REPORT OF THE

JOINT SUBCOMMITTEE TO STUDY THE

CARE OF THE IMPAIRED ELDERLY

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 20

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Report of the
Joint Subcommittee to Study the
Care of the Impaired Elderly
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1981

To: Honorable John N. Dalton, Governor of Virginia
and
The General Assembly of Virginia

HISTORY OF THE JOINT SUBCOMMITTEE

House Joint Resolution No. 162 of the 1980 Session of the General Assembly requested that the Chairmen of the House of Delegates Committee on Health, Welfare and Institutions and of the Senate Committee on Education and Health establish a joint subcommittee to study the improvement of the Commonwealth's public policies and system concerning the care of the impaired elderly. Accordingly, the members of the Joint Subcommittee to Study the Care of the Impaired Elderly were appointed. Delegate Glenn B. McClanan of Virginia Beach was selected to be Chairman of the Joint Subcommittee. Appointed to serve with Delegate McClanan were: Senator A. Joe Canada of Virginia Beach; Delegate James A. Davis of Ferrum; Senator Edward M. Holland of Arlington; and Delegate Mary A. Marshall of Arlington.

At the request of the Joint Subcommittee, Dr. Jean L. Harris, Secretary of Human Resources, appointed an interagency task force. The task force membership comprised representatives of each of the primary State agencies which administer long term care services in the Commonwealth. The Secretary of Human Resources and the interagency task force worked with the Joint Subcommittee throughout 1980 offering assistance and guidance to the legislative effort. The members of the interagency task force were: Peter Clendenin of the Office of the Secretary of Human Resources; Wilda Ferguson, Mary Payne, Jeff Schaffer and James Stamper of the Office on Aging; Gregory Arling of the Virginia Center on Aging; Raymond Perry and Betty Jo Wright of the Department of Health; Mary Blackwood and Saundra Rollins of the Department of Mental Health and Mental Retardation; and Linda Sawyers of the Department of Welfare.

The Joint Subcommittee wishes to express its appreciation to Dr. Harris and to the members of the interagency task force for their contribution to the work of the Joint Subcommittee. The expertise and guidance of the executive agencies was an asset to the legislative members of the study. The task force contributed to a better understanding of the Commonwealth's current system of programs and services providing long-term care and provided invaluable suggestions for future coordination and improvement of those programs and services. In the fall of 1980, the interagency task force presented a report and recommendations to the Joint Subcommittee. The task force report is included as Appendix A of this document. In addition, the Secretary of Human Resources offered recommendations to the Joint Subcommittee. The Secretary's recommendations are included as Appendix B of this report.

In October, 1980 the Joint Subcommittee held five public hearings. Hearings were conducted in Virginia Beach, Lexington, Abingdon, Richmond and Falls Church. The testimony received during the hearings confirmed the need for better coordination of community and institutional services for elderly individuals who require assistance with the tasks of daily living. The Joint Subcommittee expresses its sincere appreciation to everyone who spoke during the hearings. Many concerned citizens recounted both professional and personal experiences in seeking assistance for elderly persons. The testimony received and the information gathered throughout the year was a valuable resource to the work of the Joint Subcommittee.

FINDINGS

The Impaired Elderly

Early in its deliberations, the Joint Subcommittee and the interagency task force attempted to

define and to identify the impaired elderly persons who are the focus of statewide concern.

The "impaired elderly" were defined as persons over sixty years of age who have physical or mental impairments or a combination of impairments which cause such individuals to seek assistance with the tasks of daily living for an extended period of time. The impaired elderly persons who are the focus of this study are unable to pay for the care they need. Therefore, they seek assistance available through State and local human services agencies. At any one time in Virginia, there are approximately 28,000 persons over the age of sixty whose capabilities are limited by physical or mental impairments. It is approximated that: 15,000 of these individuals live in nursing homes; 750 are in acute care facilities awaiting discharge; 1,500 are auxiliary grant recipients living in homes for adults licensed by the Department of Welfare; 2,700 live in institutions operated by the Department of Mental Health and Mental Retardation; and 8,000 live in their own homes or in the homes of relatives.

Long-Term Care Services

Services designed to provide assistance for an extended period of time to impaired elderly persons are commonly referred to as "long-term care services." An elderly person whose capabilities are limited by physical or mental impairments or both may require only minimal help with dressing and bathing depending upon the severity of his or her disabilities. On the other hand, the individual's needs may require that he or she be placed in a nursing home where skilled medical care is available on a twenty-four hour basis. Because of the disparity of individual needs, state and local governments and private enterprise have developed services to assist with the medical, social, economic and personal needs of elderly persons. These services can be arrayed along a continuum ranging from continuous care (24 hours a day, 7 days a week) to referral services which direct an individual to the appropriate care.

Table I outlines the continnuum of long-term care services that may be needed by an elderly person depending upon his or her capabilities. The continuum ranges from institutional care to home-based community care.

TABLE I

The Long Term Care Continuum

Service or Provider Category	Role in the Continuum
Skilled Nursing Facility (SNF) Continuous skilled nursing care or other skilled rehabilitative care provided in a residential facility on a 24 hour a day basis; requiring the care of a skilled nurse or under the supervision of a skilled nurse or other skilled rehabilitation provider.	Necessary for people in need of continuous intense services; especially those in need of nursing care with rehabilitative therapy.
Intermediate Care Facility (ICF) Health related services that can only be offered in an institutional setting which are below those offered in a hospital or SNF, but above that of room and board.	Viewed as critical for those who are chronically ill and incapable of independent living.
Homes for Adults A residential institution for people not in need of health related services but in need of personal assistance, such as bathing, grooming, dressing, eating, etc.	Critical for people who do not need intense medical care but are nevertheless unable to maintain an independent life-style and need the constant services of others; may be replaced by congregate housing.
Congregate Housing A group living environment which promotes independent living by supplying supportive medical and social services either directly or through referral to elderly people who are in good health despite financial or social impairments.	Viewed as a necessary service to prevent elderly from using medically oriented facilities unnecessarily. Predominantly a long term prevention technique as elderly tend to enter these facilities in the early part of their old age and remain in them throughout their old age.
Home Health Care Medically oriented care for acute or chronic illness provided in the patient's home. Includes services like cleaning wounds, changing bandages, giving injections, inserting catheters.	Considered a way to provide medical care to people outside of an acute care, skilled nursing or intermediate care facility. Under some circumstances may serve as a replacement to institutional care.

TABLE 1 (con't)

Service or Privider Category	Role in the Continuum
Companion and Chore/Homemaker Services Household services, such as shopping, cooking, and cleaning.	Seen as an essential aspect of any home care program. May be delivered in conjunction with home health care or as a separate service to those with limitations who are otherwise healthy. Under some circumstances, may serve as a replacement to institutional care.
Personal Care Services Personal care includes such services as bathing, dressing, and grooming provided in the participant's home.	Seen as an essential aspect of any home care program usually delivered in conjunction with home health care or companion and chore/homemaker services. There is ambiguity in the definition of the boundaries between these services and personal care. Under some circumstances may serve as a replacement to institutional care.
Respite Care Short term inpatient or outpatient care delivered to an elderly person in lieu of his or her regular source of support. The program is normally designed to provide relief to relatives and friends who care for an elderly person on a regular basis.	Seen as a way to encourage families to take care of their elderly relatives by providing periodic relief from the demands of caring for an older person. It may be provided as a component of other services in the continuum. Primarily a financing issue as nursing homes, home health agencies, and private duty nurses frequently provide this service when money is available.
Meals on Wheels The delivery of inexpensive, nutritionally sound meals in the participant's home. As well as providing meals to people who are unable or unlikely to cook for themselves, the program provides social contact to isolated people.	Seen as a health promotion service which also acts to prevent the isolation of the elderly with limited mobility.

TABLE I (con't)

Service or Provider Category	Role in the Continuum
Nutrition Programs Programs designed to provide inexpensive nutritionally sound meals to elderly people in congregate settings.	Seen as a health promotion service which also encourages social interaction among elderly people.
Adult Day Care A wide variety of day care programs exist. Two major models are: Medical Model: An outpatient center for people in need of physical rehabilitation or other health services on a limited yet regular basis. Frequently, providing meals and limited social activity as well, this approach to day care has a strong health care orientation. Multipurpose Model: Programs which provide social interaction and some social and medical services to elderly people in a fixed location for a limited number of hours.	Seen as a needed service for frail and vulnerable elderly who are not being served by the long-term care system. Viewed as a way to improve the quality of life of its users.
Senior Centers and Recreation Services Programs which increase the elderly's vigor and social interactions by providing formal social activities and a central meeting place. In addition, senior centers act as clearing houses for elderly people in need of information or services.	Seen as a way to improve the quality of life of its users through the promotion of social activity.
Transportation Services Programs designed to increase an elderly person's mobility by improving his or her financial and/or physical access to transportation. These programs range from the provision of subsidies or public transit systems to the operation of special mini buses for the exclusive use of senior citizens.	Viewed as critical to insure adequate access to community services.

TABLE I (con't)

Service or Provider Category	Role in the Continuum
Telephone Reassurance A program designed to decrease social isolation by providing regular telephone contact to elderly people living alone.	Seen as a way to improve the quality of life of its users by increasing social interaction and making the users feel secure that help is available in times of emergency.
Friendly Visiting A service designed to decrease the social isolation of the elderly through regular in-home visits by professionals or volunteers.	Seen as a way to improve the quality of life of its users by increasing social interaction and making the users feel secure that help is available in times of emergency.
Legal Assistance Free or partially subsidized assistance with legal matters, such as wills and tenant rights.	Important to a limited number of people. Normally cited as a way to guard against housing problems such as displacement.
Case Management and Channeling An administrative service which acts as a link between the client and the providers of long term care. Often case management and channeling programs provide client assessment, service plan development and follow-up monitoring.	Viewed as a critical service for all long term care users. Help to assure the appropriate, timely, and cost effective delivery of long term care services.

NOTE: For more specific information about long-term care services available in Virginia and their funding sources, please refer to the Interagency Task Force Report, Section II, Appendix A.

CONCLUSIONS

The Joint Subcommittee believes strongly that increased emphasis must be placed on the development of community and home services for the impaired elderly citizens of the Commonwealth. The goal of this legislative effort is to assure that services are available throughout Virginia which will allow impaired elderly persons to remain in their homes in every case where home care is most appropriate and less costly than institutional care. The public must understand, however, that high quality institutional care is necessary and appropriate in many instances. Additional planning is needed to ensure an efficacious mix of community and institutional long-term care services in Virginia.

The Joint Subcommittee received a great deal of oral and written testimony documenting the need for more community-based long-term care services. Further information is required, however, to assure that future investments in long-term care services by the State and localities are directed toward serving the impaired elderly population at greatest risk of institutionalization. The goal of all long-term care services should be to permit elderly citizens to enjoy the most independent lifestyle possible for as long as they can.

During the public hearings, the Joint Subcommittee learned that a number of localities in Virginia have developed their own methods of obtaining appropriate community or institutional services for their impaired elderly citizens. These localities are aware of the resources available in their communities to serve impaired elderly citizens and have established organizational mechanisms for referring those persons to appropriate services. The Joint Subcommittee commends these localities and encourages similar innovations by other jurisdictions.

Although progress has been made by individual localities, the development and coordination of long-term care services on a statewide basis continues to be necessary. Specific data is needed on the numbers of elderly individuals in Virginia who seek public assistance with long-term physical and mental disabilities. The figures presented earlier in this report are only approximations of the impaired elderly population in the State. Additional information is needed to determine the present costs and sources of funds for long-term care services in Virginia in order to project future costs of additional services and to better coordinate funding practices. The Joint Subcommittee does not wish to create new categories of individuals eligible for public assistance. However, during the public hearings the legislative members became acutely aware that many elderly individuals are entering nursing homes because services are not available in their communities to allow them to remain at home. As noted earlier, some localities are doing their best to prevent this kind of forced institutionalization by linking elderly citizens with community services. The Joint Subcommittee believes that the experience of these localities will provide valuable information to foster the planning of long-term care services on a statewide basis.

Initial steps must be taken during 1981 to begin the development of community-based long-term care services in Virginia. The coordination of community and institutional services is essential to assure equitable access to all citizens who require public assistance with long-term care needs.

The Joint Subcommittee to Study the Care of the Impaired Elderly, therefore, offers the following recommendations to the 1981 Session of the General Assembly.

RECOMMENDATIONS

Continuing the Joint Subcommittee

It is recommended that the 1981 Session of the General Assembly be requested to continue the Joint Subcommittee to Study the Care of the Impaired Elderly. During 1981, the Joint Subcommittee shall continue to work with the Secretary of Human Resources to plan the coordination and delivery of long-term care services in the Commonwealth.

Long-Term Care Research Project

The Joint Subcommittee recommends that the Secretary of Human Resources be requested to conduct a one-year research effort to collect additional information essential to the planning and coordination of long-term care services in Virginia. The research design shall provide for the

selection of no less than three and no more than five localities in Virginia which have established their own programs for providing long-term care services to impaired elderly persons. The research shall be designed to determine the most appropriate and least costly methods that localities, both urban and rural, may utilize in obtaining community services to help impaired elderly persons remain at home. The research must recognize that there are instances where institutional care is most appropriate. However, the study shall focus on the characteristics and numbers of impaired elderly persons who, with assistance, could remain in the community. Since long-term care services are provided through a variety of local agencies and are funded by several sources, the study shall be designed to provide information that will improve interagency coordination at the local level and that will assist in the consolidation of State, local and federal funds whenever feasible.

