S. HRG. 101-1202

AGING IN PLACE: COMMUNITY-BASED CARE FOR OLDER VIRGINIANS

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

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WEDNESDAY, APRIL 11, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Charlottesville, VA.

The committee met, pursuant to notice, at 10:03 a.m., at Charlottesville City Hall, 7th and East Main Streets, Charlottesville, VA, Hon. John Warner [acting chairman of the committee] presiding.

Present: Senator Warner.

Also present: Remmel Dickinson.

OPENING STATEMENT BY SENATOR JOHN WARNER

Senator WARNER. Good morning, ladies and gentlemen. I thank you very much for coming today.

As you well understand, the U.S. Senate sits in your Capitol in Washington, D.C., but on rare occasions we are able to hold hearings outside of the Capitol. I think it is a good practice. It enables the people to come and see how a hearing is conducted, saves them a lot of travel, expense and time.

I am privileged to serve on the Aging Committee where we are in the process now of preparing to reauthorize the Older Americans Act, which is a very important piece of legislation. As such, our committee is holding hearings in various places across the United States to gain information firsthand from individuals about the experiences they are having today under this law, how the law works, and how the law—in their judgment—does not work so that when we put pen to paper—beginning this fall and more likely a year from now we will finish it—we will be able to improve this legislation so it can better serve America. That is the purpose of my coming to Charlottesville today.

I must say that Charlottesville has a very special place in my heart, having had the privilege of going to the University to attend law school and then having a son who subsequently attended the University as an undergraduate, so it has been a part of my life for many, many years.

I am greatly in debt to Mayor Elizabeth Walters and the Charlottesville City Government for having so graciously donated the use of these chambers and other facilities.

Furthermore, I'd like to express my appreciation to the Jefferson Area Board for Aging, known here as JABA, for their essential support services. I wonder if the various persons from JABA would

rise and be recognized. The Executive Director has been working with me since early this morning.

JABA and its Executive Director, Gordon Walker, should receive full credit for helping to assemble our first panel and for serving as our local center for planning and organization.

Our joint purpose, again, is to show to America and listen to America about the Older Americans Act. The important concept, and there is a term that has grown into use now, an important term, called "aging in place." The important concept of aging in place is now being emphasized across the Nation in the programs and policies authorized under the Federal Older Americans Act.

I am proud to note that the Commonwealth of Virginia is playing a strong leadership role. We are proving that with the provision of essential home care and community services, many older Americans are now being maintained in their homes when formerly they would require specialized training and care provision in a nursing home.

This is now possible because we have shown in many cases—I say we, that is the workers in this program, not Congress—that Medicaid funding of home and community care can be more economical both to the State and to the Federal Government and basically there is a 50/50 cost sharing, as you may know, between the Federal and State authorities. In other words, you can cut down the more expensive nursing home in favor of the aging in place concept.

We recognize that there will always be individuals whose health in decline requires admittance to skilled nursing facilities, so in no way is the concept of aging in place trying to discriminate against the very valuable contribution to health care made by these skilled nursing facilities, but, as we will show momentarily in our charts, with the growth—this is a very happy thing in America and a very wonderful thing—of older Americans in terms of numbers, the skilled facilities are becoming in short supply.

I'd like to add a personal note here. I became interested in this subject by virtue of the fact that I and my brother, just the two of us, were blessed with a mother who lived to be 97 years old. We think 98, but the only mistruth I think my mother ever told was she would not define with precision the year in which she was born and to the best of our knowledge, we were never able to determine that with precision. Anyway, we do know, give or take 18 months, it was around 97 years old that she lived to share life with us.

It was only in the last few months that her physical decline was such that she required some very specialized care. She was an intimate part of the family for many years until she elected, on her own, to go into a nursing facility. It was a marvelous experience for me and for my brother, and, indeed, my children. I became so interested in the subject that I elected to go on the Aging Committee in the Senate where I have now served several years and hope to serve for many more.

It is our intent to support the provisions of home care and community-based services for the needy, older persons until it is simply no longer viable for them to remain in the home setting.

The Senate has convened this hearing so we can put on public record, take back to Washington and share with other Senators,

and also other persons who come to consult with us on this, a written record which this gentleman is compiling here this morning.

