REPORT OF THE SECRETARY OF HUMAN RESOURCES

PURSUANT TO HOUSE JOINT RESOLUTION NO. 294

ON THE CARE OF THE IMPAIRED ELDERLY

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 11

COMMONWEALTH OF VIRGINIA
RICHMOND
1982

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I. INTRODUCTION

The 1981 Session of the General Assembly requested the Secretary of Human Resources to study the need for community resources to avoid inappropriate institutionalization of the impaired elderly. House Joint Resolution No. 294 requested several components: data on current services, the description of the client population, the cost of current services, the use of informal support systems, and the impact of geographics on service needs and costs. Additionally, the State Department of Health was requested to develop a plan for a Bureau of Long-Term Care. The Virginia Office on Aging was requested to develop a plan for an evaluation unit for long-term care services and a plan to expand the Virginia Office on Aging Long-Term Care Ombudsman function to include handling complaints about community services for the impaired elderly. The full text of the resolution is as follows:

> WHEREAS, throughout 1980, 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 study of a variety of established programs in Virginia 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 1, 1981; 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 1982 Session of the General Assembly.

In order to respond to the resolution's request, the Secretary of Human Resources contracted with Dr. Marilyn Biggerstaff of Virginia Commonwealth University to collect the required data. The Secretary requested that the Virginia Department of Welfare evaluate its practice of contracting with relatives for provision of chore and companion services and examine the use of auxiliary grants to reimburse families for such care and to pay for adult foster home care. In addition, the State Department of Health and the Virginia Office on Aging were requested to develop those plans required of each agency as part of the resolution.

After reviewing the data collected and the plans presented, the Secretary of Human Resources developed a framework for a Continuum of Long-Term Care. It should be noted that this system includes recommendations which differ from the plans presented by the State Department of Health and the Virginia Office on Aging; however, both agencies have reviewed the total report and support the recommendations of the report. This report includes the plans from these agencies, a summary of the data collection efforts of Dr. Biggerstaff and the findings of the Department of Welfare. The full text of Dr. Biggerstaff's report and the report of the Department of Welfare are available in the Office of the Secretary of Human Resources.

II. FRAMEWORK FOR A SYSTEM OF LONG-TERM CARE

A. BACKGROUND

One of the most critical issues facing Virginia today is the development of a comprehensive system to provide care to the impaired elderly in the Commonwealth. Virginia has followed the national trend to expand nursing home care and has developed a system of care which frequently requires an individual to accept a range of 24 hour services in a restricted environment when a more independent, less expensive alternative would be sufficient and, indeed, more desirable.

The 1980 General Assembly established, through the passage of House Joint Resolution 162, a joint subcommittee to study the improvement of the Commonwealth's public policies concerning care of the impaired elderly. This joint subcommittee held Statewide hearings at which testimony was presented which helped confirm that a more coordinated system of long-term care was needed. Testimony also supported the need to focus the long-term care system on the development of community-based services. These efforts formed the basis for passage of House Joint Resolution 294. (HJR #294)

In addition, numerous studies have been undertaken which review the needs of older Virginians as well as the philosophy promoting self help, family support, and the maintenance of independence for as long as possible. The General Assembly passed House Joint Resolution 294 requesting further information so that a policy establishing such a philosophy could be developed. The information collected in the research efforts of HJR #294 contributed to the development of a Continuum of Long-Term Care. The findings of the research effort is summarized in Part III of this document.

Since research efforts on HJR #294 were begun, there has been a change in the environment which has a direct impact on the provision of long-term care.

During the last year, Congress consolidated more than 50 programs into nine block grants. Funding of block grants has been reduced and mandates for some specific services have been changed. In some instances these changes may allow the Commonwealth the option to fund some of those community services for which the research indicates a need. The specific requirements and the funding levels for block grants are still being finalized; therefore, it is necessary to develop a framework for long-term care around the concept of block grants with flexibility to incorporate additional requirements from the federal government.

The anticipated deficit in the Medicaid budget has a major impact on the issue of care to the impaired elderly. Forty-nine percent (49%) of the Virginia Medicaid budget presently is used to pay for nursing home care, a service used predominately by the elderly. It is estimated that approximately 30% of the individuals presently in nursing homes could remain in the community if services were available there. These facts dramatize the need to develop a comprehensive long-term care system with a full range of services.

Any plan to provide long-term care must take into account the changing funding sources and amounts of funding from the federal government, the increased demand on the Medicaid budget, and the projected increase in the aging population. By the year 2000, there will be 1,020,000 Virginians over the age of 60. These citizens will constitute 14% of our population. Changes in the Commonwealth's system of care must be made or care will not be available to provide for that segment of the population who require long-term care services.

The following is a framework for the development of a long-term care system which allows individuals to remain independent as long as possible, encourages families and other informal support systems to continue to provide care, requires the Commonweatlh to provide the minimal level of care required when no other sources are available, and provides a mechanism of control of the expenditure of State funds. This framework also requires that localities establish a plan to provide services in the community. The development of a long-term care system includes: defining the target population, defining the necessary core services, establishing an

administrative mechanism on the State level, providing localities the opportunity to design a plan to coordinate service delivery and administration, and appropriating funds for needed services.

B. TARGET POPULATION

Approximately 38,300 persons in the Commonwealth have the potential need for some level of service in order to perform activities of daily living and maintain their independence. Of that figure each month, 1,000 persons are admitted to a nursing home and 2,400 more are on admission waiting lists. These 3,400 persons in most critical need are the persons at risk of institutionalization. It is recommended that the services provided at public expense be targeted to these 3,400 persons in most critical need.

Services must also be provided to the remaining 34,900 who have chronic illness which impedes their activities. If assistance is not available to allow these persons to maintain their independence, these individuals will deteriorate and seek entrance to a long-term care facility. These persons should be the second target population for the use of community-based services at public expense.

Not all of the 38,300 persons will require financial assistance to pay for these services; many need only to have them available for purchase. Public funds should be used only for those persons who have no other resources. Many of the 38,300 persons are already receiving services included in a Continuum of Long-Term Care. Others will be able to avoid the personal and financial cost of institutionalization if a full range of services is available.

C. CONTINUUM OF LONG-TERM CARE SERVICES

Presently the array of services available is provided based on a general concept of need, available funds and the interest of each community. Institutional services such as Nursing Homes, Homes for Adults and Mental Health/Mental Retardation Geriatric Facilities are currently available on a regional, if not local basis. These services are essential to the continuum of care, as are community-based services.

The community-based services can be grouped under the following categories: Institutional/Residential, Health Care, Nutrition, Daily Living, Supportive Services, Socialization, and Coordination. In order for an individual to remain in his own home, there usually is a requirement for several of the services in the continuum of care. In analyzing the array of services, some clearly fall into a category which can be described as "core services," those essential to avoid institutional placement. Those services included in core services are those which are most likely to assist the largest percentage of the target population in remaining independent.

It is recommended that each locality provide the following core services:

Socialization	Health Care	Nutrition
Telephone Reassurance	Home Health Care	Home Delivered Meals
Friendly Visiting	Community Medical Care	Food Stamps
Daily Living	**Supportive Services**	
Homemaker/Companion/ Personal Care/Chore	Adult Protective Service	
	Mental Health/Mental Retardation Counseling	

Other services are needed for the second target population to prevent their deterioration. These are classified as "quality of life services," and should be provides as funds allow. Quality of life services include:

Socialization	Institutional/Residential	Nutrition
Congregate Meals	Homes for Adults	Congregate Meals
	Adult Foster Care	
	Congregate Housing	
Daily Living	**Supportive Services**	
Home Repair/Weatherization	Legal Services	
Adult Day Care		

In order to remain independent, an individual may require an array of services from those listed as core services and those classified as quality of life services. A system to provide long-term care services must be flexible enough to allow an individual to receive whatever services meet his needs.

The Department of Mental Health and Mental Retardation has instituted the Division of Rehabilitative Services which will focus primarily on long-term care services in the psychiatric hospital as well as in community mental health programs. Initially, emphasis is being placed on the long-term care geriatric patient. However, the focus will eventually be expanded to all ages. Long-term care in institutional settings and in the community is the focal point of this effort.

D. ADMINISTRATION OF LONG-TERM CARE SYSTEM

In order to assure that the limited funds available for services are expended correctly, a system to administer and monitor the use of these funds must be established. Coordinated efforts of the State and local agencies will be required to overcome the existing fragmentation in the service delivery system. The following plan for administration includes an organizational plan for the State and a framework for localities.

Within State government, there are at least six agencies who are involved in providing services to the impaired elderly. To coordinate these efforts and to assure the target population is served, a plan for a Bureau of Long-Term Care has been designed. This Bureau will be within the State Department of Health and will be the State entity responsible for coordinating and planning the Continuum of Long-Term Care Services. The Bureau should be staffed by professionals from the health and social work fields to assure that planning in the Bureau focuses on the total needs of the individual, not just on the medical needs. The establishment of such a bureau is critical to assess the needs of citizens Statewide and to monitor the expenditures being used to provide needed services.

To assure coordination of the efforts of all the State agencies, a Long-Term Care Council should be established to give direction to the Bureau of Long-Term Care. The Council will be composed of the Commissioners of the Departments of Health, Welfare, Mental Health/Mental Retardation, Visually Handicapped, the Director of the Office on Aging and the Director of the Virginia Center on Aging.

The Council should be chaired by the Secretary of Human Resources. This Council will be charged with the continuing development of a long-term care policy, evaluation of long-term care needs and services, and assurance of interagency coordination. The activities of this Council eliminate the need to establish an Evaluation Unit in the Virginia Office on Aging as requested by House Joint Resolution 294.

It is recommended that the Virginia Office on Aging be given legal authority to investigate complaints about community services. The Office's Long-Term Care Ombudsman Program currently provides protection to institutional residents by handling complaints made by, or on behalf of these residents. This legal authority would allow the Virginia Office on Aging to provide similar protection to individuals receiving services in their homes.

Virginia already has established a preliminary framework for the organization of long-term care services on the local level. Presently, there are 117 local Nursing Home Pre-Admission Screening teams. These teams usually involve the local health director, a public health nurse, and a social worker from the Department of Social Services. These teams screen persons who are seeking admission to a nursing home from the community and who are likely to become Medicaid eligible within 90 days. A plan has been submitted to the 1982 Session of the General Assembly to expand the screening program to include admissions to nursing homes from the acute care facilities. It is recommended that the screening teams be used as the basis of a coordination effort for all long-term care services on the local level.

At a minimum, it is felt that the coordination function, as depicted on the chart of core services in the Attachment, be designed to: assess the needs of individuals who require services in the continuum of care at public expense, assist families who can pay for long-term care in securing services, assist the individual in receiving the appropriate level of service, and include the existing Nursing Home Pre-Admission Screening teams. In addition to the Nursing Home

Pre-Admission Screening team, the coordinating team should include representatives of the local offices of the State agencies serving on the Long-Term Care Council. This coordinating team would be responsible to the Bureau of Long-Term Care and any other funding agencies on the State level. Each locality would have the option to include others on the team and to organize the activities and administration of the coordinating team as best suits its needs as an individual jurisdiction or in conjunction with other localities.

