

programs. Public and non-profit agencies will have their programs certified by the State Department of Health and will continue their participation in the Medicaid and Medicare programs.

Local departments of public welfare purchase services from many vendors in accordance with the procedures established by the State Department of Welfare for social services funded by Title XX of the Social Security Act. Some services are, in fact, purchased from some of the same home health agencies which will be licensed by the State Department of Health, as indicated above. However, the Department of Welfare is not mandated by federal or State law to license or certify such programs, even when services are purchased from them. However, the Department of Welfare does.....

1. Approve all rates of pay for services purchased from vendors;
2. Expect agencies to meet basic standards for services; and
3. Requires the local departments of public welfare to insure that services are provided prior to payment for service.

Delivery By Public And Private Sectors

As indicated in trends in homemaker-home health aide services, the private sector is rapidly expanding its services capabilities. The Advisory Task force agreed that demand for home health services is expanding to the extent that public and non-profit agencies cannot meet that demand. The Task Force further agreed that all organizations public, nonprofit and private for profit -- which can deliver quality services to clients should participate in meeting the public need. In fact, there was also agreement that the non-public agencies can often provide adequate service at a lower unit cost than public agencies, and such agencies should have an opportunity to do so.

Unit costs among agencies for apparently comparable services vary considerably. It is appropriate to point out study results which have documented the fact that proprietary agencies can have a lower unit cost than others. One primary factor for this situation is the greater overhead, administrative costs experienced by public agencies. This often results from better salaries and benefits to employees, but also from the obvious requirement that public agencies must provide services in localities in which it may not be cost-beneficial to do so.

Other studies have shown that while the hourly cost of some agencies is greater than others, due to additional supervisory controls, the actual cost per case will often be lower due to the impact of those controls. Adequate supervision usually insures that clients receive no more services than that which they need. Agencies without adequate supervision often provide the service long after the individual no longer needs it, thus wasting many hours of service delivery and costs for providing the service.

The type of service provided by proprietary agencies can be further understood by the "Client Bill of Rights" found in Appendix J.

SECTION VII -- FUNDING ALTERNATIVES

Introduction

As indicated in Section VI, many types of agencies can and do deliver homemaker-home health aide services to clients in need throughout the nation. Trends in service delivery support the fact that the types and numbers of agencies providing the service in future years will continue to increase, particularly with respect to proprietary and private non-profit agencies. The continuation of such national trends is dependent upon the continued availability of funding for the service.

The availability of funds is especially important to the delivery of homemaker-home health aide service in Virginia. As the service is in its infancy in Virginia, growth and expansion in the service can only occur if appropriate funding mechanisms are identified and utilized. Virginia does not have the tradition of service delivery as do other states, where such tradition has created a constituency of clients and agencies who advocate for the service and help maintain the needed commitment for its funding and expansion.

Current Funding Mechanisms

Certain methods for funding homemaker-home health aide services are now available. The type of mechanism used for an individual client depends upon several key factors:

1. Agency providing the service;

2. Client resources and program eligibility; and

3. Level of service needed.

Each of these factors will be discussed with the identification of available funding mechanisms.

If the individual is in need of homemaker-home health aide services and has available financial resources, one obvious funding mechanism is payment for the service by the client. This method of funding allows the client the greatest flexibility in the service received to meet the client's needs and in the type of agency to provide the service. Of course, client resources are usually so great in such circumstances that the client is not eligible for funding from most public resources.

Another potential funding mechanism, usually for those with resources greater than that which qualifies them as eligible for public services, is available through private insurance. Not all health insurance companies include in their coverage the funding of home health services, but trends do indicate a distinct growth in this pattern. This trend is due to the recognition that services provided at home can be less expensive than hospital or institutional services, thus providing a cost savings to the insurance companies. Services funded in this way may be more limited in type and length of service but can include

homemaker-home health aide services. The services reimbursed may usually be provided by any appropriate certified agency.

One of the greatest resources for funding of homemaker-home health aide is federal funding. Current federal funding in Virginia for this service is primarily available through the Medicaid and Medicare Programs. However, the funding is only available with certain limitations and restrictions, which include:

1. financial and categorical eligibility requirements must be met;

2. services can only be provided to support skilled nursing care for the Medicare Program;

3. service can only be given for the personal care of the patient, as federal reimbursement is not available for extended services to family members.

As explained in more detail in Section III, the enactment of recommendations for Medicaid or Medicare which are included in the HR 3 report would ease some of these restrictions. However, eligibility factors and the components of service needed will continue to be issues for reimbursement. Service delivery for Medicaid and Medicare will expand to proprietary agencies in Virginia, when such agencies qualify under the new Home Health Agency Licensing Law, now being implemented by the State Department of Health.

As indicated in Section IV, social services programs funded through Title XX of the Social Security Act can also provide homemaker-home health aide services. The current Title XX contract between the State Department of Welfare and the State Department of Health provides federal funds which can reimburse expenditures of local health departments for home health services which are provided to individuals who are Title XX income eligible but not eligible for Medicaid or Medicare. Such funds can be used for home health aide and personal care services.

Potential Funding Mechanisms

The Advisory Task Force and the Departments of Health and Welfare have become aware of other states, such as North Dakota, which have extensively utilized Title XX funds to provide homemaker-home health aide services. While the state-to-state Title XX contract described above is one approach to achieve this end, this contract is limited in scope and has not yet achieved 100% utilization. Virginia is limited in the extent to which its social services programs can be expanded using Title XX funds, since it is already spending at its current ceiling. However, an additional approach to expanding homemaker-home health aide services to individuals who are not eligible for Medicaid or Medicare would be to expand the current definition of the homemaker service in the State's Comprehensive Title XX Social Services Plan to include homemaker-home health aide services. This additional option provided

localities would allow them greater flexibility in meeting the needs of clients, if the locality chooses to do so in its geographic area plan. Furthermore, homemaker service could be identified as a mandatory home-based service in the Title XX Plan.

Another approach to expanding homemaker-home health aide services would circumvent the tendency toward fragmented service delivery which results from fragmented, uncoordinated funding sources for the individual components of the service. That is, Medicare and Medicaid will currently reimburse personal care expenditures for eligible individuals, but will not reimburse environmental aspects of in-home care which are not closely related to the health problem. This is often a problem for families who need the environmental aspects, which can be covered by Title XX. Department of Health, Education, and Welfare officials have ruled that Medicare and Title XX regulations permit the same individual to provide services which would be reimbursed by the separate programs, if the appropriate program were only billed for those services covered under it. Such separate billing procedures would help to eliminate the need for two separate individuals to provide different but related services on separate trips to the home. Duplicative and wasteful procedures could be prevented in this way. A homemaker-home health aide of any certified home health agency could provide the joint service with separate reimbursements, with an adequate system to segregate the separately reimbursable services.