We want to hear not only of our progress, that is, the progress in Virginia, but also of the problems that we are experiencing. If any of you have brought specific case problems, we'd like to hear about them.

We've got several panels here this morning, but I hope to reserve about 20 or 30 minutes, whatever the time required, to hear from other persons in the audience at the conclusion of the formal part of the hearing. If anyone wishes to volunteer some thoughts after joining us here for a while this morning, you will be given a chance to stand and put on the public record for the Senate your own views.

Allow me to recommend to you my valued assistants who serve on my staff in Roanoke, Ms. Camellia Crowder and Ms. Leslie Atkinson. They work on my staff in Roanoke and on a daily basis, consult with persons on the problems of aging as well as many other problems.

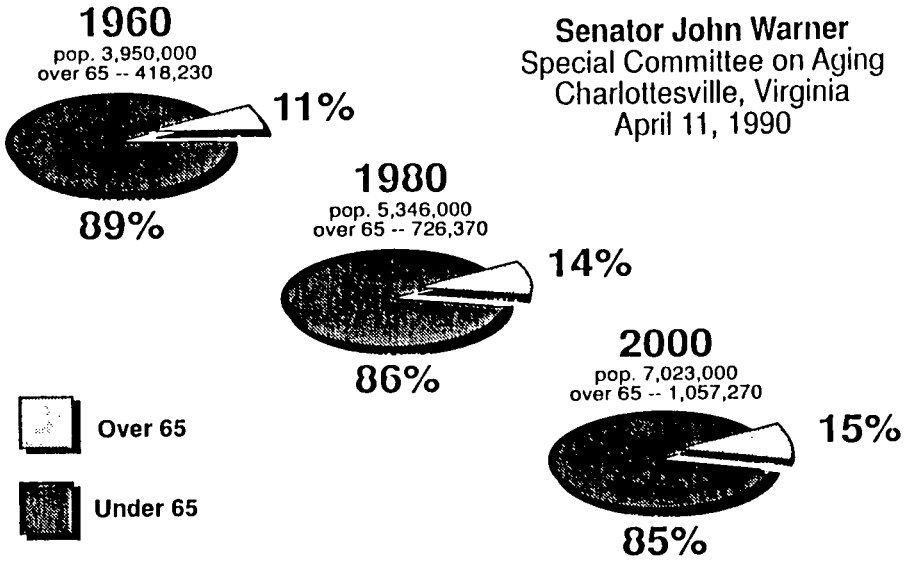
I also want to extend a special tribute to the Chairman of our Committee, Senator David Pryor of Arkansas. He is a very dear friend of mine. We came to the Senate 12 years ago and it's unusual, I have to tell you, for a Republican to be allowed to chair a Senate hearing. For six years, the Republicans were in the majority in the Senate and I chaired many hearings at that time, but I'm not here to be political this morning—in fact, to be totally nonpolitical and nonpartisan.

We feel that the subject of aging has no political dimensions, no basis for political partisanship. Chairman Pryor and the ranking Republican, Senator Heinz of Pennsylvania, we work together, all of us, all of the members, all 20 members of the Aging Committee, as a team to do what we can to learn and to improve the lifestyles of our older Americans.

The Commonwealth of Virginia is blessed with a growing population but one which will considerably challenge our resources in the coming year. Permit me now to call to your attention Chart 1 which graphically displays population trends of the recent past and projections for the future.

This is Mr. Remmel Dickinson of my staff, who has spent 12 years working for me. His specialty is the field of aging and all medical programs. I am proud to have him as a member of my staff. He has worked on this and if you'd kindly give some of the details on this chart, Mr. Dickinson.

CHART NUMBER ONE



Mr. DICKINSON. Yes. Thank you, Senator.

This, I think, reveals simply the population growth but it's the population we are going to have to deal with under the Older Americans Act, through Medicaid and Medicare, through the Social Security Trust Funds and the whole gamut.

You will see that while the actual number of population over the age of 65 increases from 11 to 15 percent, in actual terms of numbers, the population almost triples from 419,000 in 1960 to more than a million by the year 2000.