E. TIME FRAME FOR IMPLEMENTATION

In order to establish the administrative mechanism for the assessment of service needs, the following time frame is recommended. The Long-Term Care Council will begin planning immediately to provide assistance to the Department of Health in the establishment of the Bureau of Long-Term Care. This Bureau will begin operation on July 1, 1982. By July 1, 1983, each locality will have developed a plan for the coordination of long-term care which has been approved by the Bureau of Long-Term Care and is ready for implementation on that date.

During Fiscal Year 1983-84, the Bureau of Long-Term Care will monitor the expenditure of funds for long-term care services to assure that the target population is given priority to receive core services and quality of life services where available. To control expenditures, no individual will be allowed to receive services which cost in excess of the average nursing home cost per month. An individual whose home care exceeds the average cost would be considered for nursing home placement.

The Bureau of Long-Term Care will report to the Governor and General Assembly in 1985 the average cost for services per individual, the trend of diversion from institutional care or the time by which this is delayed, and any change in the services or funding needed to be provided in the continuum of care.

F. FUNDING SOURCES

Funding for long-term care must address the funding of the services to be provided in the Continuum of Long-Term Care and the funding of the administration of the long-term care system.

The critical issue is how to pay for the services listed as core services. There are several options available: the provision of personal care under Medicaid through the waiver process, the use of monies under the block grants of Social Services and Community Services, and the targeting of individuals to receive services under Title III of the Older Americans Act as being in "greatest social and economic need". The State Department of Health is developing a plan to request Medicaid waivers. Because no final plan has been established for the utilization of block grant funds and because the use of Older Americans Act funds may be changed within the year by federal legislative action, no request for State funds is being made in these areas.

The State Department of Welfare is currently examining options for funding an adult foster home program. The Department estimates that to implement the program Statewide for the 1982-84 biennium would cost about $3,000,000. Because funding for this proposed program would be from Auxiliary Grant funding, only 62½% or $1,875,000 would be State money. The remaining 37½% or $1,125,000 would be local funds.

The timetable established for the implementation of a Continuum of Long-Term Care Statewide and the mandated coordination between State agencies with funds available for long-term care services will allow the Commonwealth time to absorb the federal changes, review State options for expenditures with the priority of community services in mind, and assess the possible need for additional monies for specific services.

The administrative cost for the activities related to a system of long-term care will include several components. The State Department of Health has submitted a budget for the Bureau of Long-Term Care which will cover State administration. This budget totals $121,000. A budget has been submitted to

expand Nursing Home Pre-Admission Screening to acute care facilities to pay hospital staff for the screening services. The activities of the Long-Term Care Council should be covered with the administrative budgets of each agency represented. Additionally, the coordination teams on the local level should be funded by the administrative budgets of the agencies represented. Presently each agency is providing assessments of client needs individually. The activities of the coordinating team should eliminate possible dulicate client assessments so that the agencies' existing administrative funds would be sufficient.

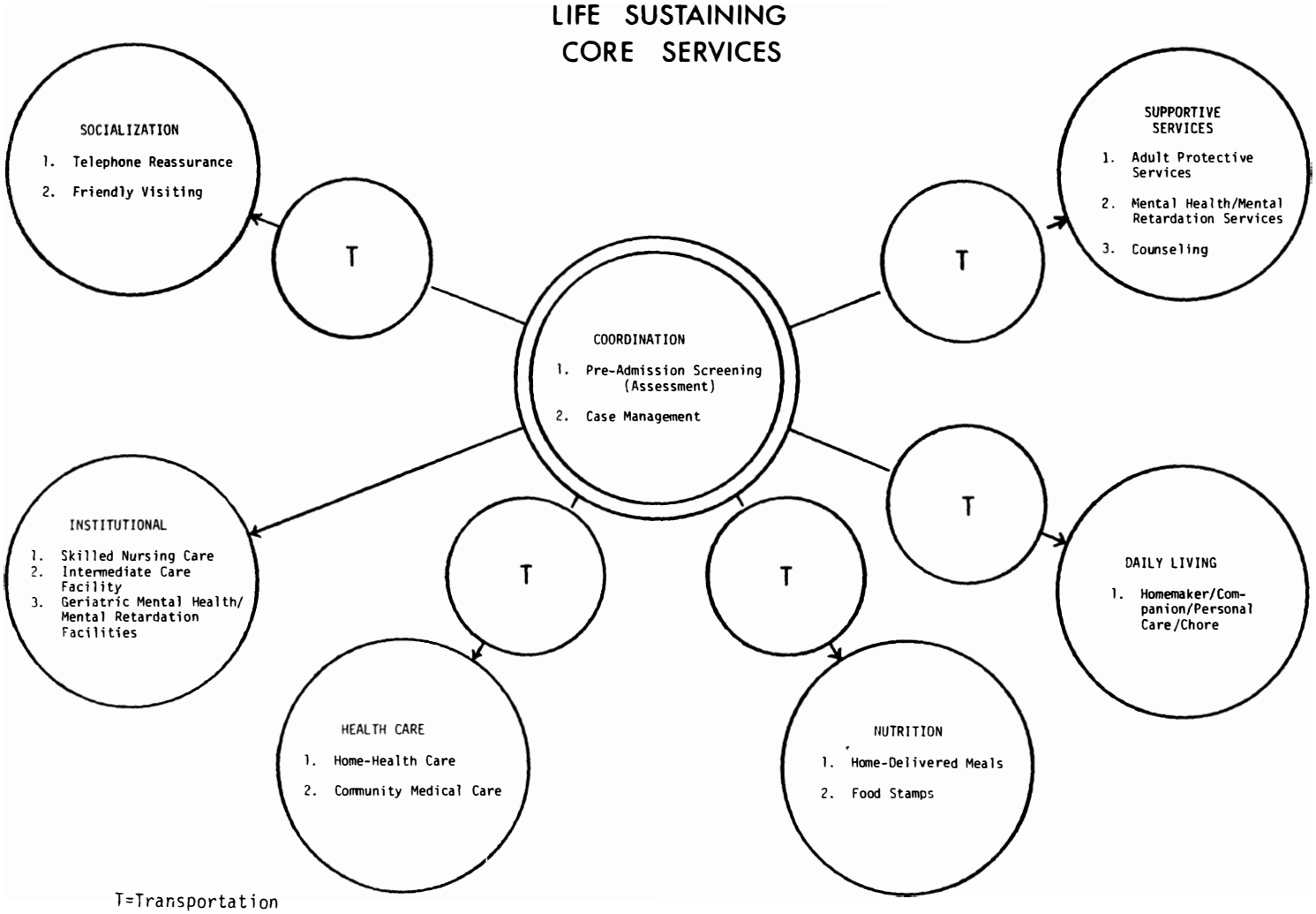
G. CONCLUSIONS

Virginia must move to a Statewide system of delivery and coordination of long-term care services. A system has been designed which formalizes what some localities are already doing on an informal basis. The coordination function will assure the citizen of the availability of assessment for long-term care services and assure the State a uniform data base and control of total expenditures. Funding for services in the continuum must be available and, within the time frame developed, concrete data will be gathered to determine the funding levels needed.

This plan attempts to meet the needs of the impaired elderly while meeting the needs of all our citizens for sound, fiscally efficient government. It builds on nationally recognized efforts already in place in the Commonwealth. It establishes a policy for localities to design their system. It is not a model to serve a few; it is a beginning to serve the entire Commonwealth because all of our citizens are potential clients of long-term care.

ATTACHMENT

LIFE SUSTAINING CORE SERVICES



T=Transportation

III. FINDINGS OF DATA COLLECTION EFFORTS

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

A major program serving the elderly in Virginia is the State Health Department's Home Health Services Program (Figure 1). The total number of patients served by the Home Health Services Program has increased from 4,466 patients served in 1975 to 11,411 patients in 1980. (This includes patients of all ages.) Based on July 1, 1980 through March 31, 1981 figures the Department of Health reports that 67.7% of patients served by the community health program are 65 years of age or over.

Social services to elderly persons are also provided through Title XX funding by local departments of welfare (Figure 2). Some of the Title XX services which may be directed toward elderly persons include: chore services, companion services, day care services for adults, adult foster care services, health related services, homemaker services and protective services to aged, infirm or disabled adults. In Fiscal Year 1979/80, 9,061 individuals received companion services and 1,299 individuals received homemaker services.

Community-based services are provided across the State by a variety of profit, non-profit and public agencies. During the course of the HJR #294 study an enumeration of the community-based long-term care services offered in each planning and service area was provided by the 25 Area Agencies on Aging (AAA's). The AAA's correspond roughly with the planning and service areas. The Area Agencies provide a variety of services for persons 60 years of age and over. Clients served by the AAA's are typically women (67%), and white (62%) while 28% of the clientele is Black. Eight of the AAA's serve predominately urban areas, while 17 serve rural areas.

FIGURE 1

HOME HEALTH SERVICES PROGRAM

VIRGINIA STATE DEPARTMENT OF HEALTH*

Total Patients Served	
1975	4,466
1977	7,441
1978	8,740
1979	9,584
1980	11,411
1981 (projected)	11,430

*SOURCE: Virginia Department of Health.

Figure 2

Title XX Services

Fiscal Year 1979/80

ACTUAL EXPENDITURES AND NUMBERS SERVED*

Services	Expenditures	Numbers served
Chore Services	$ 53,804	300
Companion Services	$10,395,165	9,061
Day Care	$ 467,739	215
Foster Care Services for Adults	$ 7,300	14
Health Related Services	$ 4,397,261	21,602
Homemaker Services	$ 631,745	1,299
Protective Services to Aged, Infirm or Disabled Adults	$ 1,038,337	3,693

*SOURCE: Virginia Department of Welfare Title XX Plan, 1981.

All of the AAA's provide transportation, congregate meals and home delivered meals. Legal services, outreach, homemaker services, socialization and recreation services, telephone reassurance, friendly visiting and counseling/casework services comprise the majority of other services offered. (Figure 3).

The 36 Community Services Boards of Mental Health and Mental Retardation through the mental health, mental retardation and substance abuse system, provide a range of community services such as psychotherapy, counseling, substance abuse and adult day care. Of the 35 local agencies responding to the HJR #294 survey, it was reported that 6,480 clients over the age of 60 were served during the first six months of 1981.

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 areas of the State.