The research effort shall:

(1) Document the kinds of community-based long-term care services currently available to Virginia's impaired elderly citizens, i.e., adult care, transportation, home health care, etc.

(2) Identify a core of community-based long-term care services that are essential in each locality to prevent the inappropriate institutionalization of impaired elderly persons in the future. In addition, the research shall determine whether variations in community-based services are appropriate to meet the needs of individuals living in various geographic and demographic areas of the State.

(3) Identify the current costs by service category of providing community-based services to impaired elderly individuals.

(4) Compare the cost of institutional care to the cost of providing the basic core of community-based long-term care services in each locality.

(5) Project the costs of community-based services that are essential because of a locality's geography or demography.

(6) Provide information about the extent of the physical and mental impairments of elderly persons who presently receive community-based long-term care services.

(7) Specify the number of impaired elderly people in Virginia who are currently at risk of institutionalization.

(8) Identify informal supports provided by family and friends of impaired elderly persons and suggest methods for maintaining those supports.

(9) Evaluate the current practice of local departments of social services for contracting with relatives of the impaired elderly for the provision of chore and companion services. The analysis shall seek to determine whether family members would provide chore and companion services even if they were not paid. If families would not provide such services without compensation, the analysis shall determine whether the current practice ought to be expanded to offer compensation to families for a wider range of services. The analysis shall specify any additional services for which compensation shall be considered and specify the costs of such compensation.

(10) Evaluate the potential use of auxiliary grant payments which are available through the Department of Welfare to (a) compensate families who provide custodial or personal care to impaired elderly; and (b) subsidize adult foster home care.

The Secretary of Human Resources may seek outside assistance to conduct the research study. The Office of the Secretary shall, however, direct and monitor the project to guarantee that the data compiled will be useful for planning long-term care services statewide.

The Joint Subcommittee recommends that the sum of $100,000 be allocated to the Secretary of Human Resources to carry out the research study. These funds shall be used to pay: (1) the costs of any consultants commissioned for the research effort; (2) expenses incurred by the localities which are requested to compile data for the study; and (3) the administrative costs of the Office of the Secretary of Human Resources for directing and monitoring the research effort.

The Joint Subcommittee to Study the Care of the Impaired Elderly shall assist the Secretary in

the planning and implementation of the research design. The Secretary of Human Resources shall be requested to report the findings and recommendations of the study to the House of Delegates Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health no later than December 1, 1981.

State-Level Coordination

During 1981, while additional information is being gathered to assist in the planning and development of community-based long-term care services, initial steps to coordinate the delivery of services statewide should be implemented. Currently, the State Department of Health administers the Virginia Medical Assistance Program (Medicaid) which is the primary funding source for long-term care services. In addition, the Department of Health is the major provider of home health services. The expertise available within the Department and the five Health Systems Agencies provides the capability for statewide planning of long-term care services.

The Joint Subcommittee recommends, therefore, that the State Department of Health be designated the lead agency with clear authority and responsibility for statewide policy formulation and management to coordinate the provision of long-term care services. The Department of Health, in cooperation with the Secretary of Human Resources, all State agencies which currently administer long-term care services and local human services agencies, shall formulate a plan and budget for the coordination and administration of long-term care services. Data collected by the Secretary of Human Resources in the long-term care research project shall be utilized by the Department of Health in the formulation of the long-term care plan and budget. The Joint Subcommittee recommends that the Department of Health prepare the long-term care plan and budget for submission to the 1982 Session of the General Assembly. Accordingly, funds to implement the long-term care plan may be included in the 1982-1984 biennial budget of the Commonwealth.

The Joint Subcommittee recommends further that the Virginia Office on Aging be designated the agency responsible for the evaluation of long-term care services on a statewide basis. The Office on Aging shall be requested to develop a plan for evaluating long-term care services and for expanding the Long-Term Care Ombudsman Program to serve elderly individuals residing in the community. It is recommended that the Office on Aging prepare budget projections for implementing these responsibilities as well. The Office on Aging shall submit the plan and budget to the 1982 Session of the General Assembly so that sufficient funds may be included in the 1982-1984 biennial budget.

Pre-Admission Screening

The current Nursing Home Pre-Admission Screening Program in Virginia was begun in 1977 under the administration of the Department of Health. The Program has improved significantly the capability of localities to assess the social and medical needs of impaired elderly individuals who are eligible for public assistance and who apply for nursing home admission. Many elderly individuals are being diverted from costly institutional care to community-based care whenever community services are more appropriate. The lack of sufficient community-based services, however, inhibits the ability of pre-admission screening efforts to achieve maximum success in delaying institutionalization. Pre-admission screening efforts must be accompanied by a sufficient base of long-term care services in the community so that the elderly may obtain assistance which allows them to remain at home. Despite the lack of sufficient community-based services, Virginia's Nursing Home Pre-Admission Screening Program has been successful in diverting elderly people from entering nursing homes. The Program has proven to be cost effective and an asset to the Commonwealth in identifying the need for long-term care services to prevent or delay institutionalization of the elderly. The Joint Subcommittee supports the concept of local screening for all community services to the impaired elderly and encourages localities to initiate screening programs.

In order to provide increased screening services by localities, the Joint Subcommittee recommends that the current Nursing Home Pre-Admission Screening Program which screens individuals from the community who apply for nursing home admission be expanded to include the screening of individuals who:

(1) at the time of application for admission to a nursing home would be likely to require financial assistance from the Medicaid program within a 13-month period; and (2) are attempting to enter a nursing home from an acute care facility.

The participation of local human services agencies, health care and social services professionals and hospital staff must be consolidated in a team effort devoted to the provision of appropriate and cost effective services to the impaired elderly. Thus, the Joint Subcommittee recommends that the human services agencies be reimbursed for the participation of their representatives who conduct the individual assessments.

The Department of Health shall be required to prepare a plan and budget for the expansion of the Nursing Home Pre-Admission Screening Program for submission to the 1982 Session of the General Assembly. Accordingly, sufficient funds to expand the program may be included in the 1982-84 biennial budget. Upon adoption of the recommendation, the expanded program shall begin operating in the localities on July 1, 1982.

Tax Incentives

During its deliberations, the Joint Subcommittee learned that several states have enacted provisions in their tax laws which offer incentives for individuals to care for impaired elderly relatives at home. In 1979, the Joint Subcommittee to Study Tax Incentives for Persons Caring for the Elderly in Their Own Homes (House Document No. 29, 1979) considered the provision of similar tax incentives in Virginia. Presently, however, Virginia's tax laws offer little encouragement to those who assume the care of dependent adult family members in their own homes.

The Joint Subcommittee recommends that the Department of Taxation be requested to study the provision of tax incentives to encourage individuals to care for dependent adult family members. The study shall consider the development of a tax deferral system similar to the current system for child care. The Department of Taxation shall be requested to report its findings and recommendations to the 1982 Session of the General Assembly.

Guardianship

The Virginia Office on Aging is studying alternatives to the appointment of sheriffs as the guardians of last resort for impaired elderly persons who need assistance. The current study will be completed in June, 1981. The appointment of proper guardians for impaired elderly persons was a paramount concern of many who appeared before the Joint Subcommittee during its public hearings. The Joint Subcommittee, therefore, commends the work of the Office on Aging and looks forward to the study's recommendations for legislative and executive action.

Swing Beds in Hospitals and Nursing Homes

A number of amendments to the federal laws governing the Medicare and Medicaid programs were signed into law on December 5, 1980 as part of the Federal Omnibus Budget Reconciliation Act of 1980. One set of amendments pertains to the use of swing beds by hospitals. (The term "swing beds" refers to the practice of allowing a hospital or nursing home bed licensed to serve a patient requiring an intensive level of care to be used to serve a patient who requires a lower level of care.) The amendment effectively allows rural hospitals of 50 beds or less to implement swing-bed policies and to receive reimbursement through the Medicare and Medicaid programs for the care of a patient in such a bed whenever appropriate. Large urban hospitals are allowed to implement swing-bed demonstration projects under the recent amendments. The amendments do not address the swing-bed policies of nursing homes.

The Joint Subcommittee recommends that the State Department of Health investigate and take advantage of the options available through the Medicare and Medicaid programs for the use of swing-beds by hospitals. The Department of Health is encouraged to develop swing-bed policies for nursing homes to allow skilled nursing home beds to be designated for intermediate level care whenever appropriate.

Additional Nursing Home Beds

Throughout 1980, the Joint Subcommittee to Study the Care of the Impaired Elderly and other legislative and executive groups have discussed the need to curb the escalating costs of nursing home care in the Commonwealth. During the 1981 Session of the General Assembly, consideration will be given to revisions of the Certificate-of-Public-Need Law which governs the construction and renovation of health care facilities and the addition of health services. In addition, proposals

presented to the General Assembly during 1980 seek to limit the amount the State will reimburse a nursing home for the costs of construction and daily operation. The Joint Subcommittee, therefore, offers no additional recommendations to the General Assembly with regard to the cost of nursing home care. It is the desire of the Joint Subcommittee, however, that every effort be made to contain the cost of nursing home care and that less costly community care services be utilized whenever possible.

Funding of Community Services

As noted earlier in this report, the Joint Subcommittee heard a great deal of public testimony confirming the need for additional community-based services to assist the impaired elderly. Among essential services needed are transportation, respite care, companion and chore services, home health care, geriatric day care, personal care, adult foster care and homemaker services. The Joint Subcommittee believes that additional information is needed, however, to plan for the funding and the provision of these services equitably on a statewide basis. Therefore, no recommendations are offered on the direct funding of community services at this time.

The Joint Subcommittee is concerned that the current rate of reimbursement for the care of elderly persons in homes for adults is not adequate. The Department of Welfare which licenses and reimburses homes for adults has recently surveyed the costs of 30 homes for adults in Virginia. It was found that the current reimbursement rates were lower than the actual operating costs of the homes. The House of Delegates Committee on Appropriations is considering proposals to increase reimbursement rates to homes for adults and for offering incentives for the homes to maintain maximum occupancy. The Joint Subcommittee looks forward to the legislative recommendations of the Appropriations Committee to the 1981 Session of the General Assembly as a mutual effort to improve the quality and efficiency of homes for adults in Virginia.

Respectfully submitted,

Glenn B. McClanan, Chairman
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APPENDIX A

The Interagency Task Force Report to the Joint Subcommittee to Study the Care of the Impaired Elderly

I. OVERVIEW

A. Introduction

HJR 162, passed by the 1980 Session of the General Assembly, instructed the Chairman of the House Committee on Health, Welfare and Institutions and the Chairman of the Senate Committee on Education and Health to establish a joint subcommittee to study the improvement of the Commonwealth's public policies and systems concering the care of the impaired elderly.

The subcommittee established four objectives for care of Virginia's impaired elderly population:

A. The maximum feasible independence of the individual in making decisions and performing everyday activities.

B. The provision of services in the least restrictive environment, preferably at home and other community settings.

C. The encouragement and support of the informal services of care provided by family, friends, volunteer organizations, et cetera.

D. The need to provide services in the most cost-effective manner possible while still providing humane care for individuals.

It is apparent that the existing system of care of the impaired elderly is unlikely to accomplish these objectives. The following problems are frequently identified:

A. Current programs are costly to everyone, particularly, consumers and frequently result in the impoverishment of the individual who must purchase service.

B. Eligibility criteria, which differ from program to program, often prohibit people from receiving some or all of the services they need.

C. Many persons who enter nursing homes do not require the high levels of service that nursing homes are intended to provide. Studies have shown that 10 to 40 percent of the residents of nursing homes could have remained in the community if appropriate services were available. The Pre-Admission Screening program in Virginia has addressed this problem for Medicaid eligible patients admitted from the community; however, there is no screening of private pay patients or persons admitted directly from hospitals.

D. There is an inadequate supply of accessible and affordable in-home and community services which might reduce or deter institutional placements.

E. There are relatively few mechanisms at the local level which can inform consumers and providers of available service options and which can coordinate and manage a broader range of services on behalf of individual clients.

F. The task of resolving these problems is becoming increasingly urgent. The costs of long-term care services are rising at a rapid rate. In addition, the population most vulnerable to nursing home placements is increasing.

This report was produced as the result of combined efforts of staff from the Office of the Secretary of Human Resources, the Office on Aging, the Department of Health, the Department of Mental Health and Mental Retardation, the Department of Welfare and the Virginia Center on Aging.

It is intended to be a staff document which the Joint Subcommittee may use in generation of the report required by HJR 162, not necessarily a synthesis, or even consensus, of all possible points of view on care of the impaired elderly. The art of development of public policy concerning care of the impaired elderly is new and the processes of reconciling potential policies concerned with the care of the elderly with well-developed policies for other, older human services programs are just beginning. Not every possible alternative or divergent point of view is expressed in this document. It provides a starting point by which the Subcommittee, through its own deliberations and hearing processes may evoke and illuminate issues for consideration in the final report of the Subcommittee.