SECTION VIII -- RECOMMENDATIONS

According to federal guidelines, the home health aide is assigned to a particular patient by a registered nurse. The aides's duties include:

1. the performance of simple procedures and extension of therapy services;
2. personal care;
3. ambulation and exercise;
4. household services essential to health care at home;
5. assistance with medications that are ordinarily self-administered; and
6. reporting changes in the patient's conditions and needs.

The Virginia Medicaid Program guidelines are the same as those for the Medicare Program, with the exception that Medicare is limited to the patient requiring a skilled care service.

RECOMMENDATION #1:

The position of homemaker-home health aide should be created to provide personal care and household services essential to health care and health-related services to home bound individuals.

Each local health department in the Commonwealth of Virginia is a certified home health agency and provides part-time or intermittent nursing services and at least one other covered therapeutic service,such as physical, speech or occupational therapy, medical social services, or home health aide services.

The job title currently used for the provider of home health aide services, as a member of the home health team, is Public Health Nursing Aide A or Public Health Nursing Aide B.

Federal guidelines state that home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write and carry out directions, and maturity and ability to deal effectively with the demands of the jobs. The local health department position of Public Health Nursing Aide additionally requires an individual to have graduated from high school or to have successfully completed an equivalency examination, in accordance with requirements established by the State Department of Personnel and Training.

RECOMMENDATION #2:

The State Department of Personnel and Training, working cooperatively with staff of the State Departments of Health and Welfare and other appropriate persons, including the private sector, should develop a job description, job requirements and training for the position of homemaker-home health aide.

The Department of Health, Education, and Welfare (HEW) administers the principal federal programs which provide home health care -- Title XVIII, Medicare, and Title XIX, Medicaid. The Department is also responsible for administering various home care or in-home service programs which are authorized under the Social Security Act, Title XX Social Services, and Title III of the Older Americans Act.

Under current legislation, the various federal home health programs cannot be coordinated. Likewise, other related home delivered services for the elderly are available through so many different programs, that effective coordination and delivery of home health and other in-home services cannot be achieved.

RECOMMENDATION #3:

The Virginia Office on Aging should take the lead in coordinating Virginia's efforts in support of the development of a sound State and national policy which would consolidate home health and in-home service programs.

The Medicare and Medicaid Programs are primarily for the medical care aspects of in-home services to eligible beneficiaries. Title XX primarily covers the environment aspects of in-home care for those who are eligible. Sending two paraprofessionals into the same individual's home, one to furnish home health aide services and another to furnish homemaker services, is duplicative, time-consuming and wasteful.

Current regulations, however, do not prevent the agency providing homemaker-home health aide services from billing Medicare or Medicaid for the home health services provided and Title XX for homemaker services. The primary requirement is to establish procedures to ensure that the programs are billed only for the services provided.

RECOMMENDATION #4:

Local welfare departments, which provide homemaker services and local health departments, which provide home health aide services, should

work closely together to ensure that cases requiring both homemaker and home health care receive homemaker-home health aide services from a single individual whenever possible.

Paraprofessionals are key persons in caring for people, and they must be strong, reliable, and competent for the tasks. They need in-service training which is meaningful and related to their capacities, and they must have the physical tools to perform their work.

The Bureau of Nursing of the State Health Department has been awarded a grant for the training of homemaker - home health aides. The manual to be used for the eighty hour training experience was proposed by educators in the field working cooperatively with the National Council for Homemaker-Home Health Aide Services, Inc. Implementation of the grant will be carried out through local community colleges and vocational technical schools.

RECOMMENDATION #5:

Staff of local welfare departments who provide direct homemaker services and who meet the job requirements of the position of homemaker - home health aide should be given priority to participate in the nursing project for the training of homemaker - home health aides.

The principal federal programs providing home health services are Titles XVIII, XIX and XX of the Social Security Act and Titles III and VII of the Older Americans Act. Each program is designed to provide health or social services to specific population groups -- Medicare for the aged and disabled and Medicaid for the poor or public assistance recipient. Social services funded by Title XX and Title III of the Older Americans Act are broadly defined social services with emphasis on persons with low incomes.

The list of home services not only varies from state to state, but also, in Virginia varies between the Title XX geographic areas and the area agencies on aging. Furthermore, in-home services that are available may be limited, for example, to income maintenance recipients. In light of Title XX expenditures in Virginia reaching the federal ceiling and the required local spending for mandated services, there is concern that services to the aged will be low priority services.

RECOMMENDATION #6:

In the Virginia Title XX Comprehensive Social Service Plan for the fiscal year ending June 30, 1981, homemaker service should be expanded to include home health services and homemaker - home health aide

services and consideration should be given to make such service mandatory in all localities.

In order to provide complete, comprehensive and workable health programs, the resources of both public and proprietary health care providers must be expanded. Even when all public and private tax-paying and tax-supported providers are combined, a shortage of adequate staff, financial resources and coordination is projected.

RECOMMENDATION #7:

Non-profit, voluntary and public certified home health agencies should consider subcontracting with proprietary home health agencies as one alternative means of expanding services without hiring additional staff.

APPENDIX A -- TITLE XIX (MEDICAID) NURSING HOME PRE-ADMISSION SCREENING

On May 15, 1977, the Virginia Medical Assistance Program implemented the Nursing Home Pre-Admission Screening Program. The purpose of the Program was to delay or avoid unwanted and/or inappropriate nursing home placements through the use of the interdisciplinary team approach and the mobilization of community resources. A second purpose of the Screening Program was to identify services required in the community to meet the needs of elderly and disabled persons.

Persons screened are applicants for nursing home admission who are not in a community hospital or another nursing home at the time of application. Screening occurs if the individual is or will become Medicaid eligible within 90 days of nursing home admission.

Persons who are applying for nursing home admission are screened by the screening committee of the local health department in the area in which they reside. This committee is, at a minimum, composed of a local health department physician, a public health nurse and an adult service social worker. Local committees are encouraged to seek participation of other community agencies which offer services to the elderly and disabled.

In addition to screening those persons previously described, screening of prospective nursing home candidates from facilities of the Department of Mental Health and Mental Retardation is done by the Utilization Review Section of the Virginia Medical Assistance Program.

In order to capture information which is reflective of the individuals being screened and to identify the kinds of services that are available and not available throughout the State, a form is submitted by the screening committee to the Virginia Medical Assistance Program on each individual screened.

During the first year of the Screening Program, 2,062 individuals statewide were screened by the local screening committee, 444 of which were kept in the community (22%).