Life sustaining core services (Figure 4) are those services essential to maintain the impaired elderly in the community and deter them from using institutional services. These services fall into the following six categories:

Institutional/ Residential	- skilled nursing care, intermediate care facility, geriatric mental health/mental retardation facilities
Socialization	- telephone reassurance, friendly visiting
Health Care	- home-health care, community medical care
Nutrition	- home-delivered meals, Food Stamps
Daily Living	- homemaker/companion/personal care/chore
Supportive services	- adult protective services, mental health/mental retardation services, counseling
Transportation	

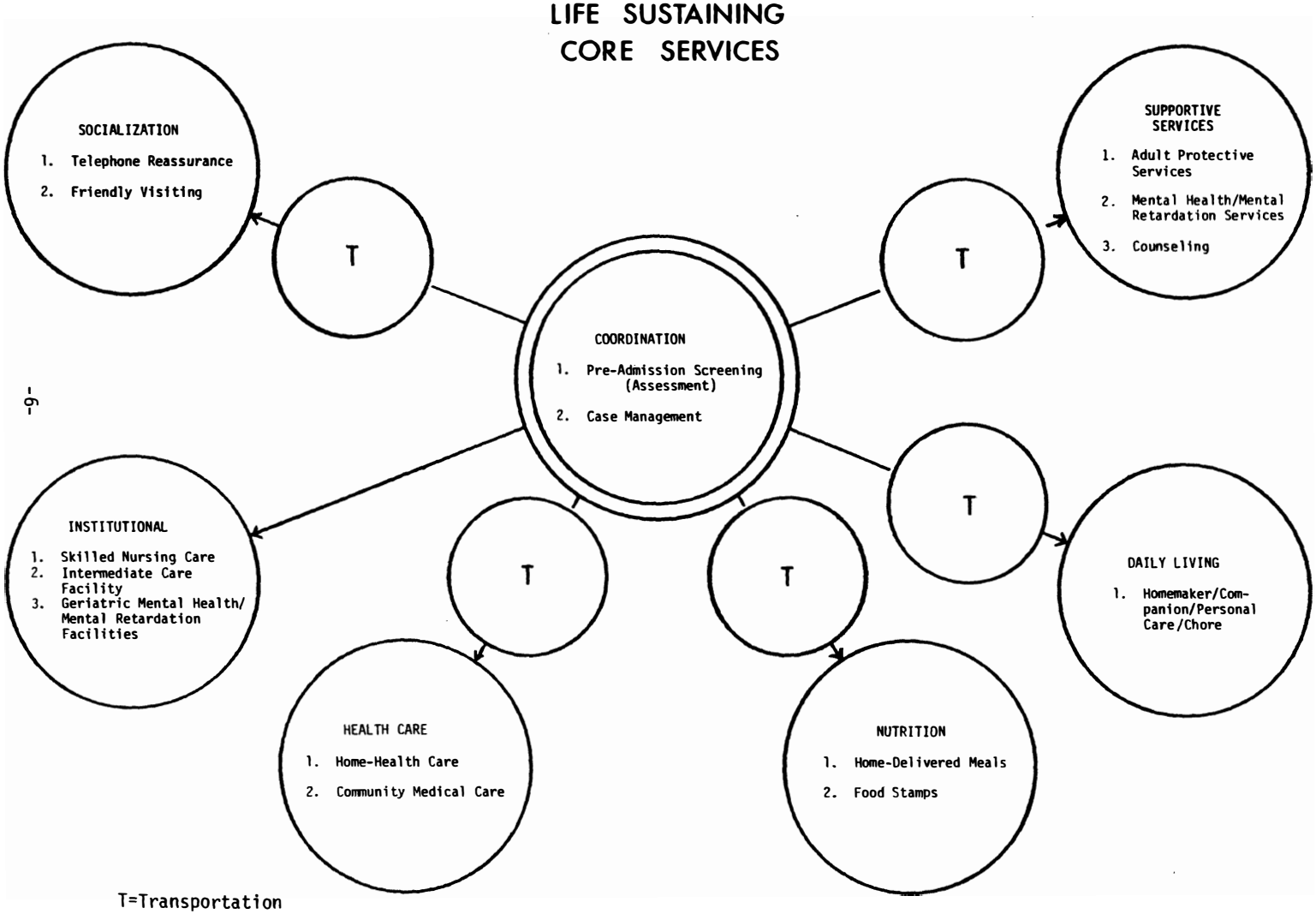
FIGURE 3

SERVICES BY AAA'S AND NUMBER OF RECIPIENTS*

SERVICE	NUMBER OF AAA's PROVIDING SERVICE	NUMBER OF ELDERLY RECEIVING SERVICE (1/1/81-6/30/81	UNITS OF SERVICE AVAILABLE	PROJECTED NUMBER TO BE SERVED
Home Health Care	2	1,010	27,483 hours	1,106
Homemaker	15	1,535	152,999 hours	7,716
Personal Care	4	349	2,013 hours	10,781
Chore Maintenance	11	707	69,745 hours	10,861
Telephone Reassurance	14	2,429	188,565 calls	4,066
Friendly Visiting	12	3,641	107,440	11,825
Home Delivered Meals	25	3,946	676,291 meals	7,052
Congregate Housing	1	--	--	40
Congregate Meals	25	18,750	1,943,264 meals	22,765
Adult Day Care	3	93	17,825 days	142
Soc/Rec	15	18,314	1,287,575 hours	32,297
Transportation	25	19,299	1,377,570 one-way trips	22,503
Legal Assistance	22	3,018	10,849	5,074
Home Repairs/Renovation	6	923	1,219	411
Respite Care	0	--	--	--
Counseling/Casework	10	5,879	91,841 (n=9)	11,737
Outreach	22	61,257	365,501 hours	87,634
Case Management	5	418	20,651 hours	2,117
I&R	9	8,683	38,401 hours	17,983

FIGURE 4

LIFE SUSTAINING CORE SERVICES



T=Transportation

The question still remains as to how the impaired elderly will obtain the above services. The key is coordination, essential for making certain that the impaired obtain the services they need. Coordination is also essential to ascertain which of the core services are appropriate for the elderly and to monitor and control the utilization of those services. Coordination consists of pre-admission screening and case management services.

Core services are targeted to those severely to totally impaired persons who would require institutionalization if they did not have core services.

There is another group of persons which must be served. These are those persons who are mildly to moderately impaired who might quickly become severely impaired without community-based services. These individuals may need a combination of some of the core services plus quality of life services (Figure 5). The core services include:

Institutional/Residential	Socialization	Health Care
Skilled Nursing Care Intermediate Care Facility Geriatric Mental Health/ Mental Retardation Facilities	Telephone Reassurance Friendly Visiting	Home-health care Community Medical Care

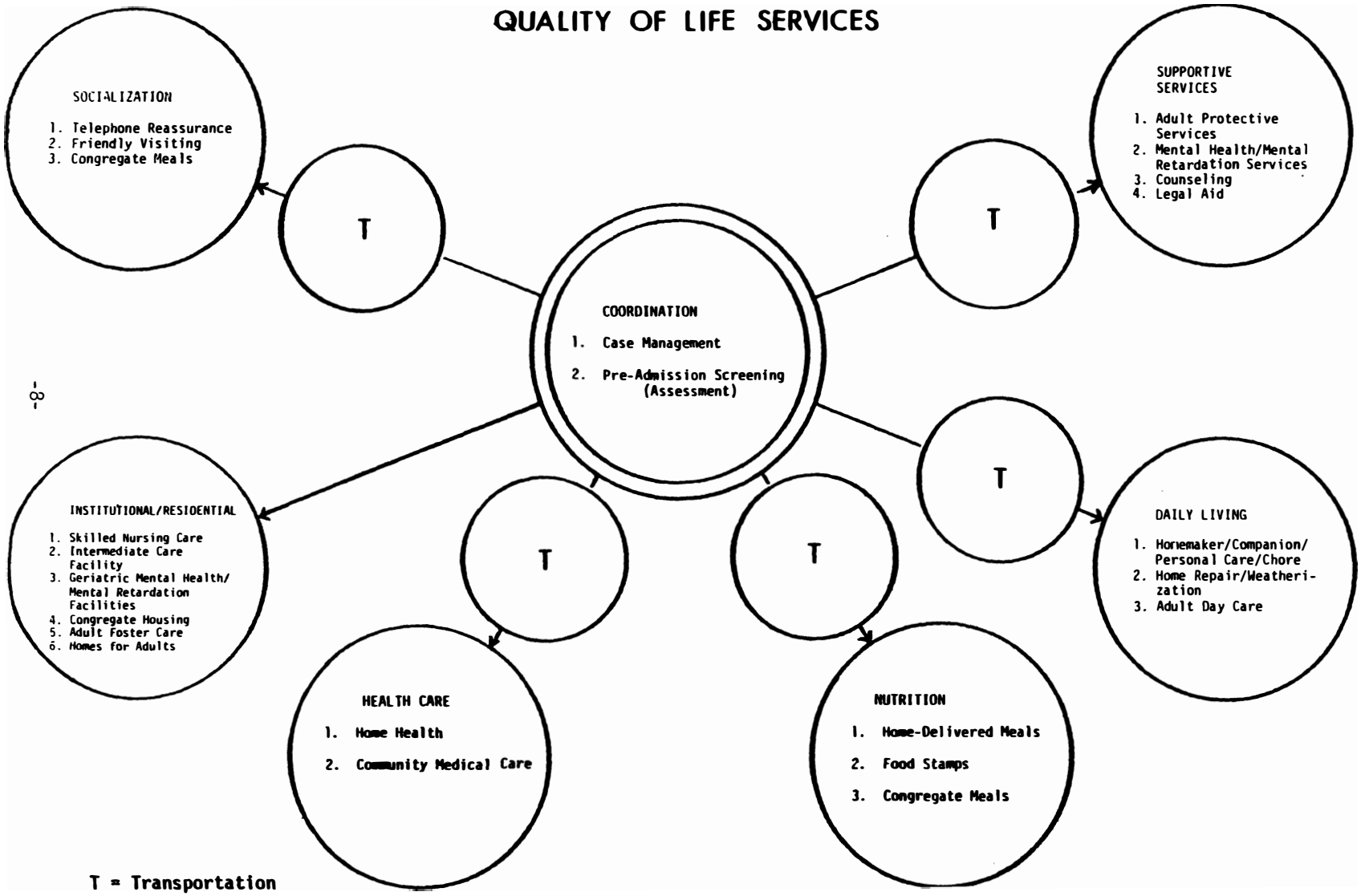
Nutrition	Daily Living	Supportive Services
Home-delivered meals Food Stamps	Homemaker/Companion/Personal Care/Chore	Adult Protective Services Mental Health/Mental Retardation Services Counseling
Transportation		

The quality of life services include:

Institutional/Residential	Socialization
Congregate Housing Adult Foster Care Homes for Adults	Congregate Meals

Nutrition	Daily Living	Supportive Services
Congregate Meals	Home Repair/Weatherization Adult Day Care	Legal Aid
Transportation		

FIGURE 5


QUALITY OF LIFE SERVICES
SOCIALIZATION
1. Telephone Reassurance
2. Friendly Visiting
3. Congregate Meals
T
SUPPORTIVE SERVICES
1. Adult Protective Services
2. Mental Health/Mental Retardation Services
3. Counseling
4. Legal Aid
T
COORDINATION
1. Case Management
2. Pre-Admission Screening (Assessment)
INSTITUTIONAL/RESIDENTIAL
1. Skilled Nursing Care
2. Intermediate Care Facility
3. Geriatric Mental Health/ Mental Retardation Facilities
4. Congregate Housing
5. Adult Foster Care
6. Homes for Adults
T
T
T
DAILY LIVING
1. Homemaker/Companion/ Personal Care/Chore
2. Home Repair/Weatherization
3. Adult Day Care
HEALTH CARE
1. Home Health
2. Community Medical Care
NUTRITION
1. Home-Delivered Meals
2. Food Stamps
3. Congregate Meals
T = Transportation

Again coordination consisting of assessment and information and referral are essential for making certain individuals receive the appropriate level of care.