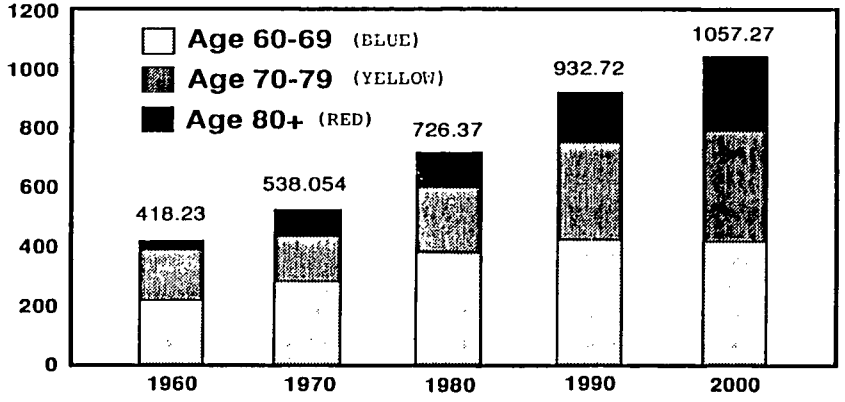
The significance for the Commonwealth of Virginia to project the amount of resources that we will be needing to help provide for these people is enormous.

Senator WARNER. We will show you on a subsequent chart that 1 million seniors in 2000 represents the anticipated one-seventh of the total population of the Commonwealth of Virginia. Why don't you take us through Chart 2, Mr. Dickinson? This chart was provided by the Virginia Department of Aging.

Mr. DICKINSON. I thank them very much for giving us this information.

CHART NUMBER TWO

Older Virginian Population



Source: VA Data Center

This even more dramatically reveals the challenge which is facing us because—thank goodness people are living longer—this red portion is the population over the age of 80. This is what we call potentially the frail elderly population for whom the Older Americans Act programs are most specifically designed.

If you look, in 1960, again, you had a fairly small portion here and you go up to this figure, this represents a 91 percent growth in the population over the age of 80 over 40 years. It is a blessing that we have our older citizens with us, but it is a challenge to make sure that they receive every possible service they deserve.

Senator WARNER. Thank you, Mr. Dickinson.

We brought those charts down because they graphically demonstrate the problem that is in the future, so we want to learn more today about how we are dealing with far fewer numbers of individuals so that in the future we can provide as well, but hopefully better for the ever increasing number of individuals who are blessed with the opportunity to stay with us and join in our activities.

Our panels this morning each will bring a different perspective on the challenge of "Aging in Place." Our first witnesses will provide us with the rare opportunity to learn the value of community-based services on a first-hand basis. We will then be informed by our second panel on the role of a local aging agency in coordinating services for older Americans and the accomplishments of public/private partnerships which have been developed to better serve the needs of the region. To conclude, we are honored to have on our third panel members of the State leadership on aging issues to share with us the view from Richmond—remember, all roads lead to Richmond. [Laughter.]

I hope that we may all take home an increased understanding of both current and future objectives to better serve our older Virginians.

Now, ladies and gentlemen, please understand that again, I am here to learn from you—I call it listen and learn—because I will take an active role in drafting the provisions to amend the Older Americans Act. I appreciate this morning and all who have gathered.

If you will call the first panel, please, Mr. Dickinson?

Mr. DICKINSON. Ms. Landford and Mr. and Mrs. Hasty.

Senator WARNER. Would you kindly introduce the guests and give the specifics?

Mr. DICKINSON. We are privileged this morning to have with us, Ms. Helen O. Landford. Ms. Landford is what we call a prime example of a family caregiver. Working with the Jefferson Area Board for Aging, she is caring at home for her 98-year-old father and 95-year-old uncle. She will detail her case and the services she receives to help avoid placing her loved ones in a nursing home.

We are also please to have with us Mr. W. Arthur Hasty and Mrs. Olivette P. Hasty. Mrs. Hasty is acting as a family caregiver for her husband with the assistance of the Jefferson Area Board for Aging. Mr. Hasty has been utilizing the Thomas Jefferson Adult Day Care Center during a period of declining health which has enabled Mrs. Hasty to help maintain proper home life.