The report consists of a description/definition of the "impaired elderly" population under consideration, a discussion of present and needed services, a description of the role of families and friends in provision of services to the impaired elderly, and recommendations for changes the Commonwealth ought to consider. Since the number of persons requiring care is increasing and the cost of care is escalating, the issue of care of the impaired elderly is of grave consequence to the Commonwealth. This report describes issues to be considered in order to move Virginia towards a more humane, comprehensive, coordinated and cost-effective system of care.

B. Definition of the Impaired Elderly

For purposes of formulation of public policy and programs, the "impaired elderly" are persons over 60 who have impairments which now cause them to need care at public expense or who are likely, in the foreseeable future, to need care at public expense. This includes six groups of people:

1. Patients in intermediate care or skilled nursing beds (nursing homes) whose care is financed by Medicaid or who will become eligible for Medicaid when resources are exhausted. At any given time, this is about 15,000 persons.

2. Patients in acute care hospitals awaiting discharge to intermediate care or skilled nursing beds whose care is, or potentially will be, financed by Medicaid. This group is estimated to be about 400 persons at any one time.

3. Patients in acute care hospitals awaiting discharge to their homes whose care is, or potentially may be financed from public funds, or persons who need one or more of the home and community services as an alternative to being in acute care, an adult home or a nursing home. At any one time, this group includes about 250 persons.

4. Residents of licensed adult homes whose care is financed in part by auxiliary grants through the Department of Welfare. There are somewhat less than 1,500 persons in this group at any given time.

5. Patients under treatment in facilities of the Department of Mental Health and Mental Retardation. This includes about 2,700 persons over 60 in six hospitals.

6. Persons living in private homes who, because of chronic physical, mental or emotional conditions are unable to care for themselves and need persistent help from others over an extended period of time and who, without one or more home and community services would, in a short time (less than 90 days), be reasonably likely to be at risk of need for admission to an adult home or nursing home and who, presently, or in the foreseeable future, would require care financed or administered by the Commonwealth. The exact number of persons in this group is uncertain, but is estimated to be no more than 8,000 persons.

Virginia's "impaired elderly," for purposes of this report, includes, at any one time, about 15,000 persons in nursing homes, 750 persons in acute care hospitals, about 1,500 auxiliary grant recipients living in licensed adult homes, 2,700 persons in institutions of the Department of Mental Health and Mental Retardation, and less than 8,000 persons living in their own homes. At any one time, therefore, Commowealth policy must deal with the care needs of between 26,000 and 27,000 persons.

C. Issues for Consideration

About 70 percent of the impaired elderly under consideration are in nursing homes, State hospitals, awaiting discharge from acute care hospitals, or are auxiliary grant recipients residing in adult homes. The remaining 30 percent live in private homes and are at risk of institutionalization.

The following home and community services are believed to be helpful in delaying or preventing institutionalization:

1. Checking Services. This includes such activities as telephone reassurance and friendly visiting.

2. Continuous Supervision. Companion service in the home or geriatric day care in the community cares for a person who cannot be left alone.

3. Homemaker-Household Services. In Virginia these services may be rendered under the names of "homemaker", "chore", or "companion" services. It involves the person's surroundings rather than the person's body: usually housework, et cetera.

4. Meal preparation. This may include preparing meals with the person's own groceries as might be done by a homemaker or companion or taking the person home delivered meals through a meals-on-wheels program or the nutrition program of an Area Agency on Aging.

5. Nursing Care. Rendered by a home health agency.

6. Personal Care. May be provided as "home health" or by a companion service.

7. Physical Therapy

8. Protective Services

There obviously is an important issue concerning how to finance and deliver the foregoing list of services believed to prevent or delay institutionalization. Of equal importance is consideration of how to plan organize, manage, prescribe, coordinate and evaluate these services. Presently they are delivered by many different agencies: some local, some regional and some statewide. There are a number of terms currently in use to label organizations or mechanisms for dealing with this situation: "case management," "channeling", "screening and assessment," "service brokering," et, cetera. The term "care management" has been selected for use in this report.

Care management is both an administrative necessity and a service. It provides an assessment of the individual to determine services needed, to formulate a plan of care and to arrange for the services to be rendered. It helps make arrangements to assure family supports remain in place. It provides monitoring both to insure that needed services are rendered and that changes in the condition of the individual result in appropriate changes in services given. While Virginia has, at the local level, the eight types of services listed above, there is, at this time, no systematic, comprehensive, care management system which arranges or brokers these eight services. Even persons working in the field with considerable knowledge of the services system find it difficult to arrange necessary services for an elderly person.

The budget for the Commonwealth for 1980-82 includes the following amounts for institutional care of the impaired elderly during the biennium:

AGENCY	STATE FUNDS	FEDERAL FUNDS	TOTAL
Department of Health	$111,756,000	$143,381,550	$255,137,550
Department of MH/MR	28,495,855	19,414,510	47,910,365
Home for Needy Confederate Women	250,000	-0-	250,000
Totals	140,501,855	162,796,060	303,297,915

Source: 1980-82 Budget for Services and Programs to the Elderly; Virginia Office on Aging, May, 1980.

The costs of community care services for the impaired elderly are somewhat more difficult to determine since budgets and reports are not drawn separately for the population this report defines as "impaired elderly."

For the year beginning July 1, 1980, the Title XX Plan of the Department of Welfare and Department for the Visually Handicapped proposes to spend $12,811,278 ($9,608,459 federal, $640,564 State, and $2,562,255 in local funds) for adult protective services, geriatric day care, chore service, homemaker service and companion service which services normally are rendered for those considered impaired elderly. If the same amount is spent the following year, the total for the biennium will be $25,622,556.

Under Title III of the Older Americans Act, area agencies on aging for the year beginning October 1, 1980, plan to spend $1,922,076 ($1,633,764 in federal funds, $96,104 in State funds, and $192,208 local funds) for visitor and telephone reassurance services, geriatric day care, chore services, homemaker service, personal care services, and home delivered meals which services also are normally rendered to the impaired elderly. For a two-year period, at the same spending rate, this could come to $3,844,152 per biennium.

For the year beginning January 1, 1980, the Department of Health estimates the combined State and federal cost of Medicaid home health services to the impaired elderly of $1,170,580 or $2,341,160 for a two-year period at the same spending rate. The 1980-82 Budget for Services and Programs to the Elderly shows, in addition, $9,878,190 for the biennium from State funds for Department of Health home health care services. For a two-year period, therefore, the amount for home health care for the impaired elderly is approximately the sum of the two figures, $12,219,350.

Keeping in mind that budget periods differ, and some estimations are involved, we know of at least $41,686,058 per biennium for community services to the impaired elderly managed by Welfare ($25,622,556), area agencies on aging $3,844,058) and Health ($12,219,350).

In a biennium, therefore, the Commonwealth, along with local agencies is managing at least $344,983,973 of which $303,297,915 goes for institutional care and $41,686,058 goes for community services. The actual figure is probably higher.

A frequently raised issue is whether costs might be reduced by simply increasing community services. The present system of care is regarded as unsatisfactory both by the elderly themselves and by public policy makers. Not only does the rapid and unacceptable growth of costs make the system unpopular, but it also seems to favor institutionalization over the more desired alternative of "staying in one's own home". There is, therefore, obvious intuitive appeal to changing the mixture of community and institutional services so as to give higher priority to community services with the intention of controlling costs and of providing services more acceptable to the public.

This impulse simply to increase community services must be tempered by two facts. First, there are many persons who truly are in need of institutional care and for whom there is no "alternative" no matter how much financing is available. Second, the evidence currently available from experience in other states suggests future institutional costs cannot be substantially reduced by

putting more funds into community and home services. It is possible, however, that provision of more of the needed kinds of community and home services, coupled with effective care management, would somewhat attenuate the rate of growth of the costs of institutional care. The new and better community services, however, would undoubtedly service additional "borderline" cases. It is probable, therefore, that simply changing the "mixture" of home services, community services and institutional services will not reduce overall costs.

Although an increase in home and community services for the care of the impaired elderly will probably not reduce utilization of institutional care, there are other, persuasive arguments for changing the system of care which reaffirm the objectives on which this study is based.

1. Taxpayers are probably more willing to pay for increasing total costs of the impaired elderly when that care system includes more home services than they are to continue to pay for the current system. The available research shows families will go to heroic lengths to keep elders in their homes in spite of public policy which provides payment for institutional care. Changes in the system which help children and spouses do that which they wish, in any event, to do, are bound to be more acceptable than the present system.

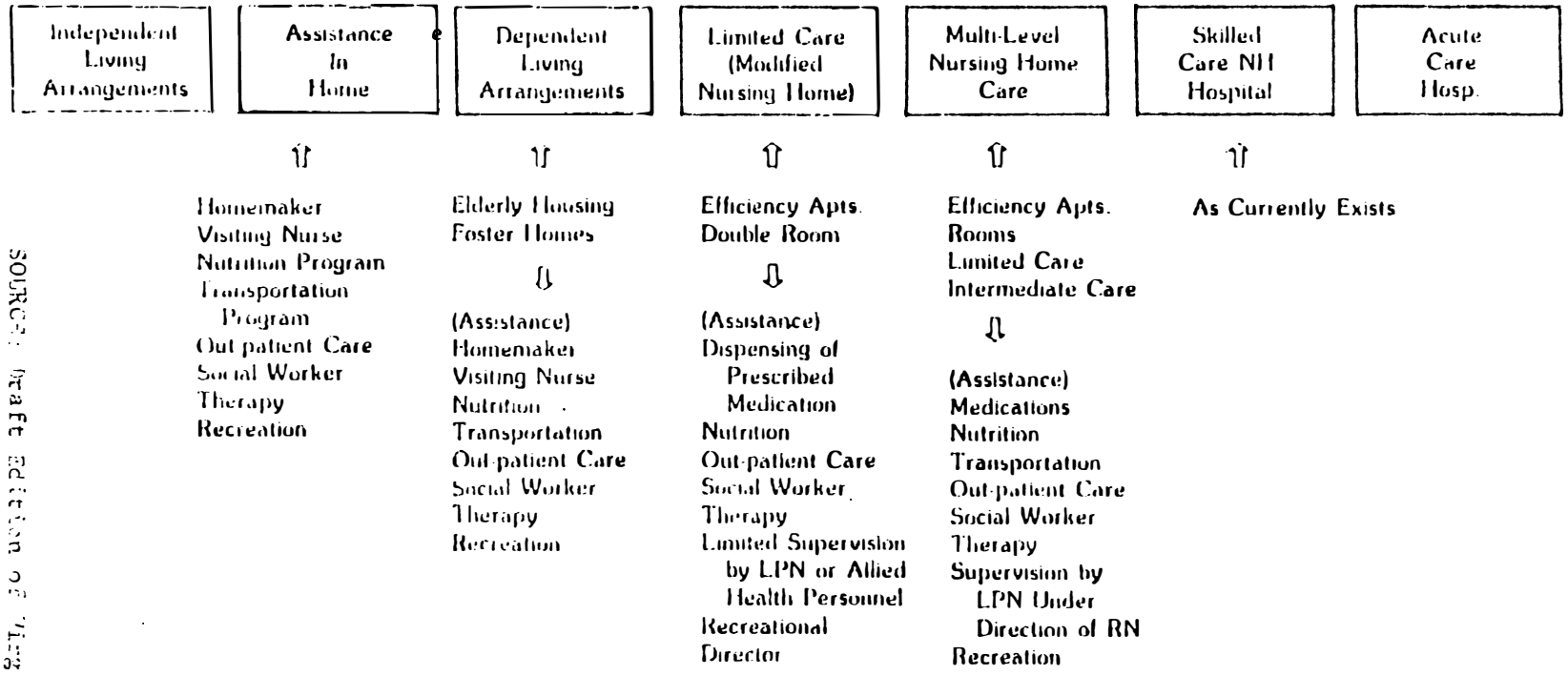
2. In a carefully designed research study, participants in Georgia's Alternative Health Services Project (1979) had lower mortality rates than a matched control group of nonparticipants. If some older persons are dying for lack of appropriate care, there is a strong argument for finding the means to provide the care.

3. Generally, home and community services are regarded as more humane because of the possibility of providing help without creating dependency or loss of freedom.

These are reasons people want home and community services. They must be considered along with potential costs and benefits of any attempt to provide additional home and community services, along with a system of care management to improve efficiency and accessibility of services.

Figure I illustrates a continuum of care alternatives which could be available to elderly persons in need of intervention.

ALTERNATIVES IN CARE OF THE ELDERLY



The continuum for levels of care are not set. Individuals may move in either direction or skip levels.

NOTE - The assistance outlined is not complete but is an example. Only that assistance necessary would be provided and this could would be adjusted as needs change.

NOTE - Necessary assistance in the home or any other living arrangements could possibly be provided by a combination of many resource people - to include - church groups, retired RN's and LPN's, allied health personnel who only want part time work, civic groups, etc.