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

The Area Agencies on Aging offer 17 services for the elderly. The average cost per unit of service for those five services which most AAA's provide includes:

Congregate Meals	$ 3.96
Home Delivered Meals	$ 3.16
Transportation Services	$ 2.08
Outreach	$14.87
Legal Assistance	$66.78

A survey of local welfare departments revealed an average cost per hour of $3.26 for companion services and $5.17 per hour for chore services. Homemaker services provided by local welfare departments costs $486.33 per case, based on Fiscal Year 1979-80 expenditures. The average cost for adult protective services for Fiscal Year 1979-1980 is estimated to be $281.16 per year, per client.

Local Mental Health/Mental Retardation agencies report that a mean cost for the provision of a range of MH/MR services on an outpatient basis averages $73.90. The outpatient mental health service cost for one hour of counseling is approximately $30.00.

The State Department of Health reports a figure of $52.65 for a skilled nursing visit of one hour and a cost of $27.76 for a one hour visit by a home health aide.

Figure 6 summarizes the costs of community-based services.

Figure 6

Estimated Costs of Long Term Care Services

Institutional		
Skilled Nursing Care	$43.59 (Medicaid) @ day	
Intermediate Care Facility	$34.08 (Medicaid) @ day	
MH/MR Geriatric	$55.22 @ day	
Residential		
Adult Foster Care	$13.33 @ day based on an estimate of a $400.00 maximum payment per month	
Adult Day Care	$15.75 @ day average amount reported by 3 AAA's. Includes administrative costs and costs of in-kind resources.	
	$7.24 Title XX Day Care Services for adults based on $277,252 expenditures for 184 clients for 208 day @ year	
Congregate Housing	$58.63 @ day based on the cost of meals, personal services and housekeeping in congregate housing	
Homes for Adults	$183.92 average per month not to exceed $450 per month. Based on data gathered by the Department of Welfare	
Socialization		
Telephone	$ .58 @ call	
Friendly Visiting	$ 2.37 @ visit	
Nutrition		
Home Delivered Meals	$ 3.16 @ meal	
Food Stamps	$ 70.00 maximum - most any one person in any household can receive	
Health Care		
Skilled Nursing Visit	$ 52.65	
Home Health Aide Visit	$ 27.76	
Medical Cost - Cost of community medical services per person per year (Medicaid)	Physician's Services	- $102
	Other Practitioners Services	- $ 26
	Outpatient Hospital Services	- $ 65
	Clinic Services	- $183
	Lab and X-Ray Services	- $ 16
	Prescribed Drugs	- $213

Figure 6 (Continued)

Supportive Services	
Adult Protective Services	$281.16 @ year of service Based on 79/80 actual expenditures and numbers of clients served
MH/MR Counseling	$ 30.00 @ hour of outpatient Mental Health service
Daily Living	
Companion Services	$ 3.26 an hour Based on a survey of 102 local welfare departments regarding companion services offered in March, 1981.
Homemaker	$ 8.35 an hour Based on reports from 15 AAA's. Includes administrative costs and the costs of in-kind resources. Homemaker services provided by local departments of welfare estimated to be $486.33 per case. Hourly cost for homemaker services is not to exceed $4.50 an hour according to State Welfare policy.
Chore	$ 4.70 an hour Based on reports from 11 AAA's $ 5.17 an hour Based on a survey of 102 local welfare departments regarding chore services offered in March, 1981.
Coordination	
Pre-Admission Screening (assessment)	$ 44 at present - HJR 295 has recommended $65
Case Management	$ 6.09 AAA's cost @ hour figure for providing case management services
Transportation	$ 2.08 (per one-way trip) Based on responses of 25 AAA's surveyed

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.

The State Department of Health reports a total aggregate nursing home cost for 1980 of $181,592,043. The greatest proportion of the expenditure is for Intermediate Care Facilities. The range of average cost per day for Intermediate Care Facilities was $27.50 to $41.81 (Figure 7). The range of average cost for Skilled Nursing Facilities was $37.06 to $52.26 per day. Approximately 66% of all nursing home residents are funded by Medicaid.

The State Department of Mental Health and Mental Retardation reports an expenditure of $39,344,185 during Fiscal Year 1980-1981 for geriatric facilities. Costs range from $50.68 to $61.77 per diem (Figure 8). Medicaid funded 79.8% of the MH/MR geriatric costs for a total of $21,068,511.

State expenditures through the Auxiliary Grant Program, of the Department of Welfare for elderly residents of adult homes, was $305,116.44 for March 1981. This amount funded 1,659 elderly residents with an average grant payment of $183.92.

The costs of institutional and community-based care are listed in Figure 6.

It is difficult to compare the cost of institutional care to that of community-based care because agencies do not currently maintain data in the same format concerning the full range of community services each individual uses. The Bureau of Long-Term Care will be instrumental in gathering and maintaining the appropriate information to allow costs to be compared.

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

Figure 9 compares the costs of selected community-based services for urban and rural areas. In every instance, the cost for providing services in the rural areas is more costly than providing services in urban centers. This can be attributed to the great distances which have to be traveled to deliver services; the scarcity of services, which inflates prices; and the cost of transporting resources to a rural area.

FIGURE 7

1980 MEDICAID COST PER DAY FOR ICF AND SNF

BY PLANNING DISTRICT*

(HOSPITAL-BASED FACILITIES NOT INCLUDED)

PLANNING DISTRICT	SKILLED COST PER DAY	INTERMEDIATE COST PER DAY
1	--	41.81
2	--	--
3	--	27.50
4	--	32.21
5	40.84	31.97
6	37.06	31.07
7	--	30.21
8	52.26	38.08
9	44.20	32.88
10	--	36.32
11	42.68	32.52
12	41.74	34.65
13	--	36.67
14	--	41.28
15	44.23	35.55
16	--	31.63
17	--	31.93
18	--	34.67
19	47.57	33.44
20	41.72	31.88
21	--	33.19
22	--	36.24

*SOURCE: Virginia State Department of Health.

FIGURE 8

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

1980-81

GERIATRIC EXPENDITURES*

CENTER	TOTAL EXPENDITURES	PER DIEM COST
Piedmont	5,004,943	56.43
Catawba	4,823,961	51.43
Hancock	9,498,276	50.68
Barrow	6,597,127	54.42
Shenandoah	9,454,722	60.15
Porterfield	3,965,156	61.77
	$39,344,185	55.22

Expenditures for Hancock, Barrow, Shenandoah, and Porterfield includes administrative and support expenditures for Eastern, Central, Western, and Southwestern State Hospitals.

*SOURCE: Virginia State Department of Mental Health and Mental Retardation.

FIGURE 9

Cost Comparison for Selected
Community-Based Services for

Urban and Rural Areas

SERVICE	URBAN	RURAL
Congregate Meals		
Units of Service Available	668,942	1,274,322
Projected Number to be Served	8,055	14,710
Average Cost per Meal	$2.97	$4.43
Range	$1.93-$5.30	$2.00-$15.25
	25 AAA's providing cost data	25 AAA's providing cost data
Friendly Visiting		
Units of Service Available	87,600	23,728
Projected Number to be Served	1,123	10,702
Average Cost per Visit	$3.05	$2.58
Range	.68¢-$5.00	.03¢ to $5.72
	3 AAA's providing cost data	8 AAA's providing cost data
Homemaker		
Units of Service Available	47,472	105,527
Projected Number to be Served	474	12,342
Average Cost per Hours of Service	$9.43	$18.57
Range	$6.53-$14.58	$2.31 to $89.17
	6 AAA's providing cost data	8 AAA's providing cost data

Figure 9 (Continued)

SERVICE	URBAN	RURAL
Home Delivered Meals		
Units of Service Available	225,801	450,490
Projected Number to be Served	2,129	4,923
Average Cost per Meal	$2.36	$3.54
Range	$1.20-$3.88	$1.31-$9.98
	25 AAA's providing cost data	25 AAA's providing cost data
Socialization/Recreation		
Units of Service Available	328,171	*959,404
Projected Number to be Served	17,479	17,598
Average Cost per Hours of Service	$12.18	$1.39
Range	.60¢-$48.85	.05¢-$5.50
	5 AAA's providing cost data	8 AAA's providing cost data
Transportation		
Units of Service Available	425,920	951,650
Projected Number to be Served	7,000	15,503
Cost per One-way Trip	$1.96	$2.13
Range	$1.00-$3.37	$1.09-$8.92

* 10 AAA's were able to provide data concerning the units of service available but only 8 had cost data available

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

According to the 1980 census those individuals age 60 and over make up 13.6% of the population or 726,340 individuals (Figure 10). This is an increase since 1970 when the elderly made up 11.7% of the total population. The fastest growing segment of the elderly population is those individuals 85 years and over. These individuals are more likely to require nursing home care.

Figure 11 indicates the percentage of elderly persons who are impaired in their ability to carry out the activities of daily living--those activities needed in day-to-day living such as cooking, cleaning and shopping. The majority of elderly between the ages of 60-79 are rated as good to excellent in this project. But the number of elderly persons mildly to totally impaired increases significantly for those 80 years of age and over.

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

The total number of Virginians over the age of 60 equals 726,340. Of these, 30,114 reside in institutions. This figure includes 18,860 residents of nursing homes, 2,035 residents of mental health/mental retardation facilities, and approximately 9,219 persons in homes for adults. (Figure 12).

The total number of elderly Virginians living outside of institutions in the community equals 696,226. Of these it has been estimated that 10.2% or 71,015 persons are moderately to totally impaired in their ability to carry out the activities of daily living (ADL). (See Figure 13 for ADL ratings.) Furthermore, it has been estimated that 5.5% or 38,300 of those living in the community are severely to totally impaired.