We also would like to acknowledge that Mr. James Davis, another client of the Jefferson Area Board for Aging, had planned to attend but was not able to come this morning. He has submitted written testimony, copies of which are available, and will be included in the public record.

[The prepared statement of Mr. Davis follows:]

JAMES DAVIS (Submitted for Hearing Record)

I am 76 years old. I grew up mostly in South Carolina, but my home is Atlanta, Georgia. I used to break ice, float timber. The ice leg would be frozen. Mother would have a fire for us when we got there every night. I had a hard life, that is why I am broken down the way I am. I have a right, I should have arthritis. I retired seven years ago, and a year after that, we came to Charlottesville. We have lived at Midway for three years. Mary wanted to come here, she used to live near here when she married the first time.

In my time, there wasn't any money to be had. I worked for 40 cents/hour, $18/week, the highest was $30/week until I went out on my own to paint. I did that for 20 years and did well. But my mistake was I didn't take out Social Security. It was only 15 cents out of $30/week, was nothing if they took it out. So, I have almost nothing today because there wasn't anything in there.

We ran a nursing home in D.C. for 16 years. Not much money made there, but it was better than something else. Mary was an R.N. for many years at St. Elizabeth's in Washington.

I am really taking care of Mary straight out, quite natural. She had a stroke in '83, vessels to her heart didn't connect, and she has shortness of breath. She can only sit down and move around a little, that's about it. She goes downstairs sometimes. As far as cleaning or keeping the house or cooking, she don't do that. It is not possible. I do all the cooking, am chief cook and bottle washer, dust around.

The full check between the two of us is $500/month, nothing else comes in from nowhere. I am trying to keep her here at home.

A social worker takes her to the doctor, Primary Care. This is the third one. They come and go. They just pass on her history. There are a few elderly doctors, but this one is just an intern. Medicaid pays what it can. We used to get more in food stamps , but because I got a $6 raise, it pulled us down to $39. It's like being crabs in a tub. If we get anything too much, anything from the outside, they have to know about it and they will cut you. I do think that what you folks are doing is great and if you can help anybody that is living through it, it ought to be done. I will do the very best I can.

Senator WARNER. Thank you.

Mrs. Landford, we are privileged to have you with us here this morning.

Mrs. LANDFORD. Thank you.

Senator WARNER. Would you kindly speak to the Senate of the United States—not just this one, but for the record, all 100.

STATEMENT OF HELEN O. LANDFORD, FAMILY CAREGIVER

Mrs. LANDFORD. My name is Helen O. Landford. I live in the eastern part of Albemarle County. I am a caregiver for my father, who is 98, and my uncle, who is 95.

Senator WARNER. I'm going to interrupt you a minute because this lady needs to reposition her microphone. It's more important that the people of Virginia hear you because I can hear you quite well. We are fortunate to have the media in attendance this morning because they are projecting these proceedings to just untold hundreds of thousands who just couldn't come to the hearing today.

Mrs. LANDFORD. My name is Helen O. Landford. I live in the eastern part of Albemarle County. I am a caregiver for my father who is 98 and my uncle who is 95. They are both wheelchair patients and I have been caring for my uncle since 1983. He does not qualify for Medicaid. My father does. I have been taking care of him since 1986.

I have to do just about everything for my father because with the help of Medicare, he has a bed, also a bed lift. Without the bed lift, I would not be able to get him up and down, which I have an aide from the Jefferson Area Board who comes and now she's giving me 30 hours a week, which is very good. Between us, we just make out.

Senator WARNER. You really couldn't manage without the help of JABA?

Mrs. LANDFORD. No.

Senator WARNER. That allows you to have some time for your own purposes. Also, the bed lift equipment, why don't you detail that, the cost of it?

Mrs. LANDFORD. The cost of it, Medicare is taking care of it. What I do need, I have to have Pampers, of course, and my father has to have—the Pampers, I have searched all over Charlottesville and the cheapest place I can get them—I guess Food Lion would love to hear this—is Food Lion. [Laughter.]

So I go through about two packages a week which they cost me $16.49 per package; it's 24 in a package.

Senator WARNER. I think we'd be particularly interested in your view that it means a great deal to you and other members of the family to have these persons still in the family circle. That's the important thing.