SOURCE: Draft Edition of Virginia State Health Plan, 1983-84/Virginia Statewide Health Coordinating Council and Virginia State Department of Health, April, 1983

FIGURE 1

II. SERVICES FOR THE IMPAIRED ELDERLY

A. Introduction

According to the Virginia Health Survey (1978), more chronic conditions are reported as age increases. This survey indicates that approximately 50 percent of persons 65 and over reported three or more chronic conditions. As people grow older and suffer from more chronic diseases, the more vulnerable they are to a decrease in functioning level. This prevalence of chronic illness, therefore, provides the universe of clients for long term support services.

Three significant characteristics of the impaired elderly population influence services required:

1. The individual's degree of initial impairment;

2. The individual's progression of impairment over time; and

3. The recurring need for intervention.

Because of the heavy impact of federal financing and regulations, federal initiatives have had a great influence in shaping Virginia's programs for the impaired elderly. Programs for the impaired elderly are categorically designed to provide specific services. Eligibility is based on age, income, geographical location, medical need or other factors. The problem is further compounded by the lack of agreement on the definition and range of such services.

The current mix of services available to the impaired elderly can be delineated into home and community based, and institutionally based services. Institutional services which are funded to a greater degree are estimated to include over 85 percent of aging services appropriated for the 1980-82 biennium.

B. Home and Community Services

The U.S. Department of Health and Human Services administers the principal federal programs which provide in-home, long-term services. Medically oriented programs are funded by Title XVIII (Medicare) and Title XIX (Medicaid). Other in-home and community-based service programs are authorized under Title XX of the Social Security Act (Comprehensive Social Services Program) and Title III, the Older Americans Act.

1. Home Health Services

Home health services are primarily medically oriented service programs provided by home health agencies. These agencies are licensed public or private organizations which provide professional nursing services and at least one additional health service to patients in their place of residence. Services are purchased by Title XVIII (Medicare), Title XIX (Medicaid) and through private insurance coverage.

Title XVIII of the Social Security Act established the Medicare program to help eligible people meet the cost of health care services. This program is administered by the Social Security Administration. Eligible persons under Medicare, generally age 65 and over or disabled, may receive two basic forms of protection:

Part A, Hospital Insurance Benefits: Generally financed by the Social Security Act, covers in-patient hospital services and certain post-hospital care in skilled nursing facilities and the patient's home.

Part B, Supplemental Medical Insurance Benefits: A voluntary program, financed by premiums of enrollees and contributions covering physician services and many other medical and health benefits.

Home health services purchased through Medicare are currently limited to 100 visits per year per qualifying hospital stay under Part A. There is also a limit of 100 visits per year under Part B, but a hospital stay is not required. However, there is legislation pending in the U.S. Congress (HR 3990) which, if approved will eliminate the numerical limit on home health visits.

Title XIX (Medicaid), like Medicare also provides for home health services for program eligibles. However, unlike Medicare there is no skilled care requirement and there are no limits on the number of visits in the Virginia program.

As of July, 1980, the following home health agencies have been certified under the Medicare program:

MEDICARE CERTIFIED HOME HEALTH AGENCIES

	Local Health Department	Visiting Nurse Association	Hospital Based	Nursing Home Based	Other	Pending
HSA I Northwestern	6					
HSA II Northern Va.	5	2			1	1
HSA III Southwest	8			1		
HSA IV Central	7	1	1		1	1
HSA V Eastern	10				2	1
HSA VI ARCHA*	2					

* Includes Lenowisco Health District

Services currently available from home health agencies include the following:

Home Health Aide: Works under the direction and supervision of the registered professional nurse. An aide is used when there is a specific need for personal care services for the sick or disabled person.

Speech Therapy: Involves planning and implementing treatment for the management of communications disorders.

Occupational Therapy: Provides prescribed activities designed to improve physical and psychosocial functioning of the patient.

Medical Social Services: Are provided to help the patient and family adjust to illnesses and treatments and to help them take advantage of all community programs which exist to assist them.

Help with activities of daily living such as assisting the patient to bathe, to get into and out of bed, and personal grooming may be provided by the home health aide as well as certain designated household services such as changing the bed, light cleaning, laundering essential to the comfort and pleasantness of the patient, and food purchase and preparation.

Services of a home health aide in both the Medicare and Medicaid programs are given under the supervision of a registered professional nurse or other appropriate person, such as the physical therapist. The assignment of the 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 needs for personal care services. The specific personal care service to be provided by the home health aide must be determined by a registered professional nurse.

A state may also include in the Title XIX (Medicaid) program personal care services in the patient's home (Section 1904(a)(17) of the Act and 42CRF440.170(f). Personal care services are also medically oriented tasks having to do with a patient's physical requirements. The distinction between personal care services in general and the personal care services provided by the home health aide under home health services is that home health aide care must be provided through a certificated home health agency, while general personal care services need not be. The Title XIX program in Virginia does not pay for personal care services.

The personal care provider performs such tasks as assisting the patient with personal hygiene, dressing, feeding, or transfer or ambulatory needs. Any household tasks performed are to be purely incidental to the patient's health care needs. Personal care services vary, depending on the needs and requirements of each individual patient, and based on the judgement of the patient's attending physician and/or assigned registered nurse.

Table 1 lists Medicare and Medicaid home health visits and cost data for public home health agencies from July, 1978 to June, 1979.

2. Title XX

Title XX of the Social Security Act (Comprehensive Social Services Program) is administered in Virginia by the State Department of Welfare and the Department for the Visually Handicapped.

The Title XX Comprehensive Social Services Plan for 1980-81 includes distinct services (see Table 2) which may be available to the impaired elderly who are eligible for such services, that is, are in the required income base, reside in a geographical area where the service is provided, and meet need requirements, such as medical.

Title XX services primarily required by the impaired elderly are:

1. Chore Services

2. Companion Services

3. Homemaker Services

4. Protective Services to Aged, Infirm, or Disabled Adults.

The amount and scope of services that may be provided under the Title XX program are controlled by a ceiling on the amount of federal dollars allocated to a state. The ceiling for fiscal year 1980-81 for Virginia is $89 million, of which $66 million is federal dollars. Of the total federal allocation, 13 million dollars have been appropriated for adult services.

One of the largest Title XX programs within the Commonwealth is companion services which is available in 123 Title XX geographical areas, but is primarily available only to SSI recipients. The total budget for this service for Fiscal Year 1981 is $9,899,175 (see Table 2). It is expected that services will be provided to 7,721 persons who because of advanced age, blindness, disability, or infirmity, are unable to perform light housekeeping and personal tasks and have no one available to provide these services without costs.

TABLE 1

MEDICARE

CALCULATION OF REIMBURSABLE MEDICARE COSTS OF HOME HEALTH SERVICES
FOR JULY 1, 1978 - JUNE 30, 1979

Line No.	Type of Visits	Average Cost Per Visit (include cents)	Post Hospital Plan Part A		Medical Plan Part B	
			No.of Visits	Costs (Omit cents)	No.of Visits	Costs (Omit cents)
1	All Visits Combined	$ -	73,775	$ -	35,790	$ -
2	Skilled Nursing Care	39.39	43,828	1,726,385	22,053	868,668
3.	Physical Therapy	26.58	11,061	294,001	4,073	108,260
4.	Speech Therapy	28.74	1,294	37,190	675	19,400
5.	Occupational Therapy	20.38	786	16,019	233	4,749
6.	Medical Social Services	46.08	326	15,022	110	5,069
7.	Other Covered Visits(Specify) Male orderly	33.69	440	14,824	238	8,018
8.	Home Health Aide (No.of Hourss: Part A - / B -) Un	$ 21.67	16,040	347,587	8,408	182,201
9.	Cost of Rental Equipment					
10.	TOTAL COST INCURRED (Items 1 thru 9) OR TOTAL COST (Sch.A-9 line 8)			2,451,028		$ 1,196,365

Source: Virginia Department of Health, Division of Medical Assistance.

TABLE 2

LONG TERM CARE SERVICES IN VIRGINIA TITLE XX PLAN
YEAR BEGINNING JULY 1, 1980

SERVICE	TITLE XX FUNDS	MINIMUM STATE FUNDS	MINIMUM LOCAL FUNDS	TOTAL
Adult Protective Services	$1,032,767	$ 68,851	$ 275,405	$ 1,377,023
Continuous Supervision				
Geriatric Day Care	$ 278,029	$ 18,535	$ 74,141	$ 370,705
Homemaker-Household				
Chore Service	$ 100,483	$ 6,699	$ 26,795	$ 133,977
Homemaker Service	$ 772,799	$ 51,520	$ 206,079	$ 1,030,398
Personal Care				
Companion Service	$7,424,381	$494,959	$1,979,835	$ 9,899,175
TOTALS	$9,608,459	$640,564	$2,562,255	$12,811,278

3. Older Americans Act

Title III of the Older Americans Act, administered throughout the Commonwealth by the Virginia Office on Aging, supports State and local planning, coordination, and services for persons 60 years of age and older.

Services delivered to the elderly through the 25 designated Area Agencies on Aging (AAA's). Those services primarily directed to the impaired elderly include homemaker, home health, chore, friendly visitor, telephone reassurance, day care, and nutrition.

Table 3 shows proposed spending for the current federal fiscal year for these services. For the current 1980-81 biennium, a total of $34,267,200 in State and federal funds has been appropriated for Virginia Office on Aging functions and services.

TABLE 3

LONG TERM CARE SERVICES IN AREA PLANS FOR AGING SERVICES
TITLE III, OLDER AMERICANS ACT
YEAR BEGINNING OCTOBER 1, 1979

SERVICE	TITLE III FUNDS	MINIMUM STATE FUNDS	MINIMUM LOCAL FUNDS	TOTAL COST
Checking				
Friendly Visitor	$ 87,997	$ 5,176	$ 10,352	$ 103,525
Telephone Reassurance	$ 18,306	$ 1,077	$ 2,154	$ 21,537
Continuous Supervision				
Geriatric Day Care	$ 42,267	$ 2,486	$ 4,972	$ 49,725
Homemaker-Household				
Chore Service	$ 131,610	$ 7,742	$ 15,484	$ 154,836
Homemaker Service	$ 52,569	$ 3,093	$ 6,185	$ 61,847
Personal Care				
"Home Health"	$ 248,105	$14,594	$ 29,189	$ 291,888
Meal Preparation				
Home Delivered Meals (Estimated)	$1,052,910	$61,936	$123,872	$1,238,718
TOTALS	$1,633,764	$96,104	$192,208	$1,922,076

4. Geriatric Day Care

Geriatric Day Care is a comprehensive set of activities provided for frail individuals for a defined portion of a 24-hour day as a supplement for family care in a protective setting for purposes of personal attention, care and supervision.

Title XX (July 1, 1980-June 30, 1980) will provide $350,705 and Title III (October 1, 1980-September 30, 1981) approximately $59,000 for adult day care for the elderly in Virginia.

Table 4 lists Virginia's 12 adult day care centers which primarily serve the elderly. As of July 1, 1980, the system was operating at a licensed capacity of 319 and is serving an average 182 persons daily. The average total daily cost per participant for day care is $17.66.

TABLE 4

DAY CARE FOR THE ELDERLY IN VIRGINIA AS OF JULY 1, 1980

Center Name and Location	Persons Enrolled	Average Daily Attendance	Licensed Capacity	Day Care Cost Per Participant Per Day	Transpor. Cost Per Participant	Total Cost Per Participant Per Day
Day Care Center Patrick Henry Hospital, Newport News	21	18	25	$ 8.07	$3.00	$11.07
Richmond Community Senior Center Richmond	16	16	30	$10.17	$2.28	$12.45
Stuart Circle Center Richmond	28	16	30	$18.10	$ .90	$19.00
Center of Leisure Activities for Older Adults Virginia Beach	21	14	25	$10.45	$12.74	$23.19
Adult Development Center Richmond	59	15	25	$14.12	$2.60	$16.72
Day Care Center for Older Adults, Norfolk	8	6	9	$13.00	$5.28	$18.28
Madison Center Day Care Arlington	60	35	70	$17.00	$4.00	$21.00
Adult Day Care - Hanover Friends Center, Inc. Mechanicsville	15	10	Not Licensed	$18.21	$4.50	$22.71
Bethlehem Center Day Care for Older Adults, Richmond	20	13	30	$ 9.45	$2.00	$11.45
Leewood Wayside Day Care - Leewood Nursing Home Annandale	9	5	50	$20.00	0	$20.00
Woodbine Day Care Center - Woodbine Nursing Home Alexandria	20	12	25	$18.00	0	$18.00
Annandale Day Care Center Fairfax	22	22	Not Licensed	$16.00	$ 2.00	$18.00
TOTALS	299	182	319	$14.38*	$3.28*	$17.66*

*Average Costs

C. Institutional Services

1. Nursing Homes

The Board of Medicine and the Bureau of Medical and Nursing Facilities Services within the Health Department are responsible for licensure and certification of nursing home beds for Title XVIII (Medicare) and Title XIX (Medicaid). The Virginia Medical Assistance Program (Medicaid) is responsible for monitoring compliance with both federal regulations and guidelines in regard to quality of nursing home care, specifically physician or nursing plans, medications, and patients' rights. Currently, 88.5% of the nursing home population is 65 and over.