Approximately 38,300 persons residing in the community have the potential

FIGURE 10

POPULATION INCREASE *1970-1980

% 60+

AGE GROUP	1970	1980	% INCREASE/ DECREASE 1970-1980
60-64	31.9	30.4	-1.5
65-69	24.9	25.2	+ .3
70-74	18.3	18.6	+ .3
75-79	12.2	12.6	+ .4
80-84	7.8	7.5	- .3
85+	4.8	5.7	+ .9

Total Virginia Population	4,648,479	5,346,279
Total Virginia Population 60+	541,579	726,340
% of Total Population	11.7%	13.6%

*U. S. Department of The Commerce, Bureau of the Census, 1970 and 1980.

FIGURE 11

IMPAIRMENT RATING FOR ACTIVITIES OF DAILY LIVING

BY AGE CATEGORY*

AGE	ADL IMPAIRMENT			
	Good to Excellent	Mildly Impaired	Moderately Impaired	Severely to Totally Impaired
60-64	85.3	9.3	2.4	3.1
65-69	84.0	9.6	2.6	3.8
70-74	77.7	16.1	3.3	2.6
75-79	62.4	21.7	6.9	8.9
80-84	39.9	29.0	16.6	14.4
85 and over	29.0	37.8	13.2	20.0

*Center on Aging, Virginia Commonwealth University, Statewide Survey of Older Virginians, 1980.

FIGURE 12

ESTIMATE OF VIRGINIA'S IMPAIRED ELDERLY

Total Population Age 60+		726,340[1]
Institutionalized Population		30,114
Elderly Residing in Nursing Homes	18,860[2]	
Elderly Patients Under Treatment in Six Facilities of the Department of Mental Health and Mental Retardation	2,035[3]	
Elderly Residents of Licensed Homes for Adults	9,219[4]	
Elderly Persons Residing in Community		696,226
Impaired Elderly Residing in Community (Moderate to Totally Impaired)		71,015[5]
Impaired Elderly At Risk of Institutionalization (Severely to Totally Impaired)		38,300[6]

[1]U.S. Department of Commerce Bureau of the Census, 1980 Census of Population. Washington, D.C.: Superintendent of Documents, May, 1981.

[2]Estimate from the Virginia State Department of Health, (Nursing Home Bed Need in Relation to Alternatives in the Commonwealth, Report on House Bill 1452, August, 1981.) Adjusting for nonresponses at 95% occupancy rate for the February 11, 1981 Nursing Home Survey.

[3]State Department of Mental Health and Mental Retardation, July, 1981.

[4]Estimate of the number of elderly residing in Homes for Adults. No reporting systems of Census of Homes for Adults is available. As of June, 1981 there were 12,131 licensed beds. Assuming a 95% occupancy rate (n=11,524 residents) and an estimate that 80% of the Homes for Adult beds were occupied by persons 60 and over the population estimate was derived.

[5]Estimate of Impaired Elderly residing in the community is derived by subtracting the estimated elderly institutionalized population (30,114) from the 1980 Census count and applying the 10.2% reported by the Center on Aging who are "moderately" to "totally" impaired in activities of daily living rating, as an estimate proportion of impaired elderly residing in the community.

[6]Estimate of the "Severely" to "Totally" impaired residing in the community based on the 5.5% estimate reported by the Center on Aging who are impaired at this level in activities of daily living.

Figure 13

1. Excellent ADL capacity.
   Can perform all of the Activities of Daily Living without assistance and with ease.

2. Good ADL capacity.
   Can perform all of the Activities of Daily Living without assistance.

3. Mildly impaired ADL capacity.
   Can perform all but one to three of the Activities of Daily Living. Some help is required with one to three, but not necessarily every day. Can get through any single day without help. Is able to prepare his own meals.

4. Moderately impaired ADL capacity.
   Regularly requires assistance with at least four Activities of Daily Living but is able to get through any single day without help. Or regularly requires help with meal preparation.

5. Severely impaired ADL capacity.
   Needs help each day but not necessarily throughout the day or night with many of the Activities of Daily Living.

6. Completely impaired ADL capacity.
   Needs help throughout the day and/or night to carry out the Activities of Daily Living.

Source: Center on Aging, Virginia Commonwealth University, Statewide Survey of Older Virginians, 1980.

need for some level of service in order to perform activities of daily living. Of that figure each month, 1,000 persons are admitted to a nursing home and 2,400 more are on admission waiting lists. These 3,400 persons in most critical need are the persons 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.

Informal supports--those services provided by family and friends--are the major sources of caregiving to the elderly, according to the Statewide Survey of Older Virginians. Analysis of the statewide survey by the Center on Aging shows that only 10% of the moderately to totally impaired elderly live alone in the community. Thirty-five percent live with their spouse and another 35% live with an adult child. The remaining 20% live with other relatives or a non-related person.

Impaired elderly in the community rely on friends and family for those in-home services that can delay institutionalization. Seventy-four percent of the impaired elderly depend exclusively upon family, neighbors or friends for assistance (Figure 14). The majority of the elderly, regardless of level of impairment, rely on family members, friends and neighbors to provide personal care, continuous supervision, checking services (regular telephone or personal contact), homemaker-household services and meal preparation.

Figure 15 provides an example of the use of informal caregivers in the provision of a representative activity of daily living -- meal preparation.

FIGURE 14

UTILIZATION OF SELECTED SUPPORTIVE SERVICES

AND SUPPORT FROM INFORMAL CAREGIVERS*

Supportive Service	% of All Respondents Indicating Use of Service	% of All Respondents Indicating Informal System
Planned Social and Recreational Programs	31.4	73.2
Personal Care	7.5	90.3
Nursing Care	6.5	69.0
Continous Supervision	7.8	91.7
Checking Services	36.9	98.6
Homemaker-Household Services	18.3	83.9
Meal Preparation	12.5	88.9
Administrative, Legal and Protective Services	19.0	70.3
Coordination, Information and Referral Services	10.7	61.1

*Center on Aging, Virginia Commonwealth University, Statewide Survey of Older Virginians, 1980.

FIGURE 15

ACTIVITIES OF DAILY LIVING

IMPAIRMENT LEVEL*

Source of Preparation of Main Meal	Moderate (n=100)	Severe (n=66)	Total (n=52)
Prepares own meal	21.3	9.5	0.0
Household member	62.9	67.2	77.2
Friend	0.0	1.4	2.3
Family member outside home	3.4	2.7	0.0
Paid domestic	5.1	13.4	7.9
Nutrition program	.8	.7	8.4
Other sources	6.4	5.1	4.1
Total -	100%	100%	100%

*SOURCE: Analysis of Statewide Survey of Older Virginians.

The elderly tend to rely upon formal sources from professional personnel for administrative, legal, medical and protective services, as well as the provision of coordination, information and referral services.

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.

There are currently few specific criteria that would clearly determine one client's need for the provision of services by a relative over a non-relative provider. The situation each client presents is unique and complex.

In surveying local departments of welfare, the Department of Welfare looked at a variety of factors in determining whether to reimburse persons for care of elderly relatives. Some of these factors examined included: (1) whether the provider of care had to give up employment to provide care; (2) whether the client needed twenty-four hour care; and (3) whether the relative was the best qualified provider or only provider available to provide the care.

Relatives are currently being reimbursed through Title XX funds by local social service agencies for care of their elderly relatives. The Department concludes that these relatives are providing a much needed service to deter institutionalization. Because of reductions in Title XX funds under block grants, the impact of reimbursement of family members will be minimal.

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 Department of Welfare has explored the potential use of Auxiliary

Grants to subsidize families who provide custodial or personal care to the impaired elderly. It concludes that several issues surface which require further research and evaluation. These efforts may show a need to revise current State policy.

The Auxiliary Grant Program could be utilized as a payment source to subsidize the care given in Adult Foster Homes. The current legal bases would permit the use of Auxiliary Grants, with appropriate modifications in State policy. Adult Foster Care is considered a desirable alternative form of community care because it provides twenty-four hour supervision in a homelike atmosphere. Adult Foster Homes would be certified by the Department of Welfare and care for no more than three individuals. The cost of the Auxiliary Grant would not exceed the current maximum rate of Homes for Adults.

In response to House Joint Resolution 294 the Department of Welfare has explored the development of two pilot projects to test the program for cost effectiveness, efficiency in financial and social areas, and to identify the population this program might reach. A pilot approach might provide a more realistic basis on which to make cost projections.

IV. REPORT OF THE HEALTH DEPARTMENT: BUREAU OF LONG-TERM CARE

The report which follows was prepared by the Department of Health as requested in House Joint Resolution 294 (HJR 294). It should be noted that in the Secretary's Response in Part II, Framework for System of Long-Term Care Service, some of the recommendations differ from the report of the State Department of Health as a result of analyzing the total perspective of a Long-Term Care System. The State Department of Health supports the Framework for a system of Long-Term Care.

ADMINISTRATIVE PROPOSAL
FOR STATEWIDE MANAGEMENT
of the
LONG-TERM CARE SYSTEM

Prepared by:
State Department of Health
October 2, 1981

Administrative Proposal for Statewide Management of the Long-Term Care System

As requested by House Joint Resolution 294, the Department of Health has formulated a proposal and budget for assuming the responsibility as the lead agency for the Statewide policy formulation and management required to coordinate the provision of long-term care services. There are two aspects to the management proposal. One aspect is a proposal for coordination of the long-term care system among all the State Agencies involved in the delivery of such services. The second aspect involves a proposal for coordination of the Department of Health's delivery, management, and funding and planning of long-term care services.

A. Background

Issues that require resolution in the long-term care system are complex. The conflict between the goals of containing costs, while at the same time meeting human needs, enhances the complexity. Additionally, not all problems facing the elderly are "medical" but often solutions are addressed through medical programs because third-party payment is available. A final problem area is the way in which social and health programs have been developed and managed independently of one another. Specifically, in Virginia, the Report on the Care of the Impaired Elderly points out that there are six or more State Agencies "through which funds flow for the care of the impaired elderly." Some of these services are administered directly at the state level; others are handled by regional agencies; and still others are administered locally. The multiple administrative structures have created conflicts in definitions of service eligibility, diverse definitions of long-term care services, and lastly, a lack of linkages among long-term care services. In short, long-term care is fragmented. It is this problem of fragmentation which the Administrative Proposal submitted by the Department of Health addresses.

Not all the decisions on long-term care provision can be popular. The offsetting goals of controlling the financial burden and expanding programs to address severe unmet needs contribute to pressure on policy makers. Additionally, there can be wide interpretation of the various goals of State policy. The goal of restraining the financial burden might mean seeking to moderate future growth of costs or agreeing to provide a more appropriate mix of services at lower costs, or reducing the current level of expenditure and service, or a shifting of support for care to other units of government or to private resources. Expanding programs to address unmet needs can mean increasing direct support for specific services, such as Home Health, or improving linkages between clients and services or providing income supplementation to individuals so that services may be purchased. This discussion underscores the potential variation among long-term care State policies, which could be adopted. In Virginia presently there is no clearly articulated, universally accepted State policy on the long-term care system. It is important that such policy be developed. In order to capture a coherent and cohesive State policy on long-term care, representatives of all State Agencies, provider groups, community groups and clients having an investment in long-term care must assist in the formulation of an appropriate long-term care policy. The resolution of the complex array of long-term care issues requires an efficient permanent mechanism, structure and amenable climate in which issues may be studied, discussed and a consensus reached as to which most appropriate State policies should be adopted. Such a mechanism is critical if the Commonwealth is to have a cost-effective and humane long-term care system.