Reporting indicates that the service most often "unavailable" to maintain individuals in the community is companion service (28% of the cases), followed by chore service in 21% of the cases, homemaker services in 21% of the cases, meals in 19% of the cases, and adult day care in 18% of the cases. Only home health services were available in all areas of the state, and they are usually in insufficient quantity to meet the need in most cases.

Reporting reveals several reasons needed services are not available. One reason is that the individual does not meet the income eligibility requirements for the services. This is particularly true for individuals whose income is in excess of the allowable amount for Supplemental Security Income eligibility, and who are, therefore, ineligible for such services as chore and companion services under Title XX in Virginia. In many instances, the service "needed" does not exist in the community. The most striking example of this is adult day care.

Another reason is that the service is not offered for a sufficient number of hours to meet the need. In addition to the service needs previously cited, a need for sheltered living arrangements, such as homes for adults and foster homes, is indicated.

During the first year of the program, 197 patients in State Mental Health and Mental Retardation facilities were screened. Twenty-two percent were not approved for nursing home care. In those cases not approved it was felt that the most appropriate placement would be continued hospitalization or movement into a licensed adult home or foster home.

It is not possible to accurately measure the financial benefits of the Screening Program. Home care is usually less expensive than institutional care. Savings in terms of social cost are much more visible. Disabled and elderly persons are not now being uprooted from their homes and communities and placed in the unfamiliar and dependent living arrangements of nursing homes whenever alternative solutions exist. Inappropriate and unwanted nursing home placements have been delayed and/or avoided through the mobilization of community resources.

In addition, Virginia is beginning to specifically identify the services that are required in the community and to measure the service availability to meet the needs of its elderly and disabled citizens. Through demonstration of need for services, community based services, which today are not available to the elderly and disabled, should become available in the future.

COMMONWEALTH OF VIRGINIA
LOCAL NURSING HOME PRE-ADMISSION SCREENINGS

Total No. Screened 587 Quarter: July, 1978 - September, 1978 Total Person Hours 2602

SOURCE OF REFERRAL		RECOMMENDATION		SERVICES REQUIRED-AVAILABLE		NOT AVAIL.
Self	13 (2%)	Nursing Home	466 (79%)	Meals	114 (19%)	142 (24%)
Family	216 (37%)	No Change	60 (10%)	Chore Services	40 (7%)	140 (24%)
Friend	11 (2%)	Home for Adults	42 (7%)	Companion Svcs	105 (18%)	182 (31%)
Welfare Dept	239 (41%)	W/Relatives	3 (.5%)	Home Health	104 (18%)	15 (2%)
Other	88 (15%)	Other	18 (3%)	Homemaker	37 (6%)	134 (23%)
				Day Care	20 (3%)	96 (16%)
				Other	33 (6%)	228 (39%)

PRIMARY DIAGNOSIS		FUNCTIONAL CAPACITY		SPECIAL DISABILITIES	
Hypertension	166 (28%)	Completely Bedridden	65 (11%)	Paralysis/Paresis	116 (20%)
Diabetes	95 (16%)	Up in Chair only	125 (21%)	Ambulation	254 (43%)
eart Disease	185 (31%)	Ambulatory with Help - Device	176 (30%)	Contractures - Deformities	98 (17%)
her Cardio-ascular Disease	234 (40%)	Ambulatory with Help - Person	125 (21%)	Impaired Vision	133 (23%)
Cancer	42 (7%)	Independent Ambulation	135 (23%)	Deafness	125 (21%)
Arthritis	165 (28%)			Confused - Aberrant Behavior	278 (47%)
Other	338 (57%)			Other	100 (17%)

PRESENTING PROBLEM	
Personal Care	451 (77%)
Care of Home	455 (77%)
Food Preparation	473 (80%)
Menace to Others & to Self	133 (23%)

CURRENT LIVING ARRANGEMENT	
Alone	91 (15%)
W/Spouse	64 (11%)
W/Child	182 (31%)
W/Other Relative	119 (20%)
W/Friend	23 (4%)
Home for Adults	68 (12%)
Rooming Home	8 (1%)
Room & Board	12 (2%)
Other	9 (2%)

Nursing Home Approved:

466 (79%)

Nursing Home Not Approved:

123 (21%)

Average Hours per Screening:

4.42

APPENDIX B -- 1978-79 STATEWIDE SUMMARY OF TITLE XX SERVICES

Service	Total Number Served Statewide[1]	Total Expenditures Statewide[2]
Adoption Services[3]	4,872	1,302,467
Case Management Services	32,324	1,745,206
Chore Services	552	266,705
Companion Services	8,164	10,972,543
Counselling & Treatment Services	30,408	4,314,177
Court Services	9,176	1,049,198
Day Care Services for Adults	932	558,202
Day Care Services for Children[3]	16,013	11,133,981
Education and Training Services	16,639	1,211,486
Emergency Needs Services	18,642	1,720,816
Employment Services[3]	17,210	4,969,167
Family Planning Services[3]	13,669	3,941,442
Family & Personal Adjustment Counselling	54,107	4,040,871
Foster Care Services for Adults	338	137,435
Foster Care Services for Children[3]	18,091	12,149,592
Health Related Services (EPSDT[3])	56,685	2,945,300
Homemaker Services	3,507	1,348,879
Housing Services	14,895	1,261,518
Information & Referral Services[3]	146,466	3,891,190
Interpreter Services	199	24,275
Legal Services	4,264	905,664
Nutrition Related Services	6,599	491,976
Protective Services to Aged, Infirm or Disabled Adults	7,901	1,097,988
Protective Services for Children[3]	39,752	5,576,203
Socialization/Recreation Services	9,097	817,875
Services to Specified Disabled Individuals	3,371	2,559,955
Transportation Services	32,631	2,868,087
Vocational/Rehabilitation Services for WIN	1,304	105,114
WIN Medical & Remedial Services	1,144	104,649
TOTAL:	568,952	83,511,961

[1]Does not include numbers served under State contracts.

[2]Includes expenditures under client specific State contacts.