The two major methods of payment for nursing home care in the Commonwealth of Virginia are Title XIX (Medicaid), estimated to be 69% of all nursing home patients, and private pay. The appropriateness of nursing home admission of Medicaid eligibles and persons who will be eligible within the next 90 days is determined by local nursing home pre-admission screening committees under the Title XIX Nursing Home Pre-Admission Screening Program. There is no pre-admission screening requirement for nursing home admissions from acute care facilities (hospitals) and for private pay patients.

Skilled Nursing Facilities

Skilled nursing facilities provide an alternative to hospital care for patients who require general medical management and skilled nursing care on a continuous basis, but generally do not require the support service usually provided by a hospital.

According to the 1980 annual survey by the Bureau of Medical Nursing and Facilities Services, there were 1,969 certified skilled care beds as of June 1, 1980. Skilled care beds constitute only 10.9% of the total number of certified nursing home beds.

The average length of stay in a skilled nursing home is substantially shorter than that for intermediate nursing care. The reason is basically two-fold: skilled care is rehabilitative and the patient recovers sufficiently to return to the community or a different type of institutional setting, or the patient is terminally ill. In both instances, the patient requires a high intensity of nursing care for comparatively short periods.

Intermediate Care Facility

An intermediate care facility is a nursing home which provides care both in the activities of daily living, such as walking, dressing, et cetera, and in providing such health care measures as supervision of medication, and dressing changes. As of June 1, 1980, there were 17,860 certified nursing beds in Virginia. Of this number, 15,891 (90% of the total) are in intermediate care facilities.

In addition to the number of beds listed as skilled and intermediate, there are 1,312 nursing home beds that are "non-certified". This means that they are licensed but do not accept Title XVIII Medicare and Title XIX Medicaid monies or patients.

2. Homes for Adults

Section 63.1-174 of the Code of Virginia requires that the State Board of Welfare adopt "reasonable regulations, governing the construction, maintenance and operations of homes for adults." These regulations apply to any home providing room and board and discernible supervision for four or more aged, infirm, or disabled adults.

Approximately 11,000 people with a median age of 76, of whom 82.5% are over 65, live in 314 licensed adult homes in Virginia. These homes range in size from four to 52 beds with an average size of 32 beds. Although licensed homes for adults are located in all parts of the State, the largest number of homes (81) and the largest number of licensed adult home beds (3,227) are located within the Richmond region.

Three major federal and State actions have contributed to the steady growth of the number and size of adult homes in Virginia: (1) the enactment in 1933 of Title XVI of the Social Security Act,

(2) the Supplemental Security Income program which increased the number of persons able to pay for care in adult homes, and (3) the Virginia Auxiliary Grant program which permits additional payments to eligible residents who live in licensed adult homes.

Auxiliary grant monies are State and local funds. There are 1,487 adult home residents receiving auxiliary grants as of July 1, 1980. Residential costs range from $175 to more than $1,000 dollars a month. The statewide maximum for welfare payments under the Auxiliary Grant Program is $409 (effective July 1, 1980).

Homes for adults vary widely in the level as well as number of services provided to residents beyond the basic requirement of food and shelter. Standards require that there be programs within the home that are "appropriate to the need, interest, and abilities of the residents." Programs and activities range from watching television to extensive recreational, educational, individual group activities and planned entertainment.

Residents of homes for adults who are eligible for either Title XVIII (Medicare) or Title XIX (Medicaid) are eligible for home health services when ordered by a physician and provided by a certified home health agency. Mental health aftercare may be provided by community mental health clinics or the private medical sector.

3. Mental Health Geriatric Facilities

The Virginia Department of Mental Health and Mental Retardation operates four geriatric treatment centers located at the four major state hospitals. In addition, the Department operates two geriatric hospitals. Approximately 2,700 persons over the age of 60 are treated in state mental health and mental retardation facilities.

Funding for mental health geriatric programs is derived from federal programs such as Title XVIII (Medicare), federal and state programs such as Title XIX (Medicaid) and CHAMPUS, private insurance carriers such as Blue Cross/Blue Shield, and some private pay by patients and their families.

4. Hospice

Hospice is a program for terminally ill patients and their families. It has been defined by the 1979 General Assembly (House Document No. 9) to be the following:

> "Hospice means a coordinated program of home and inpatient care which treats the terminally ill patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous Hospice administration. The program provides palliative and supportive care to meet the physical, psychological, social, economic, and other special needs which are experienced during the final states of illness, and during dying and bereavement."

As of July 1, 1980, there are two hospice programs operating in Virginia: Riverside Hospital in Newport News, and Hospice of Northern Virginia, Inc., located in Arlington. An additional hospice program at Roanoke Memorial Hospital has been approved through the certificate of need process but is not operational at this time.

Hospice of Northern Virginia served 298 patients from March, 1978 through June, 1980, and Riverside admitted 104 from April, 1979 through March, 1980. Most of their clients have been cancer patients and approximately 50% of their cases have been 65 years of age and older.

As of July 1, 1980, Hospice of Northern Virginia's caseload is 23. All are home care only, but this program will eventually have in-patient care. Of Riverside's caseload of 29 (as of July 1), 7 are in-patients and the remaining 22 are home care.

The following table provides a breakdown of methods of payment and costs for hospice services provided by the two programs.

	Hospice of Northern Virginia	Riverside Hospital
Method of Payment	38% Medicare 5% Medicaid 30% Blue Cross 27% Other Insurance	47% Medicare 5% Medicaid 27% Blue Cross 18% Other Insurance 3% Self-Pay

III. CARE MANAGEMENT

A. Definition

Care management is an administrative service defined as the management of a process that includes the following:

(1) Counseling and providing information to link the person needing help to available community and institutional services.

(2) Coordinating an assessment of client's service/medical needs which include evaluation of:

a. Medical, nursing and psycho-social assessment, including level of functioning.

b. Physician consultation and work-up.

c. Review of financial assets.

d. Home assessment/Housing need.

e. Social work assessment.

(3) Developing a service plan, with the cooperation of the client and family, which includes objectives to meet client's service needs, specifies services to meet those objectives, and identifies available services.

(4) Arranging for implementation of the service plan, including service delivery tasks (i.e. referral to appropriate agency) and arrangements with client and provider for appointments and transportation.

(5) Developing a process for monitoring the service or component of service a client receives.

(6) Evaluating the impact of services and/or their components on the client.

(7) Developing a feedback mechanism to the providers, to the community, and to the agency about the need for the development of new services and expansion or elimination of existing ones based on documentation in service plan of gaps/barriers between client service needs and effective available providers.

(8) Assuring continuity of caare for the client and to monitor changes in the client's service needs.

Care management services are considered necessary because:

1. There is a need for a central source of information about non-institutional long-term care options.

2. There is fragmentation and problems in coordinating public and private community service providers.

3. There are varying eligibility requirements for services.

4. For the elder and his family, likewise, the services and organizations available may appear to be a frustrating maze of office locations, applications, and financial responsibilities.

5. For the professional charged with placement responsibilities, the complexity of locating home and community services is time consuming and frustrating.

Several model projects for care management in other states are being studied. The implications for development of a Virginia care management model are:

1. Care management is no substitute for money, clear policy, wisdom, humanity and additional

services (paraphrased from Robert Morris' Coordinating Services for the Elderly).

2. Care management seems to need the additional components of administrative and funding linkages of health, mental health, and social services, often accomplished by waivers.

3. The most successful of all projects reviewed had state legislative support and state funds indicating state/community commitment.

4. Care management may require a centralized intake and assessment system.

5. To be effective, care management should be linked to the authority to pay for the designated services.

6. Level and competence of staff involved in special projects is critical.

7. Although there may be instances where appropriate care management may result in use of less costly services instead of more expensive ones, the justification of care management lies in its matching of persons to appropriate services rather than in the probability of costs savings.

8. Care management involves responsibility for seeing that planned services are received.

9. The team approach to the care management, assessment function is universally accepted.

10. Some projects include care management as assessment for public and private pay patients, and a screening system for both is highly desirable.

11. Centralized care management is necessary to assure that planned linkages among systems occur.

B. The Assessment Process

One of the most important issues in care management is assessment, as it is a key factor in ensuring that persons receive necessary services. There are at least three care management models for assessment. In one model, the care manager performs the assessment and works out the case plan with the client. There are two benefits to the model: it is less time consuming and places heavy emphasis on the client's wishes. A second approach is to hold a case review with all persons involved in the process and make a group assessment. This approach would allow for maximum multidisciplinary decision-making and would be somewhat similar to the Nursing Home Pre-Admission Screening Process currently in use in Virginia. A third approach is to have the care manager develop the assessment and then hold a conference or have a paper review by all those involved including providers. The last two approaches allow for good resource coordination, help develop good working relationships, and increase expertise. The latter two also are time consuming and place less emphasis on the client's wishes.

The format of the assessment is varied. The factors considered in assessment are important because they determine both the depth of assessment and the agencies/resources involved in decision-making regarding case planning Major factors are:

1. Medical, nursing and psycho-social assessment

This includes demographic data, diagnoses, and physician orders, data on functional capacity in activities of daily living, psycho-behavioral conditions and functioning, and recommended medical or health services.

When persons are in a hospital or long-term care facility, members of the discharge planning staff and the client's attending physician or house staff may be involved. In the community, the public health nurse who visits the client at home may be a resource.

2. Physical consultation and work-up

A thorough medical examination should be a part of the assessment process.

3. Financial counseling

A confidential review of client and family assets should be conducted to help assure that insurance and third party payments are explored before public resources are expended. The counsling should include a discussion with client and family on optional expenditure of resources to best meet long-term care need.

4. Home assessment

A home assessment should be conducted by the care manager with consultation of an occupational therapist to determine modifications in the home which can assure safety, mobility, and independence. The visit could also help determine utility of home medical equipment, if needed.

5. Informal Support Assessment

The capacity of the family, neighbors and other informal supports should be assessed so as to assure that care plans and family capabilities are mutually consistent.

The degree of involvement with the client by the care manager is often debated and varies in the projects reviewed. However, it appears that the most effective care management occurs when that person is more than an administrative manager of services, but develops a vital one-to-one relationship with the client. This includes the care manager's availability in emergency situations to the client and his support and motivation both to the client and his family. Often, for persons requiring care management services, the need for a "significant other" is as great as the need for services. When informal support systems exist for the client, the degree to which the care manager is involved with the client in this manner may vary.

C. Organization for Care Management

There are a variety of organizational structures which can be considered to provide the care management function for the elderly. In keeping with Virginia's philosophy of local control of programs, this model for care management has been designed to assure as much local flexibility as possible for the design of a long-term care management system.

The development of a care management system at the local level will center around the establishment of a screening team for all services for the impaired elderly. The team will utilize the case review approach to assessment. The "local option" law may be exercised, if needed, by local governments establishing care management mechanisms.

Localities wishing to participate will select the structure of the team with the stipulation that, at a minimum, the following agencies be involved: Social Service Departments, local Health Departments, Community Mental Health and Mental Retardation Services Boards, and Area Agencies on Aging. The team will meet on a regular basis and be responsible for assessment, referral of persons to any system of long-term care service to be paid for by public funds, and quality assurance. Persons not referred in this manner will not receive such services at public expense, but may pay privately. For localities which exercise this option, the implementation must include an interface with the existing Nursing Home Pre-Admission Screening Program. Where localities do not exercise this option, the existing Nursing Home Pre-Admission Screening Program will continue as it presently exists.

Many models for organization are possible ranging from the establishment of a lead agency to chair the team to one which would rotate the responsibility. Localities will be urged to design a system that meets their needs using available staff and taking into consideration unique characteristics of their area. The point of entry may be an existing service agency. The "entry agency" would be obligated to refer the case to the screening team for review prior to expending public funds.

Plans for development of a screening team will be submitted to the Secretary of Human Resources, reviewed, and approved as provided under the "local option" guidelines.

Evaluation of the performance of the care management team and monitoring of these activities

will be the responsibility of the interagency staff group. A monthly briefing of the agency heads of the Virginia Office on Aging, Department of Health, Department of Welfare, and the Department of Mental Health and Mental Retardation will be required to assure the highest degree of coordination among these programs. This briefing will focus on the performance of the care management teams, an analysis of services available and services needed, an accounting of expenditures for services, and a cost effective analysis of the screening team system. These agency heads will be charged with providing an evaluation of this program for the Secretary of Human Resources.

It is recommended that three prototype care management models be established in three localities in the Commonwealth to begin operation July 1, 1981. The objective would be to obtain identification and projections of costs and programmatic issues which would have to be considered prior to implementation on a more widespread basis.

IV. INFORMAL SUPPORT SERVICES FOR THE IMPAIRED ELDERLY

A. Introduction

The term Informal Support denotes non-public sources of care or assistance which include help from family, neighbors, friends, church groups, service clubs, and other voluntary organizations. Informal support can be contrasted with formal support , which is the term applied to assistance from public and private organizations such as governmental agencies or other organizations that function with the formal or expressed purpose of delivering services or care at public cost or through payments from individuals receiving care.