B. Recommendations

(1) An Interagency Long-Term Care Council should be established through the Office of the Secretary of Human Resources to assume responsibility for the

formulation of long-term care policies which assure interagency cooperation, communication and coordination. The proposed Council would be composed of the Commissioners and/or Directors of key State Agencies involved in the management of long-term care services. At the present time there is no formal setting in which the heads of State Agencies meet with the expressed purpose of resolving issues associated with long-term care delivery systems. Yet clearly fragmentation in the management, budgeting and purposeful planning for appropriate long-term care service is compounded by the fact that six or more State Agencies administer and/or fund long-term care services (House Document 20, 1981). The Report of the Joint Sub-Committee to Study the Care of the Impaired Elderly (House Document No. 20, 1981) has identified that the Commonwealth "has need of an organizational entity with responsibility and power to oversee and coordinate long-term care for all persons." It is the belief of the Department of Health that appropriate coordination of the long-term care system cannot take place without the involvement of top management of State Agencies. With the need for interagency coordination in mind, the Department recommends the establishment of a Virginia Long-Term Care Council.

The Virginia Long-Term Care Council

Goal: To develop an appropriate State policy for the Commonwealth, thereby organizing long-term care services as a continuum of available care resulting in a flexible, comprehensive and coordinated range of services most appropriate to individualized long-term care.

Objectives: Specific objectives of the proposed Council would include at least the following:

1. Provide leadership in the development of State policies and programs for the long-term care system.
2. Assure that an appropriate supply and mix of quality long-term care services are available in the Commonwealth.

3. Assure that long-term care services are provided in the most cost-effective manner possible.
4. Assure that long-term care services are appropriately targeted to the population in need of such care.
5. Encourage appropriate relationships between public and private sectors in the development, funding, regulation, and provision of community and home-based care.
6. Assure that the highest quality of care and service is provided to the long-term care population of the Commonwealth.
7. Assure that a system of education about the continuum of long-term care services is established for both providers and consumers.

Functions: Specific tasks which require the immediate attention of the Council include:

1. Identification of the appropriate State role in the provision of long-term care services.
2. Development of a complete definition of the target population for long-term care services, both institutional and community based.
3. Development of realistic determinants for the eligibility for institutional and community-based services paid for with public funds.
4. Determination of the local community's role in the planning, delivery, and monitoring of long-term care services.
5. Assessment of the viability of a case management program for the potential long-term care population, including the cost benefit of such a program.
6. Development of administrative and fiscal controls over costs and utilization of long-term care services.

Composition and Staffing of the Interagency Council

The proposed Council should be composed of the Commissioners and/or Directors of the key State Agencies involved in any aspect of long-term care services. Representation from both the Central and Regional office levels of the State Agencies should also be assured. The Council should establish a mechanism whereby, on a regular basis, representatives of the provider and consumer sectors can meet with Council members to discuss long-term care policy issues. Consistent with the charge to the Department of Health to assume lead responsibility for Statewide long-term care policy formulation, the Commissioner of Health would be Chairman of the Council. Staffed by the proposed Long-Term Care Operations Unit (please refer to description below) the Council would meet at least quarterly, and the attendance of the Commissioners would be required. The Secretary of Human Resources would report the results of the interagency effort at least annually to the General Assembly and the Governor.

(2) Within the Department of Health an organizational unit for long-term care service planning should be established as a focal point for intra- and interagency coordination and communication. Noteworthy among the problems associated with the long-term care delivery system is the fact that no one organizational entity coordinates long-term care services so that services may be rendered on a comprehensive, effective and productive basis. This conclusion has been reached in studies of previous years, including the Report on the Health Care Needs of Ambulatory Elderly for the 1980's issued in October 1979, and 1980-84 Virginia State Health Plan, adopted in April 1979, and the Report of the Joint Sub-Committee to Study the Care of the Impaired Elderly issued in 1980 (House Document No. 20). This proposed LTC operational unit would "solidify programming within both the private and public sectors so that the fragmentation and inadequacies of long-term care services could be erased eventually. In the absence of such organizational direction, the hodge-podge of services and the lit-

tle meaningful attention given to the health needs of the long-term care population have caused patients to be admitted to nursing homes inappropriately." (Report on the Health Care Needs of Ambulatory Elderly for the 1980's)

The Office of Health Care Programs within the Department of Health oversees most aspects of the long-term care system, i.e., Home Health services, the Medical Assistance Program, Public Helath Nursing and Licensure of facilities and services. Accordingly, a Long-Term Care Unit should be created within the Office of Health Care Programs and should report directly to the Assistant Commissioner of that office. (Please refer to the attached organization chart.) Responsibility for long-term care service planning and coordination should be established within this unit, and appropriate authorities and staffing arrangements for the implementation of this responsibility should be determined by the Commissioner of Health.

The goals, objectives and functions of the Department of Health's Long-Term Care Unit are outlined below:

Long-Term Care Unit

Goal: To be responsible for long-term care service planning and coordination for the Department of Health.

Objectives:

1. Foster the establishment of a continuum of community and home-based services through development of appropriate health programs and policies.
2. Assess on an ongoing basis the need for the continuum of long-term care services for which the Department has primary responsibility.
3. Function as a focal point for long-term care planning and coordination within the Department.
4. Develop appropriate fiscal and administrative controls of long-term care services in conjunction with quality care standards.

Functions: The functions of the Long-Term Care Operations Unit should include but not be limited to the following:

1. Development of a Department of Health Long-Term Care Plan.
2. Development of a continuum of long-term care programs for the population in need.
3. Identification of grogrammatic resources and assurance of equitable State-wide distribution of these resources.
4. Coordination of activities with other Departments, Divisions and Bureaus, and providers of services.
5. Development of standards and criteria relating to quality long-term care services.
6. Performance of special studies of long-term care issues at the request of other Divisions in the Department.
7. Development of applications for Federal grants relating to long-term care.
8. Provision of support for the Virginia Long-Term Care Council and address specific problems listed by that Council.

Staffing for Long-Term Care Operations Unit

The LTC Unit should have a minimum core staff as follows:

1. Health Programs Analyst
2. Nurse Manager*
3. Clinical Social Worker*
4. Statistician
5. Clerk Stenographer and Clerk Typist

*Either the Social Worker or Nurse Manager should have documented expertise in gerontology and planning.

PROPOSED BUDGET

Long Term Care Operation/Unit

Personnel

Administrator/Health Program Analyst		$20,896.00
Statistician		11,195.00
Nurse Manager A		17,484.00
Clinical Social Worker C		17,484.00
Clerk - D		11,195.00
Clerk-Typist B		7,838.00
	Salary Total	$86,092.00
Fringe Benefit at 15%		$12,913.80

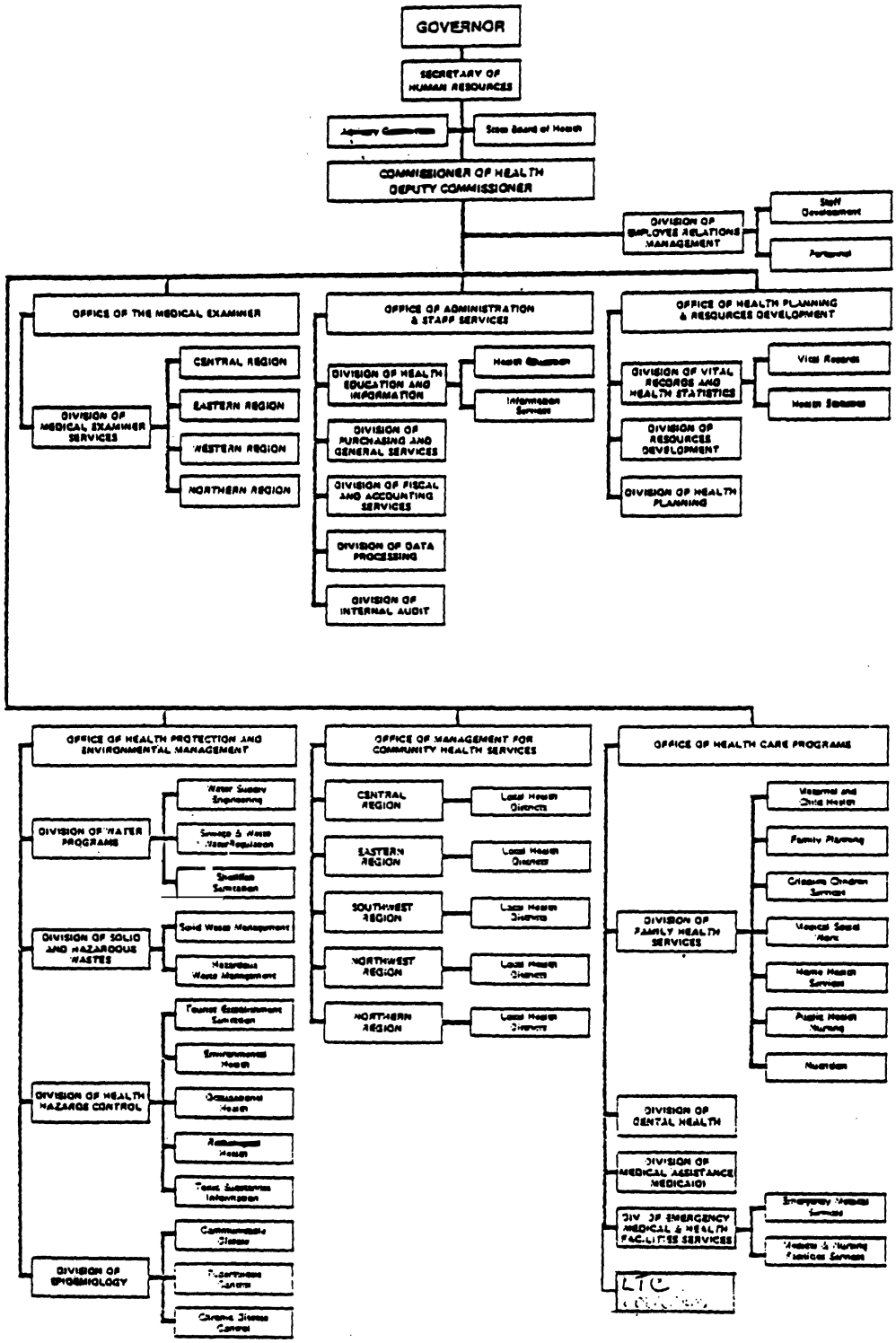
Travel Expenses

Administrator/Planner		$ 3,000.00
Nurse Manager		2,400.00
Clinical Social Worker		2,400.00
	Travel Total	$ 7,800.00