[3]Mandated Services (plus three services to SSI recipients)

APPENDIX C

1977-78 SOCIAL SERVICES PROGRAMS UNDER TITLE XX

Service Program	Total Cases Adult	Child	Total Expenditures
Adoption Services	504	2,901	$ 1,399,127
Case Management	17,986	3,974	2,982,638
Chore Services	299	-	81,335
Companion	7,902	26	8,058,674
Counseling & Treatment	12,793	2,856	4,361,332
Court Services	1,945	4,339	1,339,671
Day Care/Adults	857	30	1,590,406
Day Care/Child	12,517	1,008	10,749,569
Day Care/Child-development	65	202	29,386
Education & Training	7,955	2,446	1,426,234
Emergency Needs	11,117	1,210	1,372,881
Employment Services	9,003	550	4,496,524
Family Planning	40,602	20,345	3,753,306
Family & Personal Adjustment	30,501	5,318	5,346,211
Foster Care/Adults	66	-	43,410
Foster Care/Child	586	16,797	12,015,425
Health Related	23,960	4,967	3,827,323
Homemaker	1,373	181	494,929
Housing Services	9,587	551	1,150,269
Information & Referral	121,603	-	1,349,484
Interpreter Services	20	5	5,129
Legal Services	5,837	215	756,708
Nutrition Related	2,093	262	473,952
Prot. Services Adults	3,880	-	2,506,241
Prot. Services Child	7,013	21,904	5,541,690
Social & Recreation	2,654	1,952	739,877
Services to Specified Disabled Individuals	610	368	691,298
Transportation	13,617	3,426	2,763,294
Voc. Rehab for WIN	35	2	27,417
WIN Medical & Remedial	13	-	48,494
TOTAL	346,993	95,835	$ 79,422,234

APPENDIX D--DEPARTMENT OF WELFARE MANUAL FOR HOME BASED CARE SERVICES

HOME BASED CARE SERVICES

13100 GOAL

13200 OBJECTIVES

- 13210 Homemaker Services
- 13220 Companion Services
- 13230 Chore Services

13300 ELIGIBLE PERSONS

- 13310 Purchased Homemaker Services
- 13320 Purchased Companion and/or Chore Services

13400 BASIC POLICY REQUIREMENTS

- 13410 Homemaker Services
- 13420 Companion Services
- 13430 Chore Services
- 13440 Requirement for Maintaining Income Level of Certain Recipients of OAA or APTD, December, 1973

13500 PROCEDURES FOR PURCHASE OF HOMEMAKER, COMPANION AND CHORE SERVICES

- 13510 Application
- 13520 Verification of Eligibility
- 13530 Determination of Vendor Payment Authorization
- 13540 Method of Payment
- 13550 Determination of Eligibility for December, 1973 Recipients
- 13560 Financial and Statistical Records and Reports

13000 HOME BASED CARE SERVICES

13100 GOAL

Preservation of homelife for the aged or disabled adult and of family life within the community.

13200 OBJECTIVES

13210 Homemaker Services

1. To upgrade household, home management and child rearing skills of parents to enable them to attain economic independence.

2. To provide a means whereby an individual/family attains, regains or maintains capacity to function responsibly and achieve a maximum level of independence and self-determination.

3. To provide care, guidance, and/or instructions to an individual/ family at risk.

4. To supplement the capacity of an individual/ family to function in their own living situations.

13220 Companion Services

1. To supplement the capacity of the adult maintaining or returning to his own home who is unable to assume total responsibility for personal and/or household tasks.

2. To reduce harm or neglect by self and others through supplemental task performance.

3. To provide a resource for the performance of personal tasks to the adult who is not maintaining his own home but living as a member of another household.

13230 Chore Services

1. To enable the adult to improve his housekeeping standards.

2. To provide safety and security for the adult in his own living situation.

3. To maintain independent home or living arrangements where age or disability diminishes capacity.

13300 ELIGIBLE PERSONS

13310 Purchased Homemaker Services

1. State funds are available to match local and federal funds for purchased homemaker services for adult (18 years of age or older) recipients of SSI

where the service and the population to be served are in the geographic area Title XX Service Plan and for December, 1973 recipients of OAA or APTD for whom services are mandated to be maintained by Social Security Administration. The December, 1973 recipients must be included in the geographic area service plan.

2. Services may be purchased for individuals (adult and child) other than the population designated above, based on income maintenance or income level status when the service and population to be served are included in the Title XX geographic area service plan and where local or donated funds are available to match federal reimbursement.

3. Direct Homemaker Service Provision

Families and individuals are eligible for provision of direct services by local agency homemaker staff where the service and the population to be served are included in the geographic area service plan as follows:

a. Recipients of ADC;
b. Recipients of SSI (children and adults);
c. Families and adults based on income level status; or
d. Children in need of protective services whether or not the family income is in excess of Title XX income levels.

13320 Purchased Companion and/or Chore Services

1. State funds are available to match local and federal funds for purchased companion and/or chore services for adult recipients of SSI where the service and the population to be served are in the geographic area Title XX Service Plan and for December, 1973 recipients of OAA or APTD for whom services are mandated to be maintained by Social Security Administration. The December, 1973 recipient must be included in the geographic area service plan.

2. Services may be purchased for adult individuals other than the population designated above, based on income level status where the service and population to be served are included in the Title XX geographic area service plan and where local or donated funds are available to match federal reimbursement.

13400 BASIC POLICY REQUIREMENTS

13410 HOMEMAKER SERVICES

State Board rules and regulations establish the following basic policy for purchase of homemaker services for eligible individuals. (State Board Minutes, April 6, 1976).

1. Homemaker Services Defined

Performance of or instruction in activities such as personal care, home management, household maintenance, nutrition, consumer education, hygiene and child rearing, by a person trained in homemaking skills who is an employee of a local welfare agency or by staff of an organized homemaker agency.

2. Purchased Homemaker Services

a. Conditions for Purchase

(1) Homemaker services shall be purchased only from organized homemaker agencies. One local welfare agency may not purchase homemaker services from another local welfare agency. Local welfare agencies who have homemaker staff should make these services available to eligible individuals whenever possible, rather than through use of purchase method.

(2) Homemaker agencies, from whom services are purchased, shall meet standards established by State Board.

(3) Homemaker services shall be purchased in compliance with policy governing the State's Purchase of Service plan.

(4) Homemaker services may be supplemented by purchased chore services up to sixteen (16) hours a month.

(5) A local welfare department shall not authorize and pay a homemaker agency for the service of any one homemaker for more than forty (40) hours of service per week per client. For additional hours of service, other homemakers shall be employed.

b. Standards for Homemaker Providers

Organized homemaker agencies shall meet the standards established by State Board, as follows: (State Board Minutes, May 27, 1975).

(1) Homemaker programs shall be provided by an organization and such organization may be public, private or voluntary.

(2) Homemaker programs may be provided by an organized unit within an agency with broader functions or by an independent homemaker agency.

(3) The homemaker agency or organization from which homemaker services are purchased by local welfare departments shall have appropriate administrative authority and/or legal status for establishing program and policies which meet State Department requirements for purchase.

(4) Homemakers shall be employed in accordance with the homemaker agency's standards for selection, assignment, training and supervision.

(5) Duties of the homemaker shall be to provide instruction in or actual performance of activities related to housekeeping, home management, food preparation, personal care and in emergencies to assume the total responsibility necessary to maintain the client in his own home.