Although informal supports, such as family and friends, traditionally have provided the majority of care for the impaired elderly, formal systems such as governmental and private agencies have assumed a larger share of responsibility in the last few decades. Virginians, like other Americans, have always had a deep-rooted sense of family obligation to their elders. Research indicates that these familial values have not "broken down" in modern times (Hughston and Quinn, 1978). Instead, the means for fulfilling these obligations have changed. Medical care has improved substantially in the last few decades, but with improvement has come specialization and a phenomenal growth in costs. Families of the past were capable of providing more care for their elderly than in present times because our knowledge of diagnosis and treatment and our standards for quality of care were very minimal. The skill requirements and the financial strain on the family have increased in direct proportion to our knowledge of disease processes, treatment, and rehabilitation techniques.

B. Services Provided by Informal Systems

During the spring and summer of 1979, the Virginia Center on Aging conducted a statewide survey of older Virginians who were residing in community settings (not in institutional facilities). The survey was funded by the Virginia Office on Aging and the Virginia Department of Welfare in order to develop a descriptive profile of the needs and service use of older people in the State. The study was based on a state-level area probability sample of 2,146 people age 60 and older, who are representative of Virginia's older population.

The results of the survey demonstrate several interesting patterns in formal and informal supports. Table 5 presents the source of services or care accoridng to two categories: a) formal service providers, such as agencies, private professionals or other paid sources; and b) informal support from family, neighbors and friends. For some services the older people being studied had more than one provided, so the percentages in Table 5 represent the primary source of care, i.e., the formal or informal provider who is most likely to give the service. The types of care or assistance are divided into two general categories: a) critical in-home services that would be essential if an impaired adult were to remain in his own home; and b) supporting services which would be necessary for inpaired adults to function in the community.

Table 5 demonstrates that critical in-home services are being received by only a small proportion of older Virginians. This reflects the fact that only about one-fifth of the elderly population has serious physical or mental impairment which would require assistance in daily living tasks around the home. Eighteen percent of Virginia's elderly receive homemaking or household chore assistance, 13 percent must have their meals prepared for them, 8 percent have assistance with personal care (such as bathing, taking medication, or getting in and out of bed), 8 percent

receive supervision by a person who is with them on a continuous basis, and 7 percent have nursing care.

The critical in-home services are provided mainly by family, neighbors, and friends. Ninety-two percent of the continuous supervision, 90 percent of the personal care, 89 percent of the meal preparation, 84 percent of the homemaker care, and 68 percent of the nursing care come from family, neighbors or friends as the primary source.

Among the supporting services, medical care, dental care, psychotropic drugs and mental health treatment are given exclusively from professional or other paid sources. Yet, family, neighbors and friends give 99 percent of the assistance with regularly checking in on the older person, 75 percent of the help with housing relocation, 70 percent of the assistance with legal or home management matters, and 60 percent of the coordination or referral to other services.

SOURCE OF SERVICES
AND LEVEL OF USE:

Statewide Survey of Older Virginians (N=2146)

TABLE 5

Type of Service	Use	Primary Source	
Critical In-Home Services	Receiving Within Six Months of Interview	Agency Professional or other Paid Source	Family, Friends or Neighbors
Homemaker/Household	18%	16%	84%
Meal Preparation	13%	11%	89%
Personal Care	8%	10%	90%
Continuous Supervision	8%	8%	92%
Nursing Care	7%	38%	62%
Supporting Services			
Medical Care (Visit to a Physician within 6 Months)	71%	100%	NA
Administrative, Protective or Legal Services	19%	30%	70%
Someone to Check in Regularly	37%	1%	99%
Mental Health Treatment	2%	100%	NA
Help with Housing Re-Location	2%	25%	75%
Coordination, Information and Referral	11%	39%	61%
Dental Care (Visit to Dentist Within a Year)	38%	100%	NA
Psychotropic Drugs	21%	100%	NA

NOTE: "NA" means that professional sources were the only response option in the survey.

One objective of the Statewide survey of older Virginians was to determine the so-called unmet need for services. That is, what percentage of older people are either currently not receiving a form of assistance but feel that they need it, or are receiving a service but they feel they need more of it? For those not receiving different types of in-home services, 6.3 percent perceive a need for homemaker or household care, 1.5 percent need meal preparation, 1.2 percent need nursing care, and 1 percent need continuous supervision or personal care. These percentages of unmet need are relatively low in proportion to the total population, but in absolute numbers they range from approximately 47,000 in need of homemaker services to 7,400 in need of personal care or continuous supervision.

The unmet need for supporting services is also not large in proportion to the total older population, but it is significant in numbers of people who need basic forms of assistance. For example, 10.5 percent feel they need more transportation than they are currently receiving, 10.7 percent need more medical care, 26 percent feel they need dental care, 3.9 percent feel they need physical therapy, and 2.1 percent need mental health services. It is interesting to note that while only 1.8 percent of older Virginian's use mental health services, and only 2.1 percent perceive an unmet need for these services, 21 percent are using a prescribed psychotropic drug.

These estimates of unmet need for services are particularly relevant when considering that the vast majority of older people who are residing in the community and who are severely mentally or physically impaired are living with a family member such as a spouse, adult child or other relatives. In a special study of a small number of older people from the Statewide survey, it is estimated that only 16 percent of those people with severe physical or mental impairment are living alone.

Families and other informal supports are the primary source for most forms of care. They are undoubtedly operating at full capacity in their ability to give care, and unmet need for services represents a serious challenge to service agencies if the public sector is to avoid or delay inappropriate institutionalization. A severely impaired person, who has an unmet need for critical in-home or supporting services, is a likely candidate for a nursing home or other institutional facility.

The public responsibility for meeting the need for critical services is heightened by two additional areas of information derived from the Statewide survey of older Virginians. Whereas an estimated 29 percent of the severely impaired older population currently qualify for Medicaid services in the community, an estimated 70 percent would receive Medicaid coverage within 90 days if they were to enter a nursing home. The differences in eligibility requirements for public payment between community and institutional care are a major disincentive to families who would otherwise care for older people in their homes. Secondly, when asked which forms of long term care they would prefer in the event of serious disability and need for care, an estimated 68 percent of all older Virginians would prefer remaining in their own homes with the care of a relative or a paid source such as a housekeeper or nurse, while only 25 percent would prefer a nursing home. Sixty-three percent would prefer not to go a nursing home.

C. Stress on Informal Systems

Despite the substantial level of informal support provided by family and friends, there are problems with maintaining these support systems when the older person becomes physically or mentally impaired and requires long term care. An occasional offer of assistance does not drain the resources or monopolize the time of family or friends. But when physical or mental impairment seriously affects daily living skills, such as personal hygiene, care of the home, or management of finances, then family or friends may commit large amounts of time performing these tasks, or they may be called upon to give financial support for a paid housekeeper, nurse, or companion.

Barry Gurland, et.al, (1978) studied the relationship between impaired elderly and their family members in a community setting in New York City. They chose to conceptualize the helping relationship as personal time dependency. That is, they measured the strain on family resources by the amount of time (daily or weekly) that was required to maintain the well-being of an older person. They discovered that the probability of institutionalization was directly related to the time required for care. The inconvenience caused to the family gave a far better prediction of nursing home placement than did the degree of physical or mental impairment of the older person.

Even those adult children who had very strong feelings of obligation to their older parents could not maintain caregiving when personal time dependence became excessive. They found that their lives were being seriously disrupted because they were channeling their time and energy into care for their elders.

When faced with mounting needs for assistance, the older person and the informal caregivers may have a strain in their relationship. The impaired elderly resist and often resent a dependent status because they are adults who have functioned independently for most of their lives. The vast majority of older people prefer to retain their personal autonomy even when faced with serious problems with daily living. Based upon the finding of the Statewide Survey of Older Virginians, only about 30 percent of the elderly population would prefer to move into the home of a relative in the event of long-term disability.

The key to informal support is to maintain as much personal control and privacy as possible for the impaired older person, while at the same time keeping requirements for assistance at a moderate level so that family or friends can incorporate these demands into their daily routines. One preferred living arrangement is an independent residence that is in proximity to the family. This may be in the same part of the city, or in the same neighborhood. Another option is to share responsibilities among several family members, or between informal supports and the formal service delivery system. The family might use formal services, such as a housekeeper, personal care provider or a paid companion during certain hours of the day, to supplement their resources.

Much of the stress and indecision which occurs for the older person or the family results from their confusion about the type of care that is needed, the prognosis for return of a higher level of functioning, the capabilities of family or friends to give care, and the appropriate community resources. When faced with physical or mental impairment (such as a stroke senile dementia, or other chronic condition), it is common for both the older person and the family to expect a need for a great deal of care, to view the possibility for recovery of daily living skills as being only minimal, to underestimate the family's ability to give care and to regard the nursing home as the only viable option. Part of their confusion stems from their negative attitudes toward old age and long-term care, but equally important is their access to information about community services and the potential for rehabilitation and care.

D. Issues and Alternatives

The critical issue in informal support systems is to have the proper level of supportive community services and an adequate information and care management system in the community in order to arrive at a combination of public, private, and informal support services which are complementary and adapted to individual needs.

Probably the biggest obstacles to informal supports for the impaired elderly are the complexity and inadequacy of services, and the restrictive eligibility requirements in the formal service delivery system. Community long-term care services (such as homemaker, companion, and home health) are often not available, are difficult to obtain because of eligibility restrictions, or the costs of privately delivered services can be prohibitive. There is a large gap between family or friends shouldering the complete responsibility for care and the totally public or formal provision of care through the nursing home or other institutional facility. It is impossible to have a partnership or cooperation between formal and informal supports if the formal system cannot respond with appropriate services and if the older person or family members are not aware or cannot gain access to services that are available.

The following issues illustrate current inadequacies in informal supports, but also alternatives which may bolster informal support systems.

1. Eligibility Requirements

Eligibility for services can be an important issue for the informal caregivers – especially the spouse.

When an impaired person is living with a spouse, their combined income is used to measure eligibility for in-home services. The basic problem with eligibility comes from the criteria used to measure household income and assets for an older person living at home versus those criteria used

to measure resources for a resident in an institutional facility such as a nursing home. Whereas, the combined income of husband and wife are used to determine eligibility for Medicaid payment for an impaired spouse in the home, the individual income of the impaired spouse may be considered separately for Medicaid eligibility in an institution.

Community care options are limited for Medicaid coverage in the first place, because home health services are medically oriented and they cover personal care, homemaking, and chore services only to the extent that they relate to medical needs. Nursing home services, on the other hand, are oriented to a whole range of personal care, nutritional, and housekeeping needs whether or not they relate to an acute medical condition. Therefore, it may be financially most feasible for a family to place an impaired relative in an institution because Medicaid eligibility requirements are less stringent and the range of services is greater in the institutional facility.

If financial support for in-home and community services were expanded through public payment programs, persons now placed in nursing homes as the only option may be able to remain in their own homes. With this additional coverage of in-home and community services, the State Health Department's Pre-Admission Screening Program should be expanded to screen all persons who could be Medicaid medically needy or categorically needy within a 13-month period after entering a nursing home. The screeing team should also evaluate and make recommendations to support the informal support system available to the impaired elderly.

2. Tax Provisions and Recommended Tax Incentives

The federal income tax laws provide for a yearly tax credit of 20% of "child or disabled dependent care" expenses. The credit applies only to individuals or families where the care of the dependent is necessary for the employment of a taxpayer. If the dependent lives in the household of a married couple, they both must be employed unless the dependent is the spouse. In the case that the husband and wife are both working, they must file a joint return. The maximum tax credit for the care of one dependent is $400/year, and for two or more dependents, it is $800. To qualify as a dependent adult, the person must be disabled and must have over one-half of his or her support from the taxpayer. The Virginia income tax laws are based upon federal provisions regarding child and disabled dependent care. These laws were the subject of study by the Joint Subcommittee to Study Incentives for Persons Caring for the Elderly in Their Own Homes (House Document No. 29, 1979).

A taxpayer in Virginia may claim a tax deduction equal to five times the amount allowable for credit for federal income tax purposes for dependent care. The Virginia taxpayer need not itemize deductions in order to qualify. The maximum tax relief for care of a single dependent is $115 and for two or more dependents it is $230. However, a survey of itemized tax returns for 1977 revealed that no one claimed a deduction for dependent care for disabled adults. All deductions were for child care. The Subcommittee studying this situation concluded that the Virginia provisions for deductions for depedent adults were too restrictive, primarily because the taxpayer must itemize deductions in order to qualify. The Subcommittee recommended a change in the tax law to allow the child and disabled depedent deduction to be claimed by taxpayers who use a standard deduction. This change was enacted in 1979. The Subcommittee could not reach any conclusion about increasing the amount to be deducted, introducing a tax credit system, or relaxing the limitations on who could qualify for a child and disabled dependent tax deduction.

Federal and State tax laws presently offer modest tax relief to compensate for care of an impaired older person who would qualify as a disabled dependent. However, the $400/year federal tax credit and the $115/year State tax relief do not compare favorably to the potentially high level of expenses that a working couple might have in caring for an older relative.

Tax relief through the State income tax for care of disabled dependent adults should be considered with the explicit legislative intent that it be used to defer or avoid nursing home or other institutional care. The taxpayer(s) should not be required to work in order to qualify for the deduction.