Equipment and Supplies

3 Executive Desks @ 298.00 ea.		$ 894.00
2 Secretarial Desks @ 291.00 ea.		582.00
3 Executive Chairs @ 245.00 ea.		735.00
2 Steno Chairs @ 116.00 ea.		232.00
4 Side Chairs @ 166.00 ea.		664.00
6 File Cabinets @ 236.00 ea.		1,416.00
3 Bookcases @ 143.00 ea.		429.00
2 Typewriters @ 725.00 ea.		1,450.00
1 Calculator @ 159.00 ea.		159.00
1 Transcriber @ 260.00 ea.		260.00
3 Dictating Units @ 349.00 ea. / with transcriber		1,047.00
Postage		1,000.00
Printing		1,000.00
Office Supplies		2,000.00
Books and Subscriptions		250.00
Telecommunications		2,000.00
	Equipment & Supplies	$ 14,118.00
	Budget Total	$120,923.80

VIRGINIA DEPARTMENT OF HEALTH
ORGANIZATION CHART



VIRGINIA OFFICE ON AGING'S ROLE

AS LEAD AGENCY

IN THE EVALUATION OF LONG-TERM CARE SERVICES

V. REPORT OF THE VIRGINIA OFFICE ON AGING

The report which follows was prepared by the Office on Aging as requested in House Joint Resolution 294 (HJR 294). It should be noted that in the Secretary's Response in Part II, Framework for System of Long-Term Care Services, it is recommended that the evaluation responsibility be placed with the Long-Term Care Council rather than with the Virginia Office on Aging. The Virginia Office on Aging supports the report of the Secretary but submits this plan as required.

INTRODUCTION

The Virginia Office on Aging's designation under House Joint Resolution 294 as the lead agency for the evaluation of Long Term Care Services for the impaired elderly assigns it the responsibility for the development of a more formalized methodology for the collection, evaluation, and dissemination of data relating to Virginia's Long Term Care System. The task of developing an evaluation model at this time is difficult because there is no clear picture of Virginia's future Long Term Care System. The possible continuum of services which may make up Virginia's Long Term Care System range from the minimal intervention of telephone reassurance services to the constant care and supervision of an institutional setting. The composition of this Long Term Care continuum, the funding sources, the potential client population, and the public as well as the private agencies which may be involved, will combine to dictate the specifics of any evaluation plan that may be developed. This proposal for the evaluation of Virginia's Long Term Care Service System will review the current Long Term Care Demonstration Projects in operation through the United States, will define four evaluation models or concepts, and will make specific recommendations for a Statewide Long Term Care Evaluation System located within the Virginia Office on Aging. These recommendations will include proposals that the Virginia Office on Aging establish a Long Term Care Evaluation Section and become a central information and referral agent for consumer complaints regarding institutional and community-based Long Term Care services.

Virginia Office on Aging's Current Role

The Older Americans Act of 1965 authorized funding under Title III to support in each state a State Unit on Aging. One of the purposes of this single state agency was the disbursement of Older Americans Act monies to the various Area Agencies on Aging within the State. The State Unit is also required to submit an annual plan to the Administration on Aging in which it describes the activities which will be carried out using Older Americans Act funds, as well as the State's method of administration, monitoring and evaluation of those funds. Specifically, Section 1321.45 of the Federal Register (Volume 45 - No. 63) states that the State Agency will:

(a) Approve and monitor the administration of the activities of the Area Agencies on Aging;

(b) Evaluate the need for social and nutritional services in the State, and determine the extent to which other public and private programs meet these needs; and,

(c) Conduct periodic evaluations of activities and projects carried out under the State Plan, including at least annual on-site performance evaluations of each Area Agency on Aging.

The Code of Virginia (section 2.1-373) echoes the Federal Register and assigns the Office on Aging with nine duties. With respect to evaluation, the office must:

(a) Study the economic and physical condition of the residents in the Commonwealth whose age qualifies them for coverage under Public Law 8973, or any law amendatory or supplemental thereto of the Congress of the United States, hereinafter referred to as the Aging, and the employment, medical, educational, recreational and housing facilities available to them, with the view of determining the needs and problems of such persons; and,

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

In addition to these fiscal, service, and program evaluation mandates, Virginia's State Plan for Aging Services for the Three Years Beginning October 1, 1980, recognizes the responsibility of the individual Area Agencies on Aging to evaluate local programs so as to improve their quality, as well as to identify gaps in services (Section 4.C.1).

The Virginia Office on Aging acts, in part, as the gathering point for concerns regarding current and future service needs of Virginia's elderly residents. This role is accomplished through a variety of formal and informal information-generating, feedback, and program-testing mechanisms. The Virginia Office on Aging conducts special studies on a variety of issues such as Housing Status of Elderly Virginians (July 1978) and Virginia's Educational and Training Needs in the Field of Aging (August 1981). These studies provide information which can be used by the General Assembly, the state's human services agencies, and local service providers for program planning to meet the needs of older citizens. Reports such as the State Department of Health's Nursing Home Preadmission Screening in Virginia (1977), as well as reports issued by other State Human Services Agencies, are analyzed and the information is coupled with the descriptive and demographic data provided by special research projects such as the Center on Aging's Statewide Survey of Older Virginians (1979) to provide a picture of the characteristics as well as service needs of Virginia's older citizens. Specific information

on the service needs and demographic characteristics of Virginia's elderly population by sub-state geographic areas (cities, towns, counties, or planning districts) is obtained by the Virginia Office on Aging from the twenty-five Area Agencies on Aging located throughout the Commonwealth. Budget and program hearings conducted in various localities provide a forum for citizen input regarding service needs. These public hearings, as well as consumer suggestions and complaints, allow for feedback directly from the target population. In order for the Virginia Office on Aging to provide useful data for State and local application, knowledge of Federal policy directions and national trends, demographic, and other research data must be collected and analyzed for local dissemination. Reports such as the U. S. Department of Health and Human Services Long Term Care: Background and Future Directions (January 1981) help to provide the national perspective necessary to integrate Federal, State and local programs and policy. Finally, commentary and criticism is provided by individuals in the Human Services professions, by aging advocacy groups, and by advisory boards and special commissions. All these sources of information are used to evaluate the needs of Virginia's elderly citizens.

SURVEY OF COMMUNITY-BASED LONG TERM CARE PROJECTS

Health care, particularly among high user groups such as the elderly, has been marked by spiraling costs, difficulty of access to services, limited reimbursements for needed services coupled with reimbursement for unneeded services, uneven quality of service, and inappropriate service that is often based upon provider convenience or need. Several states around the country have undertaken demonstration projects aimed at the development of community-based and in-home delivery systems for Long Term Care services. These systems could provide alternatives to nursing home care by making a variety of supportive-living and rehabilitative services available to the elderly. Many of these systems were based on the "channeling agency" concept which relates to the design and operation of local community agencies to assess client needs, secure appropriate services, monitor their quality, and integrate the provision of medical, mental health, and social services. The main purpose of these projects was to develop a rational assessment of Long Term Care needs and to redirect and reallocate resources from an institutional setting to a community-based setting. The evaluation of the projects was primarily concerned with service cost, utilization and cost comparison. Project goal attainment and impact were generally not addressed in evaluation efforts. The literature reviewed revealed no generally accepted comprehensive evaluation model among those utilized and would therefore indicate the need for development of such a model should a comprehensive evaluation be designed and implemented. The following is a survey of the evaluation issues associated with several of these projects.

A consortium of universities led by the University of Chicago Center for the Study of Welfare Policy received a one-year grant to develop and coordinate an approach to the design and development of demonstration projects.

The design which this consortium developed included an explicit planning framework, a set of objectives, research strategy with uniform data collection, and a consistent evaluation plan.

The Monroe County Long Term Care Program, Inc., was conducted to demonstrate alternative approaches to delivery and financing of Long Term Care to the adult, disabled and elderly in Monroe County, New York. The initial proposal approved by the Department of Health, Education and Welfare in 1975 outlined some broad directions and included a provision that the program be evaluated to consider the cost benefit, the impact on consumers, the issue of accountability, and the quality of the services provided. Through a unified pre-admission assessment form, persons received a comprehensive assessment of their medical, nursing, and psycho-social needs.

A one-year planning project under the direction of the Health Central Institute of Minnesota was designed to address some of the problems of developing a rural community-based health system. The project identified the existing health-related programs and the service needs of the elderly population in the service area. Four variations of a model to deliver coordinated health and social services were developed. These models were evaluated by conducting an initial assessment of the service consumers used, their functional capacity and health status, as well as other indicators. The program was evaluated using the indicators of cost, the well-being of respondents as measured by mortality, the rate of institutionalization, and the rate of service utilization.

In July of 1976, the Georgia Department of Medical Assistance embarked on a demonstration using two of the state's local health service systems to test alternative plans to nursing home care. This state's evaluation of the program involved a comparison of average cost data for home health services versus the cost for nursing home services. After an initial assessment,

success increasing clients independent functioning was measured in terms of patient health, mobility, activity and satisfaction.

Another state which undertook a similar project was Connecticut. In May of 1972, the Governor of Connecticut directed the State Commission on Aging to conduct a feasibility study for a statewide plan to provide alternatives to institutional care for the elderly in Connecticut. Subsequently, Connecticut undertook the Triage Project in 1974, a demonstration effort to test the feasibility,cost and effectiveness of a client/consumer centered model for an alternative health care delivery system. Initial and final assessments were conducted for the clients' perception of their health status as an important evaluation measurement.

The Wisconsin Community Care organization, sponsored by the Wisconsin Department of Health and Social Services, was a five-year project begun in October of 1974, to demonstrate that a substantial segment of the elderly and disabled population could be maintained in their own homes or in community settings through the provision of a broad package of health and social services. Specific, consistent, and valid measurement of project and controlled clients was central to the project's effort to target its population precisely and to measure changes over a time period. This measurement was done by administering a battery of pretested assessment tools. The research needs of this project required that the project target its client population, assess and monitor them consistently and accurately, measure and evaluate them according to externally validated norms, and establish and maintain equivalent experimental control groups. The overall project was evaluated in terms of cost, impact on clients as measured by clients' perceptions of life satisfaction, perception of quality care, and measures of relative levels of client disability.

The recurring evaluation issues found in this review of Long Term Care service demonstration projects were: (1) first and foremost, a concern with costs - both in terms of the cost benefit and the cost comparisons of services; (2) service utilization rates; (3) and the impact of the service on the targeted client population of a controlled group. These demonstration projects were by and large limited to relatively small geographical areas and to specific target populations. The evaluation models used were subject to variation and generally lacked a comprehensive application of evaluation types. By consolidating the various evaluation indices found in the literature and by employing several major evaluation types, community-based Long Term Care services for the elderly in Virginia can be comprehensively examined and evaluated.