(6) The homemaker agency must have insurance coverage on its employees for protection of its staff, the client, and departments of public welfare/social services.

c. Rate of Payment and Extent of Coverage

(1) Routine Homemaker Services

(a) The maximum hourly rate authorized for State financial participation shall be in an amount up to but not to exceed $4.50 an hour.

(b) Routine homemaker services are to be provided as required not to exceed 20 hours a week for any one recipient.

(c) Hourly rates and number of hours in excess of the maximum may be paid from local or donated monies to match Title XX funding provided the service and the local or donated monies are included in the geographic area service plan.

(2) Emergency Homemaker Services

When the individual is at minimal functioning level or unable to function on his own, services provided on an emergency basis are defined as those in which the homemaker is required to assume direct personal and/or home management responsibilities and activities.

Emergency homemaker services to meet a crisis situation are to be provided in accordance with the following requirements:

(a) The maximum of twenty (20) hours a week is not applicable;

(b) Payment may be made for homemaker services up to eight (8) hours a day not to exceed thirty (30) days in any one fiscal year to provide time during which the crisis situation becomes more stabilized or alternate arrangements for longer term care can be made.

(c) Emergency homemaker services shall be supplemented by Emergency Companion Service of up to sixteen (16) hours in a 24 hour period where the need exists.

(3) Conditions for Direct Homemaker Service Provision

(a) Provision of homemaker services shall be based on the priority needs of the client in relation to the number of agency homemakers.

(b) The maximum coverage of twenty (20) hours a week will not apply.

13420 COMPANION SERVICES

State Board rules and regulations establish the following policies for purchase of Companion services: (State Board Minutes, April 6, 1976)

1. Definition

Companion service is the provision, through purchase, of personal aid, light housekeeping tasks and/or companionship services to an eligible adult who, because of advanced age, disability or infirmity, is unable to care for himself without assistance and there is no one to provide the needed services without cost.

2. Conditions for Purchase

a. Companion providers shall meet standards established by State Board.

b. Companion services shall be purchased in compliance with State Welfare policy governing purchase of service as related to authorization, invoice, payment and record keeping.

c. Companion services may be supplemented with up to sixteen (16) hours of chore services per month when needed.

d. Companion services shall not be authorized on behalf of any adults in an institutional setting, (e.g. domiciliary care, nursing homes).

e. Companion providers are exempt from minimum wage and overtime payment.

f. Where the provider is receiving Supplemental Security Income based on disability or age, the effect which the receipt of income as a service provider will have on his entitlement to and amount of Supplemental Security Income shall be discussed with the provider who is responsible for notifying the Social Security Administration.

g. A person whose needs are being met in the Supplemental Security Income payment as "essential to the well-being of the client" is not to be approved as a provider.

3. Standards for Companion Providers

Companion providers shall meet standards established by State Board, as follows: (State Board Minutes, April 6, 1976).

a. The provider of services shall be a responsible individual who is mentally and physically capable of performing the companion services

being purchased. It shall be the judgment of the service worker to determine whether a medical examination certifying the capability of the provider is needed. Payment for the medical examination shall be paid from Administrative funds.

b. The age of the provider from whom services are purchased shall be governed by the companion tasks to be performed; the provider shall be in an age range to have gained the basic knowledge and/or experience to accomplish the assigned tasks satisfactorily on behalf of the client.

c. Companion services shall not be purchased from any person young enough to cause performance of companion duties to be in violation of child labor laws.

d. The provider shall be capable of taking directions and following instructions for performance of companion services from the client or the person authorized to act on behalf of the client.

e. A parent/spouse or relative of an eligible recipient may be approved as a companion provider if an assessment shows that he/she is the most available and/or qualified person to provide the service and this would be the best plan of care for the recipient.

When a companion provider is a parent/spouse or relative of an eligible recipient, authorization and payment shall be made only for those companion services that are not considered to be part of the normal routine of keeping and managing a household.

The case record should clearly substantiate the reasons why a parent/spouse or relative of an eligible recipient is approved as a companion provider.

4. Basic Components of Service

The basic components of Companion services include:

a. Personal Aid Services
Help with individualized activities such as bathing, bedmaking, personal cleanliness and hygiene, room care, dressing, preparation of light meals, feeding client.

b. Light Housekeeping Tasks
Routine light housework such as cooking, cleaning, personal laundry, washing and ironing.

c. Companionship Services
Essential errand running, personal shopping for client, sitting with client, providing general supervision and escort services.

5. Levels of Care of Companion Service and Hours of Coverage

a. Routine Services - Services consist of provision of personal aid, light housekeeping and/or companionship services up to a maximum of twenty (20) hours a week when the individual is unable to care for himself without assistance and there is no one to provide the needed services without cost.

b. High Priority Service Need of a Chronic Condition - Adults eligible for this level of service have a chronic physical or mental condition, verified by a physician's statement, that would result in institutional care which would be at a level no lower than intermediate nursing home care if companion services were not provided. (Payment for physician's statement shall be paid from Administrative funds). The physician's statement shall be required of: (1) adults who are found eligible for high priority companion services after July 1, 1976; (2) those December, 1973 recipients of OAA or APTD who are being maintained at forty (40) hours or less per week and whose service need has increased. Subsequent physician's statements shall be required only if the client's condition changes in any way.

Services consist of personal aid, light housekeeping and/or companionship services. Such services shall be provided as needed up to a maximum of forty (40) hours a week. Companion services may be purchased in excess of forty (40) hours a week provided the negotiated amount per week does not exceed an amount higher than that equivalent to forty (40) hours at the minimum wage.

c. Emergency Companion Service - Adults eligible for this service must have an acute physical or mental condition.
   (1) Services may be provided up to twenty-four (24) hours a day, not to exceed thirty (30) days in any one fiscal year to allow time during which the crisis situation becomes more stabilized or alternate arrangements for longer term care can be made.
   (2) Companion service may be used in combination with Emergency Homemaker Services in a situation where the skill level of a homemaker is needed provided that the hours of homemaker services are not overlapping with those of the companion service provider.
   (3) A physician's statement shall not be required to verify need for emergency companion service.

6. Rate of Payment and Extent of Coverage

a. The hourly rate of payment for the three levels of care shall be in an amount up to but not to exceed the minimum hourly wage. Hourly rates in excess of the minimum hourly wage shall be paid from local or donated monies to match Title XX funds provided the service and the local or donated monies are included in the geographic area service plan.
b. Payment for hours of coverage in excess of the maximum allowable for each level of care shall be paid from local or donated monies to match Title XX funds provided the service and the local or donated monies are included in the geographic area service plan.

13430 Chore Services

State Board rules and regulations establish the following policies for purchase of Chore services: (State Board Minutes, May 27, 1975 and April 6, 1976).