In order to compensate persons for the care of dependent adults, there should be greater tax relief for care of disabled dependents. For example, the limit to deductions could be set at one-half of the average yearly nursing home costs per individual under the State Medicaid Program. There should be no income limitations on taxpayers who can qualify for this deduction. A person, or

persons, caring for a disabled dependent should not have to be employed full or part-time in order to qualify for tax relief. If a taxpayer has no taxable income, without considering the disabled dependent deduction, results in no tax liability, then the individual(s) who is providing dependent care should be eligible for a State grant equal to one-fifth of the allowable disabled dependent deduction to be administered through the State income tax system. This latter provision is designed for the elderly husband or wife who would be a likely caregiver, but who would not ordinarily benefit from tax relief because he or she would not have taxable income.

3. Direct Payments to Families or Non-Relatives

In several parts of Virginia, the local welfare departments (also the Virginia Department for the Visually Handicapped) have contractual arrangements with the relatives of impaired elderly to provide companion and chore services. They receive an average of $2.30/hour, but not more than the minimum wage for the time that they spend giving personal care, doing light housework, accompanying the older person to the store, or doctor's office, or performing chores around the home. In order for the family member to receive payment, the older person must be impaired and must have an income low enough to be eligible for Title XX services. Family members receive no training and they have only minimal supervision by the Welfare Department staff. This direct payment system has not been evaluated to determine whether it encourages family support or whether the quality of care is comparable to other forms of companion or chore services.

This policy should be evaluated in order to determine the quality of services delivered, the motivational impact of the wage, and the level of financial resources of those families who participate in the program. In short, the policy should be evaluated to determine if family members could otherwise provide care if they were not paid, and if the policy might be expanded to offer compensation to more families for a wider range of services.

Another direct payment method that could be used to compensate or encourage informal support is the Optional Auxiliary Grant (OAG). Auxiliary grants are presently made only to licensed adult home residents to augment their Supplemental Security Income (SSI), and/or other income, in order to cover the costs of residence in an adult home. The maximum is currently $409 per month in combined SSI and auxiliary grants. The use of auxiliary grants could be expanded to situations where families provide custodial or personal care for the impaired elderly, or the grants could be used to pay for adult foster home care. The State Department of Welfare is studying the feasibility of expanding the auxiliary grant program to different levels of care under Senate Joint Resolution No. 65.

The major argument in favor of auxiliary grants to families or foster homes is that they would not have the impersonal qualities of an institutional setting such as an adult home. The family members or adult foster care providers should have a strong personal interest in the well-being of the older person in addition to the financial compensation; care would take place in a home environment rather than an institutional facility; and the impaired older person might feel very comfortable and secure in the care of a relative or foster care provider. The administrative costs of a direct payment would no doubt be higher than a tax relief method for compensating informal supports. However, direct payments could be accompanied by standards of care, regulations, and supervision of caregiving in order to protect the rights of the older person.

V. STATE LEVEL MANAGEMENT ISSUES

Budgeting and planning the Commonwealth's involvement in long-term care of the impaired elderly is complicated both by the number of agencies involved in the flow of funds for needed services and by the fact that responsibility for some aspects of service planning and delivery rests with the State, some with district or regional agencies, and some with agencies of local governments. Several states have attempted to solve these problems by creation of "super" agencies which budget and plan for services at the state level and deliver services locally. These attempts to solve the coordination problem appear, so far, to create more problems than they are intended to solve. For that reason, and because of Virginia's strong tradition of maximum local control of programs, a less dramatic reform seems appropriate for the Commonwealth.

This report proposes that localities have the opportunity to create models by which they would do care management. These would be built on the basis of the knowledge already obtained from the

existing Nursing Home Pre-Admission Screening Program. The proposed new approach would provide not only for screening candidates for nursing home admissions, but potentially would screen and do care planning for home and community services for the impaired elderly provided by area agencies on aging, local health departments, local welfare departments, and community mental health and mental retardation services boards.

The Commonwealth presently manages about $345,000,000 per biennium for care of the impaired elderly. Of this, about $303,000,000 is for institutional care and is managed at the State level chiefly by the Departments of Health and Mental Health and Mental Retardation. The remaining $42,000,000 for home and community services is planned for and managed at a combination of State, regional, and local levels. The major State agencies involved are the Department of Welfare, Department for the Visually Handicapped, Department of Mental Health and Mental Retardation, Department of Rehabilitative Services, and the Office on Aging. Regional agencies involved are Health Districts, Community Mental Health and Mental Retardation Services Boards, Area Agencies on Aging, and, to a degree, regional offices of the Department of Welfare, Department for the Visually Handicapped, and Department of Rehabilitative Services. Some of the regions of the "regional" agencies may include only a single locality. The major local agency involved is the local Department of Welfare (or Social Services).

Local Departments of Welfare and Area Agencies on Aging are each allowed, under current law and policies, to prepare separate local plans for services to the impaired elderly. They control, in their plans, about $30,000,000 or 71% of the funds used each biennium for care of the impaired elderly.

Management of budgeting and planning for care of the impaired elderly, therefore, presents both "vertical" and "horizontal" coordination problems and possibilities. There is the vertical separation of six, or more, State agencies through which funds flow for care of the impaired elderly. There is horizontal separation since some services are administered directly at the State level, some are handled by regional agencies and some are administered locally. Matters are complicated somewhat further by the fact that the layering of "districts" or "areas" or "regions" varies from program to program.

Budgeting and planning, or even describing, services to the Commonwealth's impaired elderly is rendered more difficult because budgeting systems, management information systems, planning cycles, service definitions, and units of service differ among the agencies and administrative layers of the system.

The Joint Subcommittee believes the Commonwealth has need of an organizational entity with responsibility and power to oversee and coordinate long-term care of all persons, including the impaired elderly. The Subcommittee solicits comments from the public as to the structure and organizational placement which would be most appropriate for this organizational entity. Should an existing agency be made "lead agency?" Should a new unit be created within an existing agency to perform this function? If so, in which agency? What should be the role of the Office of the Secretary of Human Resources?

APPENDIX B

COMMONWEALTH of VIRGINIA

Office of the Governor

Richmond 23219

Jean L. Harris, M. D.
Secretary of Human Resources

December 12, 1980

MEMORANDUM

TO: The Members of the Joint Sub-Committee to Study Improvement of Care of the Impaired Elderly

FROM: Jean L. Harris, M.D. Jean L Harris/tp

SUBJECT: Recommendations for Consideration for Inclusion in the Final Report of the Sub-Committee

INTRODUCTION

House Joint Resolution 162 asked me to provide coordination and staff services in support of the efforts of your Joint Sub-Committee, and I trust, from the information I have received about your draft report and the comments you have received in your series of public hearings, this work has been successful and helped you towards your goal. I thought it might also be helpful in your deliberations if I were to step out of the role of staff support and technical assistance and speak to you from the vantage point of your Secretary of Human Resources. In that capacity, I have been able to confer with colleagues in other states and to discuss the future problems and possibilities for care of the impaired elderly with numerous Federal officials. Although matters concerning long-term care are very complex, and many questions remain unanswered, some things are beginning to emerge which will help us decide what to do in Virginia:

(1) There is general agreement that greater stress must be given to home and community based services, and less to institutional services. Costs and benefits of specific alternatives will be

debated for some time to come, but the trend clearly must be towards services to help persons remain in their homes and to slow the growth of institutional services.

(2) Although there is agreement that greater stress on home and community based services is required, most responsible analysts agree that a mechanism for determining the needs of individuals and planning services needed for each person must be in place before there is any sizeable increase in the direct services themselves. Supporting such a viewpoint may be unpopular because persons who do not understand the problem will see it as adding administrative and bureaucratic layers instead of taking necessary steps to help people. There must, however, be a management system in place to support the service system. Otherwise, the potential for abuses and uncontrollable costs, not to mention failure to provide appropriate services, is unacceptable.

Therefore, I believe we should take immediate steps to work out some of our management and coordination problems and possibilities and, at the same time, make concrete plans for the home and community based services which will be phased in as appropriate and according to our ability to finance them. Here are my specific recommendations.

CARE AND SERVICES FOR THE IMPAIRED ELDERLY

(1) The Commonwealth should unambiguously adopt as public policy that, in the future, emphasis will be on development of home and community based care and services to the impaired elderly as opposed to continuing to expand nursing home and other institutional care at the current rate. The policy should take into account that high quality institutional care is necessary and appropriate in many instances and that projected population increases may necessitate

measured growth in the number of institutional beds. Public sentiment, as expressed in such forums as the hearings of this Sub-Committee and in the results of the Statewide Survey of Older Virginians and numerous studies of care of the elderly, clearly favor, however, a shift in our policies and priorities so as to provide more ways to help people remain in their own homes as opposed to being placed in institutions or nursing homes.

(2) The testimony heard by this Sub-Committee disclosed that Virginia's local governments and agencies already have been providing home and community based services for a number of years and have considerable information and experience in every aspect of design and delivery of such services. We do not, therefore, support the concept of financing and operating local "models" to help us learn what to do. We are confident we already know the kinds of services which must be provided and believe that running model projects would delay from four to six years the planning and implementation steps which ought to begin now.

(3) Although the current study has shown us the kind of services needed, we clearly need additional information about the amounts of various services which ought to be provided, refined estimates of the nature and size of populations which potentially would use particular services and, obviously, cost information to allow responsible budgeting. The Virginia Center on Aging has already assembled an impressive data base through the Statewide Survey of Older Virginians, has a proven research capability, and, because they are not involved directly in services administration and delivery, a potential objectivity about what our operating agencies might be able to do. We, therefore, believe you should commission the Center to examine the extensive service activities we already have in place, the data available concerning Virginia's impaired elderly, and any pertinent information from the experience of neighboring states, and report back describing the at-risk population and the costs and levels of alternative service models. This study should also address the questions about arrangements with

relatives of the impaired elderly and use of auxiliary grants which were included in Recommendations 4 and 5 of the Sub-Committee's draft report.

STATE LEVEL MANAGEMENT OF CARE AND SERVICES TO THE IMPAIRED ELDERLY

(1) At least six State agencies are involved in care and services to the impaired elderly. The difficulties of assembling and comparing information about what currently is provided clearly has demonstrated the need for a single focal point within State Government where authority and responsibility for planning, coordination, and administration of care and services to the impaired elderly are clearly fixed. The Virginia Department of Health already has responsibility for administration of the Virginia Medical Assistance Program which is the major source of the money we presently spend for long-term care. The Health Department is a major provider of home health services. It has within its own organization, and through its working relationship with the HSA's, the Commonwealth's major concentration of long-term care planning capability. The Health Department, obviously, ought to be Virginia's lead agency with clear authority and responsibility for overall policy formulation and management, at the State level, for services and care of Virginia's impaired elderly. The State Department of Health ought to be responsible for formulating a plan and budget for achieving this goal which should be reported to the 1982 Session of the General Assembly. While it is possible that other agencies would, in many respects, continue to have the responsibilities they currently have, we should be open to consider proposals which might alter the way we manage resources such as funds from Title III of the Older Americans Act and Title XX of the Social Security Act.

(2) The Office on Aging should have responsibility for evaluation of care and services to the impaired elderly, and should concurrently prepare plans for fully accepting this role. Since home and community based services are subject to abuses as much as are services in nursing homes and institutions, plans should

also be made for ultimate expansion of the Long-Term Care Ombudsman function to serve the impaired elderly receiving care outside nursing homes and institutions.

LOCAL COORDINATION AND SCREENING FOR CARE AND SERVICES TO THE IMPAIRED ELDERLY

(1) The Commonwealth's policy ought to be that, as soon as is feasible, screening be provided for all care and services to the impaired elderly which are financed entirely, or in part, with public funds. For the sake of the elderly, themselves, and to control the rate of increase of public spending, the screening process should become one where services are prescribed and coordinated so people receive what they need and are entitled to, neither more nor less. Highest priority should be given in the process to provision of support to encourage the continuation of the care and services rendered to the elderly by spouses, relatives, friends, and neighbors.

(2) Because of the great diversity of opportunities and needs throughout the Commonwealth, local governments and agencies should have flexibility to adopt screening and coordination arrangements suited to their particular needs and capabilities. At a minimum, these efforts should provide for cooperation between local Health Districts, Welfare Departments, Area Agencies on Aging, and Mental Health and Mental Retardation Services Boards. Common sense will dictate inclusion, in many instances, of hospitals, United Way agencies, and other organizations.

(3) The Virginia Department of Health should be responsible to provide coordination, training, and technical assistance in support of localities or substate regions which wish to develop local screening and coordination systems. A plan describing staff, steps, and costs, both for the State and local levels, should be prepared and submitted by the Health Department to the 1982 Session of the General Assembly.

4) As will be mentioned in discussion of nursing home pre-admission screening, new program developments will have to be coordinated with the existing screening

program. Under no circumstances should there be duplication of effort between the Nursing Home Pre-Admission Screening Program and locally developed screening mechanisms for other services.

NURSING HOME PRE-ADMISSION SCREENING

(1) All persons proposed for admission to nursing homes, regardless of where they are receiving care prior to the proposed admission, who within 13 months of the proposed admission are reasonably likely to require assistance from the Virginia Medical Assistance Program or any other assistance financed in whole or in part by the funds of the Commonwealth of Virginia, should be screened by the Nursing Home Pre-Admission Screening Program.