Several of the demonstration projects contracted with consulting firms to have their evaluation done. This could be considered in approaching some aspects of evaluation in Virginia. The Office on Aging has access to the Virginia Commonwealth University Consolidated Computer System through an in-house computer terminal and could therefore likely incorporate a management information system into the process of monitoring and evaluating a comprehensive community-based service system. The VCU Consolidated Computer System features several statistical analysis packages including the Statistical Analysis System (SAS). SAS could be employed in conducting some of these statistical analyses necessary to evaluate certain aspects of the Long Term Care system, aspects reflected in the information gathered through an ongoing monitoring management information system. This feature could enable the Virginia Office on Aging to conduct a greater portion of the evaluation while leaving those aspects outside the office's realm of capabilities to external sources of the necessary expertise.

The following section describes evaluation types which can be considered in a comprehensive approach to evaluation of Long Term Care services for the impaired elderly.

EVALUATION

Evaluation of Long Term Care services in Virginia can be accomplished through four major evaluation types which can employ a great variety of strategies and methods. These major types include program activity evaluation, goal attainment evaluation, cost benefit evaluation, and program impact evaluation. The Office on Aging's Long Term Care Evaluation Section will concern itself primarily with program goal attainment and impact evaluation types while leaving program activity evaluation to the agencies normally charged with that responsibility. In order to delineate the parameters of the four evaluation types mentioned, a brief overview of each follows:

Program Activity Evaluation

Evaluation of program activity involves assessment of the quality and quantity of activities devoted to achieving program objectives. Program Activity Evaluations provide a basic description of a program at work, including, for example, service utilization rates, demographic characteristics of clients, and staffing patterns. One approach to Program Activity Evaluation is program monitoring, that is, continuous assessment of program functioning to detect deviations from objectives, plans, and procedures. Complex organizations often utilize management information systems which provide a flow of key information to program managers. The information contained in a management information system is routinely collected from forms and records. Special studies and reports can be formulated from the information that is collected through a program monitoring system to fulfill the needs of monitoring governmental agencies as well as program managers concerned with day-to-day staff performance.

Goal Attainment Evaluation

This form of evaluation focuses upon results produced by the subject of study. This type of evaluation tends to occur at two levels of assessment:

the level of the program, and the level of the individual. The most pervasive of these two occurs at the level of the program. The steps in this type of evaluation include setting goals to be obtained by the program, evaluating the program in relation to the level of goal achievement, and using this information to review goals and make corrections in the program.

The Systems model of Goal Attainment Evaluation stresses the importance of comparing the performance of a program to the performance obtained in other similar programs in addition to comparison against internal program goals. This type of evaluation can be used to supplement the goal model.

Goal Attainment Evaluation can also be conducted at the level of the client. It includes individualized goal attainment measures, standardized outcome assessment, and consumer satisfaction surveys. The first provides an assessment of the effectiveness of services for an individual whereby efficacy of services is measured according to criteria specifically tailored to the needs, capacities, and aspirations of the person receiving the services. Individualized goal attainment scaling can be conducted using standardized outcome assessment devices such as rating scales or checklists. These standardized measurement devices provide a high degree of objectivity and the opportunity to report results in fine detail and with spohisticated mathematical analysis applied to them.

Consumer satisfaction surveys assess clients' opinions, attitudes, and reactions, and can be tailored to the program under evaluation. Satisfaction surveys can also be directed toward other community agencies and toward significant relatives or friends of a client. More objective forms of program assessment are usually needed to supplement the results of consumer satisfaction survey information.

Cost Benefit Evaluation

This form of evaluation is concerned with the cost and resources of obtaining program objectives. It takes the form of cost accounting, cost benefit analysis, and cost outcome analysis. These types of evaluation are concerned with examining the amount of resources that must be expended to produce a specific quantitative program output and calculation of the ratio of benefits relative to expenditures.

Program Impact Evaluation

Impact Evaluation studies the effect of a program in the community as a whole. The purpose of this type of study is to analyze the effect of program outcomes upon the need that created the program, and also to assess the unintended social, political, and clinical consequences of the program. This type of evaluation generally employs the same research procedures as effectiveness studies but usually involves the assessment of a larger group of subjects. Impact evaluation employing the social indicators technique requires selection of a set of measures that will provide valid indications of quality of life in a given area. Social area analysis, another method for impact evaluation, involves cross-sectional and longitudinal assessment wherein groups of variables are taken together to measure change in specified domains of these variables. By developing a comprehensive picture of a community using this technique, both intended and unintended impacts of a program can be assessed.

States which have been involved in demonstration projects of long term care services in the community have evaluated them using program cost benefit and goal attainment types. The employment of those types of evaluation reflects the projects' strong concern with cost benefit and comparative costs They also reflect an interest in assessing the program goal attainment at the level of the client and his or her individual needs. A comprehensive evaluation of community-based Long Term Care services would need to incorporate aspects

of four types of evaluation in order to fulfill the needs of both program managers and policymakers.

The Office on Aging proposes to concern itself with undertaking: (1) program goal attainment evaluation examining the program goal attainment and comparable program goal attainment. Additionally, this Office's goal attainment evaluation efforts would be concerned with examining goal attainment at the level of the client using individualized assessment; (2) Impact Evaluation concerned with the effect of community-based services on other programs and the community.

These goal attainment and impact evaluation efforts could be conducted both on a routine and special project basis while leaving program activity evaluation and monitoring to other administrative units such as those within the Department of Welfare and the Department of Health which conduct routine evaluations of this kind.

These evaluation efforts could be greatly facilitated by the incorporation of a management information system to the program at an early stage. Information system facilities already in place at the Office on Aging could potentially be utilized for these evaluation efforts. Such a system and the development of standardized assessment instruments could ensure a unified system of reporting for evaluation purposes.

RECOMMENDATIONS

In order to fulfill requirements stated in House Joint Resolution 294 that the Virginia Office on Aging take the role of lead agency for the evaluation of Long Tern Care services for the impaired elderly, and to expand the Long Term Care Ombudsman Program to serve elderly persons residing in the community, the Virginia Office on Aging proposes to: (a) establish a Long Term Care Evaluation Section and to (b) become a central information and referral agent for consumer complaints regarding institutional and community-based Long Term Care services.

The Long Term Care Evaluation Section

The Long Term Care Evaluation Section will be established within the Virginia Office on Aging's Division of Program Development and Management using existing planning staff. The section will have four functions: (1) to evaluate the most cost-effective utilization of Virginia's Long Term Care resources and to make this information available to both the legislature and human services agencies; (2) to evaluate the effectiveness of Virginia's Long Term Care system in meeting the present and future needs of the Commonwealth's elderly citizens; (3) to evaluate the effectiveness of the Long Term Care system in reaching those elderly Virginians who are targeted by the legislature and human services network as being in need of, and eligible for, institutional and community-based Long Term Care services; (4) to be a focal point for information concerning the State-of-the-Art of Long Term Care Services, national trends, and future developments.

In order to carry out these functions, the Virginia Office on Aging's Long Term Care Evaluation Section may be involved in the following ongoing activities:

- The Section may conduct program impact evaluations of Virginia's various Human Services agencies to determine what effect their services have on the targeted elderly population. This can be accomplished through a variety of formal and informal activities:

Various survey instruments may be developed and administered by the evaluation section; information and reports may be requested directly from the various Human Services agencies; special surveys may be conducted on a contractual basis utilizing the staff and expertise of organizations such as the Virginia Center on Aging; and information may be gathered and recommendations made based upon public hearings and consumer suggestions and complaints.

- The Section may gather data to determine gaps in the Long Term Care service system, to minimize inappropriate utilization of Long Term care resources, to determine which services may be underutilized, and to determine which services may be ineffective and inefficient. This activity may involve the collection and monitoring of routine data concerning the utilization and cost of Long Term Care services. Information may be obtained through the Joint Legislative Audit and Review Commission as they conduct follow-up studies of Long Term Care issues such as Adult Homes and Certificates of Need. Information and financial data may also be requested from the Department of Planning and Budget. Information and demographic data may be collected by the Long Term Care Evaluation Section in order to determine the changing characteristics of Virginia's elderly population, so that future service needs might be predicted.
- The Long Term Care Evaluation Section may collect information to determine which services and methods of service delivery represent the State-of-the Art in the Long Term Care Services field. The Virginia Office on Aging will act as one of the State's resources for general information and research data regarding new and innovative Long Term Care services that may be developed nationwide as a result of demonstration projects and research plans, or

through the activities of gerontology and schools of geriatric medicine. In order for the Virginia Office on Aging's Long Term Care Evaluation Section to effectively evaluate the impact of Long Term Care services, an adequate and accurate flow of data may need to be obtained from the various human services agencies which provide Long Term Care services. It is, therefore, recommended that a Long Term Care Evaluation Committee be established. This Committee should be composed of a member from each of the State's human services agencies who will act as coordinators for information, statistics, or special reports that may be required by the Virginia Office on Aging in its evaluation role. This Long Term Care Evaluation Committee will also work closely with the State Department of Health's proposed Inter-Agency Long Term Care Council. This proposed Council, "composed of the Commissioiners and/or Directors of key state agencies involved in the management of Long Term Care Services" and charged with being the "established entity with responsibility and power to oversee and coordinate Long Term Care for all persons" is seen as the appropriate body to receive the recommendations of the Long Term Care Evaluation Section. This Council should have the authority to implement the recommendations of the Long Term Care Evaluation Section and to disseminate its findings to the various human service agencies, the Legislature, and the general public. The Inter-Agency Long Term Care Council should also be in a position to make recommendations to the Long Term Care Evaluation Section concerning aspects of the State's Long Term Care system which the Council members feel may require special study and evaluation.

The Virginia Office on Aging will not monitor the day-to-day activities of the State's Human Services agencies or perform a quality assurance role in regard to specific services which are offered. These types of quality assurance/monitoring functions will continue to be carried out by the individual agencies. The Virginia Office on Aging will also not dupicate those

functions already performed by the Joint Legislative Audit and Review Commission or the Department of Planning and Budget.

Expansion of the Long Term Care Ombudsman Program

The Virginia Office on Aging will continue to operate the Long Term Care Ombudsman Program as a mechanism for receiving and attempting to resolve complaints regarding problems in nursing homes, licensed adult homes, and geriatric treatment facilities. The program will be expanded to act as a referral and advocacy agent for individuals who have questions and/or complaints concerning one or more community-based services in Virginia's Long Term Care system. Although the Office on Aging will not conduct grievance hearings, it will act to put citizens in touch with the appropriate individuals, bureau, or agency which can answer their questions or initiate a formal grievance procedure on their behalf. The Long Term Care Ombudsman program staff will also attempt to follow up on these citizens, either directly or through a local area agency on aging, to determine if their needs were met or their complaints heard. Consumer problems and complaints will provide a portion of the data which will be used in the evaluation of Virginia's Long Term Care services system.