1. Definition

Performance of home maintenance tasks and heavy housecleaning such as window washing, floor maintenance (scouring and polishing); outdoor work consisting of yard maintenance, painting, chopping wood, carrying coal, wood and water, snow removal; and minor repair work performed in the home on furniture and appliances. Chore services are to be provided to an adult, who, because of advanced age, disability or infirmity, is unable to perform such tasks himself and there is no one available to provide these services without cost.

2. Conditions for Purchase

a. Chore services shall be purchased from providers approved as meeting standards established by State Board.
b. Chore services shall be purchased only for adults when:

   (1) there is no member of the household who is able to perform the necessary tasks, and
   (2) the client is living in an independent situation and is responsible for maintenance of his own home or apartment (rented or owned), and
   (3) the service is not available without cost.

c. Chore services may be used to supplement companion or homemaker services when needed.
d. A chore provider may also be a companion provider only within the limits specified for chore providers.

3. Standards for Chore Providers

Standards established for providers of Chore services shall be met as follows: (State Board Minutes, May 27, 1975 and April 6, 1976).

a. The provider of services shall be a responsible individual who is mentally and physically capable of performing the chore services being purchased.
b. The age of the provider from whom services are purchased shall be governed by the chore duties to be performed; the provider shall be in an age range to have gained the basic knowledge and/or experience to accomplish the assigned tasks satisfactorily on behalf of the client.
c. Chore services shall not be purchased from any person young enough to cause performance of chore duties to be in violation of child labor laws.
d. The provider shall be capable of taking directions and following instructions for performance of chore services from the client or the person authorized to act on behalf of the client.
e. Chore services may not be purchased from parent(s)/spouse or relative members of the household.

4. Rate of Payment and Extent of Coverage

a. The rate of payment for chore services shall be at the minimum hourly wage. Hourly rates in excess of the minimum wage shall be paid from local or donated monies to match Title XX funds provided the service and the local or donated monies are included in the geographic area service plan.
b. Purchased chore services are to be provided as required not to exceed sixteen (16) hours a month for any one recipient. Hours of coverage in excess of the maximum may be paid from local or donated monies to match Title XX funds provided the service and the local or donated monies are included in the geographic are service plan.

13440 Requirement for Maintaining Income Level of Certain Recipients of OAA or APTD, December, 1973

Recipients who had an allowance for homemaker or other service included in their December, 1973 money payment must continue to receive services at the December level if the need for such services has not decreased. Homemaker services shall continue to be maintained under that program. Other services which have been maintained as Chore will be transferred to Companion Services without a break in service provision. The provision of Chore services is supplemental to homemaker or companion and not to be considered in the hours to be maintained.

13500 PROCEDURES FOR PURCHASE OF HOMEMAKER, COMPANION AND CHORE SERVICES

13510 Application

Refer to service manual policy governing "Application for Social Services", Chapter 1200. Completed and signed applications are required for December, 1973 recipients.

13520 Verification of Eligibility

Refer to service manual policy governing "Eligibility Determination", Chapter 1400.

For the December, 1973 recipient of homemaker or companion (formally chore) services, the service record must contain verification that the adult received an OAA or APTD grant in December, 1973; that an allowance for homemaker or companion (formally chore) services was included; and that the allowance was converted to an Auxiliary Grant. Verification can be obtained from an examination of the public assistance record or through a written statement from the eligibility worker. The verification obtained for the service record must clearly state the number of hours of service provided and the amount of the allowance included in the December, 1973 money payment. The December, 1973 recipient is classified as a recipient of income maintenance for reporting purposed.

13530 Determination of Vendor Payment Authorization

1. Routine Homemaker and Companion Services

The number of hours of service not to exceed twenty (20) per week is applicable to all routine homemaker and companion service authorizations with the following exceptions:

a. Individuals who received homemaker or companion (formally chore) service in excess of twenty (20) hours a week in December, 1973 must continue to receive the same number of hours of service as they received in December, 1973 as long as the need remains the same. Authorization of payment is to be based on the established hourly rates of pay, even though this results in costs which exceed the December allowance. Maintenance of the December, 1973 money income level for OAA or APTD recipients required by the Federal Social Security Administration. As long as the need for service remains the same, the service payment authorization cannot fall below the December, 1973 money income level except in the instance where the hourly cost of service in December, 1973, was higher than the established hourly rate. The assurance of the same number of hours of service, even though the cost of service has decreased, meets the federal requirement of maintenance of income level.

b. If there is a decrease in the number of hours of service needed below the December, 1973 level, authorization shall cover the actual number of hours needed even though this number is in excess of twenty (20) hours a week. Whenever the need for service is reduced to or below twenty (20) hours a week, authorization of payment for this group of individuals is made in accordance with policy governing all other cases and maintenance of the December, 1973 level of service is no longer applicable.

c. For those individuals who received an allowance for routine homemaker or companion (formally chore) services in their December, 1973 OAA or APTD grant within or at the maximum of twenty (20) hours per week, their December, 1973 service level is protected by policy applicable to all cases.

2. High Priority Companion Service Need

Payment for increased hours of service may be authorized within policy for high priority service need for those December, 1973 recipients of OAA or APTD who are being maintained at or less than forty (40) hours a week or when the need for increased hours results in costs that are at or less than the negotiated amount equivalent to forty (40) hours at the minimum wage.

3. Emergency Homemaker and Companion Services

The policy on maintenance of the December, 1973 service level is not applicable to provision of Emergency Homemaker or Companion Services.

13540 Method of Payment

For policy governing procedures for purchase of these services, refer to the Purchase of Service Manual. Approval of rate for purchase of service from homemaker agencies is a responsibility of the State Welfare Department. Approval of rates for companion and chore providers is the responsibility of the local agency.

13550 Determination of Eligibility for Auxiliary Grant for December, 1973 Non-SSI Recipient

The December, 1973 non-SSI recipient who is being maintained must be determined eligible for continued payment based on financial eligibility criteria governing payment of auxiliary grants. Criteria used for determining eligibility include resources and income. Only when the recipient meets eligibility requirements for an auxiliary grant payment can he be determined eligible as an SSI recipient under Title XX. The determination of financial eligibility is the responsibility of the eligibility worker who should work in conjunction with and provide the necessary eligibility verification information to the service worker.

13560 Termination of Vendor Service Payment for SSI Recipient

The SSI recipient receiving an auxiliary grant (vendor service payment) who has been mandated to be maintained becomes ineligible for the service when:

1. Entitlement for Supplemental Security Income benefits ceases because of resources in excess of the maximum.

2. Benefits from Supplemental Security Income plus income from other sources is sufficient to pay for the number of hours of homemaker or companion (chore) services being provided in the December, 1973 OAA or APTD money payment.