(2) To the maximum extent feasible, the Virginia Department of Health should coordinate the Pre-Admission Screening Program's implementation with other agencies, health care and social services professionals, especially the staffs of hospitals, so as to make full and efficient use of the information and services which may be available from these sources.

(3) It should be the policy of the Commonwealth that impaired elderly persons should deal with one, and only one, screening organization in order to obtain long-term care services. As screening processes are developed locally for home and community based services, therefore, plans should be made either to consolidate those new processes with the nursing home pre-admission screening process or to develop new, locally designed, comprehensive screening models which include nursing home pre-admission screening as part of the overall program design.

(4) The Virginia Department of Health should prepare plans and a budget for implementation of the three items listed above, as of July 1, 1982. Funds for this implementation, if required, should be included in the budget for the 1982-84 biennium

GUARDIANSHIP

The Virginia Office on Aging currently has under study possible alternatives to having Sheriffs appointed as guardians of last resort, and other matters concerning guardianship of Virginia's impaired elderly. This study should be completedand, if appropriate, necessary legislation be proposed for adoption by the 1982 Session of the General Assembly.

SWING BEDS

No legislative action concerning swing beds is necessary at this time.

COMMONWEALTH OF VIRGINIA

EDWARD M. HOLLAND
31ST SENATORIAL DISTRICT
ARLINGTON COUNTY,
SOUTHERN PART OF
2054 N. 14TH STREET, SUITE 206
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ARLINGTON, VIRGINIA 22216

SENATE

COMMITTEE ASSIGNMENTS:
COMMERCE AND LABOR
COURTS OF JUSTICE
EDUCATION AND HEALTH
TRANSPORTATION

January 19, 1981

Ms. Martha Johnson
Legislative Services
General Assembly Building
Richmond, Virginia

Dear Ms. Johnson:

The following is offered by way of dissent to the forthcoming report of the study of long-term care for the elderly.

I dissent from the foregoing study report to the extent that it recommends continuation of the study by joint sub-committee of the Senate Education and Health Committee and the House Health, Welfare and Institutions Committee. I do not see any need for its continuation in light of our decision to authorize certain studies and program evaluations by the Office of the Secretary of Human Resources and others. I believe the present standing committee structure will be adequate to receive the reports of the specific studies when they have been prepared and as they are offered.

Respectfully,

Edward M. Holland

EMH:bb

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

MARY A. MARSHALL
2256 N. WAKEFIELD STREET
ARLINGTON, VIRGINIA 22207

TWENTY-SECOND DISTRICT
ARLINGTON

COMMITTEE ASSIGNMENTS:
PRIVILEGES AND ELECTIONS
ROADS AND INTERNAL NAVIGATION
COUNTIES, CITIES, AND TOWNS
HEALTH, WELFARE AND INSTITUTIONS

January 22, 1981

Ms. Martha Johnson
Legislative Services
General Assembly Building
Richmond, Virginia

Dear Ms. Johnson:

The following is offered by way of dissent to the forthcoming report of the study of long-term care for the elderly.

I dissent from the foregoing study report to the extent that it recommends continuation of the study by joint subcommittee of the Senate Education and Health Committee and the House Health, Welfare and Institutions Committee. I do not see any need for its continuation in light of our decision to authorize certain studies and program evaluations by the Office of the Secretary of Human Resources and others. I believe the present standing committee structure will be adequate to receive the reports of the specific studies when they have been prepared and as they are offered.

Sincerely,

Mary A. Marshall

jpv

LD9109208

HOUSE JOINT RESOLUTION NO. 296

Offered January 19, 1981

Requesting the House of Delegates Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health to continue the Joint Subcommittee to Study the Care of the Impaired Elderly.

Patrons--McClanan and Davis

Referred to the Committee on Rules

WHEREAS, House Joint Resolution No. 162, agreed to by the 1980 Session of the General Assembly, established a joint subcommittee to study the improvement of the Commonwealth's public policies and system concerning the care of the impaired elderly; and

WHEREAS, during nineteen hundred eighty, the Joint Subcommittee to Study the Care of the Impaired Elderly held five public hearings across the Commonwealth which confirmed the need for additional community services to assist elderly persons with physical or mental impairments on a long-term basis; and

WHEREAS, the Joint Subcommittee determined that community and institutional services for long-term care require improved coordination at both the State and local levels; and

WHEREAS, the Report of the Joint Subcommittee to Study the Care of the Impaired Elderly to the nineteen hundred eighty-one Session of the General Assembly recommends continued study of the establishment, funding and coordination at both the State and local levels for the provision of appropriate and cost-effective long-term care services to the impaired elderly; and

WHEREAS, legislative oversight of the continued efforts to improve the delivery of long-term care services to impaired elderly Virginians is necessary and appropriate; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the House of Delegates Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health are requested to continue the Joint Subcommittee to Study the Care of the Impaired Elderly.

The Joint Subcommittee shall monitor the development of plans for the improved establishment, funding, and coordination of community and institutional long-term care services for the impaired elderly.

The Joint Subcommittee shall submit any recommendations it deems appropriate to the nineteen hundred eighty-two Session of the General Assembly.

HOUSE JOINT RESOLUTION NO. 294

Offered January 19, 1981

Requesting the Secretary of Human Resources to study the need for additional community-based long-term care services for the impaired elderly and to initiate the State-level coordination of community and institutional long-term care services.

Patrons--McClanan, Marshall, and Davis

Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, throughout nineteen hundred eighty, the Joint Subcommittee to Study the Care of the Impaired Elderly worked with the Secretary of Human Resources and an interagency task force comprised of representatives of the primary State agencies which administer long-term care services for Virginia's elderly citizens; and

WHEREAS, the Joint Subcommittee, the Secretary, and the members of the interagency task force concluded that additional information must be compiled to determine the number and kinds of community services that are needed statewide for assisting impaired elderly citizens; and

WHEREAS, at the same time, planning for the coordination of community and institutional long-term care services across the Commonwealth must be initiated at the State level to assure that the most effective and least costly services are available for all impaired elderly citizens who require the assistance of State and local human services agencies; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Human Resources is requested to conduct a one-year research effort to collect additional information essential to the planning and coordination of long-term care services for the impaired elderly in Virginia.

The research design shall provide for the selection of no less than three and no more than five localities in Virginia which have established programs for providing long-term care services to impaired elderly persons.

The research effort shall:

1. Document the kinds of community-based long-term care services currently available to Virginia's impaired elderly citizens.

2. Identify a core of community-based long-term care services that are essential in each locality to prevent the inappropriate institutionalization of impaired elderly persons in the future and determine whether variations in community-based services are appropriate to meet the needs of individuals living in various geographic and demographic areas of the State.

3. Identify the current costs by service category of providing community-based services to impaired elderly individuals.

4. Compare the cost of institutional care to the cost of providing a basic core of community-based long-term care services in each locality.

5. Project the costs of community-based services that are essential because of a locality's geography or demography.

6. Provide information about the extent of the physical and mental impairments of elderly persons who presently receive community-based long-term care services.

7. Specify the number of impaired elderly people in Virginia who are currently at risk of institutionalization.

8. Identify informal supports provided by the families and friends of impaired elderly persons and suggest methods for maintaining those supports.

9. Evaluate the current practices of local departments of social services for contracting with relatives of the impaired elderly for the provision of chore and companion services.

10. Evaluate the potential use of auxiliary grant payments which are available through the Department of Welfare to (i) compensate families who provide custodial or personal care to impaired elderly; and (ii) subsidize adult foster home care.

The Secretary of Human Resources may seek outside assistance to conduct the research study. It is requested that the Secretary direct and monitor the project to assure that the data compiled is useful for planning long-term care services statewide.

The Secretary of Human Resources is requested to report the findings of the one-year research study 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 eighty-one; and be it

RESOLVED FURTHER, That the Secretary of Human Resources is requested to designate the Department of Health as the lead agency for the statewide policy formulation and management required to coordinate the provision of long-term care services for the impaired elderly in the Commonwealth; and, be it

RESOLVED FINALLY, That the Secretary of Human Resources is requested to designate the Office on Aging as the lead agency for the evaluation of long-term care services for the impaired elderly. Accordingly, the Office on Aging shall be responsible for the expansion of the Long-Term Care Ombudsman Program to serve elderly persons residing in the community.

The Department of Health and the Office on Aging are requested to submit plans and proposed budgets for implementing their designated responsibilities in long-term care to the Governor and the nineteen hundred eighty-two Session of the General Assembly.

Official Use By Clerks	
Agreed to By The House of Delegates	**Agreed to By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the House of Delegates	Clerk of the Senate

LD6923208

HOUSE JOINT RESOLUTION NO. 295

Offered January 19, 1981

Requesting the Department of Health to expand the Nursing Home Pre-Admission Screening Program.

Patrons--McClanan, Marshall, and Davis

Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, the current Nursing Home Pre-Admission Screening Program in Virginia was begun in nineteen hundred seventy-seven under the administration of the Department of Health; and

WHEREAS, the Program has improved significantly the capabilities of localities to assess the social and medical needs of impaired elderly persons who are eligible for public assistance and who apply for admission to a nursing home; and

WHEREAS, many elderly persons are being diverted from costly institutional care to community-based care which is less expensive and more appropriate; and

WHEREAS, many localities in Virginia are conducting very effective pre-admission screening programs which are coordinated with case management services designed to refer impaired elderly persons to services available in the community to help them to remain at home; and

WHEREAS, in its report to the nineteen hundred eighty-one Session of the General Assembly, the Joint Subcommittee to Study the Care of the Impaired Elderly recommends that the Nursing Home Pre-Admission Screening Program be expanded to provide increased screening services by localities; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health is requested to expand the current Nursing Home Pre-Admission Screening Program. The existing program which screens individuals in the community who apply for nursing home admission shall be expanded to include the screening of individuals who (i) at the time of application for admission to a nursing home would be likely to require financial assistance from the Medical Assistance Program within a thirteen-month period; and (ii) are attempting to enter a nursing home from an acute care facility. The agencies whose representatives participate as members of the pre-admission screening teams shall be reimbursed for the time spent in conducting the individual assessments of nursing home applicants; and, be it

RESOLVED FURTHER, That the Department of Health is requested to prepare a plan and budget for this expansion of the Nursing Home Pre-Admission Screening Program for submission to the Governor and the nineteen hundred eighty-two Session of the General Assembly.

LD9110208

SENATE JOINT RESOLUTION NO. 160

Offered January 19, 1981

Requesting that the Department of Taxation study the provision of tax incentives to encourage individuals to care for dependent adult family members.

Patrons--Canada; Delegate: McClana

Referred to the Committee on Rules

WHEREAS, the Joint Subcommittee to Study the Care of the Impaired Elderly, during its deliberations in nineteen hundred eighty, learned that families provide the major portion of support and assistance to Virginia's elderly citizens whose capabilities are limited by physical or mental impairments; and

WHEREAS, the Joint Subcommittee believes that the Commonwealth should encourage and assist families to care for dependent elderly relatives in their own homes in order to avoid institutionalization whenever possible; and

WHEREAS, the Joint Subcommittee to Study Incentives for Persons Caring for the Elderly in Their Homes, House Document No. 29, 1979, considered the provision of incentives in the tax laws for families to care for elderly relatives; and

WHEREAS, the tax laws of the Commonwealth currently offer little encouragement to families to provide care and support for their elderly family members; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Taxation is requested to study the provision of all possible tax incentives to encourage families to care for dependent adult family members in their own homes.

The study shall consider the development of a tax deferral system similar to the current deferral system for child care. In addition, the Department of Taxation is requested to study tax incentives which have been established by other states and to determine the applicability of similar innovations in the tax laws of Virginia. The study should determine the cost to the State associated with each tax incentive that is considered.

The Department of Taxation shall report its findings and recommendations to the nineteen hundred eighty-two Session of the General Assembly.

Official Use By Clerks	
Agreed to By The Senate	**Agreed to By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
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Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

LD6041208

HOUSE JOINT RESOLUTION NO. 272

Offered January 19, 1981

Encouraging the Department of Health to participate in the federal program options for the use of swing-beds in hospitals and nursing homes.

Patrons--Marshall, McClanan, and Davis

Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, the term "swing-beds" refers to the practice of allowing a hospital or nursing home bed licensed to serve a patient requiring a high level of care to be used to serve a patient who requires a lower level of care; and

WHEREAS, the use of swing-beds by hospitals and nursing homes promotes a more cost-effective system of medical care by allowing a bed which qualifies for a very high level of reimbursement to be reimbursed for a less costly use; and

WHEREAS, the cost-benefit of using swing-beds in hospitals and nursing homes would accrue primarily to the Medicare and Medicaid programs which are funded by State and federal tax dollars; and

WHEREAS, recent amendments to the federal laws governing the Medicare and Medicaid programs allow the use of swing-beds in hospitals and provide for their appropriate reimbursement; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health is encouraged to investigate and to take advantage of the options available through the Medicare and Medicaid programs for the use of swing-beds by hospitals.

The Department of Health is encouraged to develop swing-bed policies for nursing homes to allow skilled nursing care beds to be designated for intermediate level care whenever feasible and appropriate.

Official Use By Clerks	
Agreed to By The House of Delegates	**Agreed to By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
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