13570 Financial and Statistical Records and Reports

See Administrative Bulletin #601, dated September 29, 1975, "Instructions and Forms for Statistical and Financial Reporting to be Implemented October 1, 1975."

APPENDIX E -- COMPARISON OF HOME HEALTH SERVICES UNDER MEDICARE, MEDICAID AND TITLE XX

	MEDICARE	MEDICAID	TITLE XX
I. ELIGIBILITY:	Under Medicare, eligible persons generally 65 and over or disabled, may receive two basic forms of protection. Part A, hospital insurance benefits, generally financed by special social security taxes, covers inpatient hospital services and certain post-hospital care and skilled nursing facilities and patient homes. Part B, supplementary medical insurance benefits, is a voluntary program, financed by premiums of enrollees and federal contributions covering physician services and many other medical and health benefits. To be eligible for home health care under Medicare, a person must be confined to his/her residence (essentially homebound), be under the care of a physician and need part-time or intermittent skilled nursing service and/or physical	Under Medicaid, a grant-in-aide program, the federal government and the states share the cost providing medical assistance to persons, regardless of age, whose income and resources are inadequate to pay for health care. Two groups of people can be covered by Medicaid. The first group, known as categorically needy, are people who can or do receive public assistance under one of the cash assistance programs. The categorically needy must be covered by State's Medicaid program. In addition, States may elect to pay for medical care to medically needy persons and their families (individuals whose income exceeds the standard under the appropriate cash assistance plan but is insufficient to meet their medical costs). Virginia provides for both the categorically needy and the medically needy. The patient's identification card must show that coverage is effective at the time the home health services are rendered. The patient must be essentially homebound. Basically, the same rules apply as stated for Medicare recipients. However,	Title XX of the Social Security Act provides for social services. Eligibility is based totally on income. In Virginia, Title XX's income level is 50% of the State's median income for a family of four with variations based upon family size.

	MEDICARE	MEDICAID	TITLE XX
	or speech therapy. A physician must prescribe the need for such care. If these requirements are met, a person is eligible to receive other covered home health services.	Medicaid will reimburse home health services visits to patients who are not homebound in the following instances: 1. When the cost for transportation and medical treatment exceeds the cost of a home health services visit. 2. When the patient cannot be depended upon to go to a physician or clinic for required treatment. As a result, he would in all probability have to be admitted to a hospital or nursing home because of complications arising from the lack of treatment. 3. When the visits are for a type of instruction to the patient which can better be accomplished in the home setting; e.g., instruction to a diabetic patient in diet and medication administration. In instances where any of the above exceptions apply, an explanation should be included on the Referral and Treatment Plan.	
II.	ACCEPTANCE OF PATIENTS	Patients are accepted for treatment on the basis of a reasonable expectation	Same As Medicare	Same As Medicare

	MEDICARE	MEDICAID	TITLE XX
	that the patient's medical, nursing and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of treatment established and periodically reviewed by a physician, and care continues under the general supervision of a physician.		
A. Place of Treatment	The plan of treatment developed in consultation with the agency staff covers all pertinent diagnosis, including: 1. Mental status 2. Types of service and equipment required 3. Frequency of visits 4. Prognosis 5. Rehabilitation potential 6. Functional limitations 7. Activities permitted 8. Nutritional requirements 9. Medication and treatment 10. Any safety measures to protect against injury	Same As Medicare	Same As Medicare

		MEDICARE	MEDICAID	TITLE XX
		11. Instructions for timely discharge or referral		
		12. Any other appropriate items (Example: Laboratory procedures and any counter indications or precautions to be observed)		
B.	Periodic Review	The total plan of treatment is reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of treatment.	Same As Medicare	Same As Medicare
C.	Conformance with Physician's Orders	1. Drugs and treatments are administered by agency staff only as ordered by the physician.	Same As Medicare	Same As Medicare
		2. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature.		
		3. Agency staff shall check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side		

		MEDICARE	MEDICAID	TITLE XX
		effects, drug allergies, and contra-indicated medication, and staff reports any problems to the physician.		
III.	SKILLED NURSING SERVICE CRITERIA	Under Medicare, the home health agency provides skilled nursing services by or under the supervision of a registered nurse in accordance with a written plan of treatment.	Under Medicaid, there is no requirement for the need of skilled care in order to provide personal and/or custodial care services. However, the provision of such services must be because they are medically necessary to maintain the patient in his home. When accepting patients for personal and custodial care only, the following must be taken into consideration: 1. The patient's physical or mental condition must be such that he cannot adequately care for his own needs. 2. There is no one in the home available or capable to assist the patient with all of his personal care needs. 3. The patient is admitted because the care is a necessity, not merely convenient to the patient or his family. 4. The agency has a plan of treatment offering home health services in addition to homemaker services.	Same As Medicaid

	MEDICARE	MEDICAID	TITLE XX
		5. Homemaker services are included in the plan of treatment.	Same As Medicaid
		6. Charges for a visit would be considered one unit, up to four hours. Visits exceeding four hours would be counted as two visits.	
		7. Limit of 100 hours per month per patient for this service.	
IV. HOME HEALTH SERVICES	1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;	1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.	Same as Medicaid
	2. Physical, occupational, or speech therapy;	2. Physical, occupational, or speech therapy.	
	3. Medical social services;	3. To the extent permitted in regulations, part-time or intermittent services of a home health aide (limited to 100 hours per month).	
	4. To the extent permitted in regulations, part-time or intermittent services of a home health aide;	4. Medical supplies, other than drugs and medications including serums and vaccine, and the use of medical appliances.	
	5. Medical supplies (other than drugs and medications including serums and vaccines), and the use of medical appliances.		

APPENDIX F -- YORK COUNTY HOMEMAKER-HOME HEALTH AIDE SERVICE

Homemaker - Home Health Aide Service is a service sponsored by the County of York. Under the program certified Homemakers go into the homes of the aged or handicapped and do whatever is necessary to maintain family stability. It offers a practical way to hold homes and families together in times of crisis or stress. Homemaker services are flexible, home help services that can be provided as needed.

Service is provided:

1. When care is needed to enable an adult to shorten or avoid institutional care.

2. When a disabled or aged person needs help in caring for himself and his home, but is able to assume partial responsibility for his personal and household goods.

3. When a friend or relative is caring for an ill or aged person and needs temporary help due to an emergency or crisis.

4. When a disabled person needs to be helped in order to learn to function as independently as possible.

5. When illness or disability of a family member (usually the mother) may cause the home to be disrupted.

The homemaker-home health aide can, as needed:

1. Provide bedside nursing care, such as baths, bed making, back rubs, etc.;

2. Assist patient in dressing, walking, toileting, getting into and out of wheelchairs;

3. Perform light housekeeping chores, such as dusting, vacuuming, dry mopping, light laundry;

4. Prepare meals including special diets; and

5. Do marketing.

The types of services provided are:

1. Regular Service - Service is made available to a family or individual for a minimum of four hours or daily basis during regular work week.

2. Live in or 24-hour service - Service is available in the home on a 24-hour basis for a limited period where there is an acute temporary need.

The beginning pay schedule is $2.80 per hour, but increases with increasing amounts of responsibility. When the patient cannot afford to pay for the service, the York County department of Social Services

can reimburse the program with Title XX funds for eligible persons. This program is not currently licensed or certified as a home health agency and, thus, cannot be reimbursed under either the Medicaid or Medicare Programs.

Certified Homemaker-Home Health Aides have completed 440 hours of training in the fields of Home Management, Health, Safety, Sanitation, Foods and Nutrition, Home Care of the Aging, Understanding Self and Other People, Community Resources and Responsibilities, Driver's Education, First Aid, Home Nursing, and Mother and Child Care.

APPENDIX G "WHY IS HOME HEALTH CARE SO IMPORTANT?"

The following item was taken from "TLC" (Tender Loving Care), a quarterly bulletin published by the New River Health District for homebound patients and their families, medical professionals, governing bodies and social service agencies.

1. You can sleep as late as you please.
2. You can eat when you want and what you want.
3. You can dress in any kind of clothes you wish.
4. You can sleep in your own bed with your own type of bed clothes.
5. You can have your home as warm or cold as you like.
6. You can see your friends as often as you please.
7. More privacy in your own home with your own family.
8. Family can often help with rehabilitation therapy exercises.
9. Less worry about family when they are right there.
10. Feel more like doing more for yourself so as not to inconvenience others.
11. You can so get the individual attention you need from nurses, technicians, and other professionals.
12. "Going home" gives you a lift - shows progress ..... makes you feel better.
13. Releases a hospital bed for someone else who needs hospital care.
14. and finally ... care is less expensive at home than at hospital or skilled nursing facility.

(Excerpt from "You and Your Home Health Care", L. Bate Company.)

APPENDIX H -- INTERPRETATION OF STANDARDS FOR HOMEMAKER - HOME HEALTH AIDE SERVICES

Introduction

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

Standards

I. The agency shall have legal authorization to operate

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

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

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

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

III. There shall be no discriminitory practices based on race, color or national origin: and the agency either must have or be working toward an integrated board, advisory committee, homemaker-home health aide services staff, and clientele

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

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

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

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

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

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

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

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

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

VII. Every individual and/or family served shall be provided with these two essential components of the service:

A. Service of a homemaker-home health aide and supervisor

B. Service of a professional person responsible for assessment and implementation of a plan of care

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

Functions of a professional supervisor should include:

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

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

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

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

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

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

7. Plans for the appropriate termination of service.

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

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

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

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

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

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

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

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

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

IX There shall be: a) initial generic training for homemaker-home health aides such as outlined in the National Council for Homemaker Services Training Manual; b) an ongoing in-service training program for homemaker-home health aides

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

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

1. The Agency, the Community, and the Homemaker-Home Health Aide
2. The Family and the Homemaker-Home Health Aide
3. Care and Maintenance of the Home and Personal Belongings
4. Home Accident Prevention
5. Family Spending and Budgeting
6. Food, Nutrition, and Meals
7. The Child in the Family
8. The Ill, the Disabled, and the Aging Adult
9. Mental Health and Mental Illness
10. Personal Care and Rehabilitative Services

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

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

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

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

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

XI. The service, as an integral part of the community's health and welfare delivery system, shall work toward assuming an active role in an ongoing assessment of community needs and in planning to meet these needs including making appropriate adaptations in the service

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

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

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

XIII. The governing authority shall evaluate through regular systematic review all aspects of its organization and activities in relation to the service's purpose(s) and to community needs

Annual reviews and periodic in-depth self-studies of the agency's service are required so that its effectiveness and efficiency can be evaluated. Broad participation from all groups -- the board, committees, all levels of staff including the homemaker-home health aides, and consumers of the service should be included in the analysis of the service.

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

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

APPENDIX I -- PROPOSED DEPARTMENT OF HEALTH REGULATIONS FOR HOME HEALTH AIDE SERVICE

45.5 Home Health Aide Service

45.5.1 The home health aide shall be assigned when the responsible physician has specified in the patient's plan of treatment the need for personal care or other services the aide has been trained to provide.

45.5.2 The home health aide shall be assigned to a particular patient by an agency registered nurse.

45.5.3 The home health aide shall complete appropriate records on care provided to the patient.

45.5.4 The home health aide shall have training in those services which are required to provide and maintain bodily and emotional comfort and to assist the patient towards independent living in a safe environment.

45.5.5 The home health aide shall have satisfactorily completed at least forty-two (42) hours of classroom instructions and eighteen (18) hours of practical application in a program equivalent to the Virginia State Health Department training program for home health aides.

45.5.6 When prior training is not equivalent to the minimum described in Section 45.5.5, the necessary supplementary training must be provided and documented.

45.5.7 The duties of the home health aide may include:

(a) Helping patients with baths, care of mouth, skin and hair;

(b) Helping patients to bathroom or in using bedpans;

(c) Helping patients in and out of bed; assisting with ambulation;

(d) Helping patients with prescribed exercises which the patient and home health aide have been taught by the appropriate health professional;

(e) Performing such incidental household services as are essential to patient health care;

(f) Reporting to the agency registered nurse changes in the patient's condition or family situation; and

(g) Assisting with oral medications that are ordinarily self-administered.

45.5.8 The registered nurse, or other appropriate agency professional staff member, if other services are provided, shall make a supervisory visit to the residence at least every two (2) weeks to assess relationships and determine whether goals are being met.

(a) The clinical record shall clearly document supervision of the home health aide by the appropriate professional discipline.

APPENDIX J -- HOMEMAKERS UPJOHN HOME HEALTH CARE CLIENT'S BILL OF RIGHTS

The client has the right . . . .

1. to be treated with dignity and respect by all who service him.
2. to a plan of care that is designed to meet his individual needs.
3. to participate in the development of the care plan.
4. to have the plan of care evaluated and updated periodically.
5. to expect that all personnel caring for him will be current in the skills and knowledge of their field of employment.
6. to expect that those providing for his care in the home will receive supervision and direction from qualified persons on an ongoing basis.
7. to expect proper identification by name and title of those persons caring for him in his home.
8. to know that case-related information will be kept confidential.
9. at any time to review the record of his care.
10. to refuse treatment.
11. to know how much his care will cost and what portion (if any) is to be paid by other sources, such as private insurance or government programs.
12. to be served without regard to race, color, sex or national origin.