Mrs. LANDFORD. Yes. One year ago, I put my father and my uncle in a local nursing home for a month. When I returned and brought them home, my uncle had fallen and had two cracked ribs. My father had bed sores. The cost of the nursing home was $2,200 for the nursing home, not for medicine or for the laundry.

My father didn't have any money of course, so the family, we all got together and got the money together for him, but I was very disappointed when I got back home.

Senator WARNER. You elected to bring both back into the home?

Mrs. LANDFORD. Yes.

Senator WARNER. Which you were not only able to provide more love and care but it was a financial savings?

Mrs. LANDFORD. Yes. My father got dehydrated while he was there, plus be got bed sores and I had to—I brought him home on a Saturday and I had to put him in the hospital on Monday. He stayed there for a week, then after that, he's been with me since that one week he was in the hospital.

[The prepared statement of Mrs. Landford follows:]

HELEN LANDFORD

My name is Helen Landford. I live in Eastham, Eastern Albemarle County, near Key West, about 3 miles from Charlottesville. I am 65 years old, a divorcee, and take care of my father, Ollie Wilson, 98, and my uncle, 95. Both are in wheelchairs and incontinent.

I used to live in Boston but had promised my mother if anything happened to her, I would take care of my father. So, when she died, I came back here. At first, I worked. My father was living with me but had a hernia operation.

Seven years ago, my uncle was in an accident and then he had a stroke. His wife is dead and they had no children. So I quit work to take care of him. I was his favorite niece.

My father gets personal care through JABA. He receives a total of 25-1/2 hours/week. The aide does not come on Friday. My uncle does not qualify for Medicare. He can afford private pay. I have no help at night or weekends. I only go to church twice a month. I tried to get someone to come and stay for a week so I could go on vacation, but haven't found anyone. Some neighbors help.

A couple years ago, in order to visit my children, I put them both in a local nursing home for $2,200/month plus medicines and transportation. When I got back , my father had bed sores and my uncle had two cracked ribs and had to be admitted to a hospital. My father got dehydrated there and I had to have him put in a hospital, too. I did not file any complaint. My uncle had enough money to pay for the month, but I and my family got together for the money for my father. Medicaid won't pay for a month, they told me it was too much paperwork. I wouldn't put them in a nursing home again.

My daughter says she doesn't know how I stand it. I have a bed lift for my father. Medicare will only pay for it for 15 months. After that, I don't know. I get him up for meals three times a day and put him back. I couldn't do it without the lift.

I get blue pads for $26, but I have to buy pampers. They are cheapest at Food Lion, $16 for 24 and I use two boxes a week. I put my father to bed at 7, then get up at 12 to change him. Uncle knows when he has to use the bottle. or make a BM. I change my father at 12 and 6 to avoid bedsores. It's just like taking care of a baby, you don't just change the pamper, you have to keep him clean.

I bathe them both every day. I get Ensure, the liquid nutrient, from JABA for my father. He can only drink it once a day, otherwise it gives him diarrhea.

I tried to take care of another uncle but that only lasted a couple of weeks. I couldn't do it. He is now in a nursing home. My day off is spent running errands, paying bills, shopping. My health is okay, so far. I wouldn't put them in a nursing home again.

They can ride in a car but need help getting in and out which I can't do. We have a ramp which was built by a local carpenter.

Senator WARNER. I'll tell you what we will do at this moment. We'll hear from Mrs. Hasty and if there are any other thoughts, I'll come back to you, so if you'll collect your thinking for a moment, we'll return to you if you have any concluding remarks.

Mrs. Hasty.

STATEMENT OF OLIVETTE P. HASTY, FAMILY CAREGIVER

Mrs. HASTY. My name is Olivette P. Hasty. I am 65 years old.

Two years ago, my husband, Art, had a severe seizure and had to be hospitalized. He was completely out of his head and he was in the hospital for 2½ weeks until Medicare would not cover the hospitalization anymore. We placed him in a nursing home and he was there for approximately 2 weeks. During that time in the nursing home, he started to slowly come out of this illness.

The nursing home was extremely expensive, as Ms. Landford has testified, and I was working full-time at the time but I wasn't quite 63½—which is like a magic number when you can retire and draw enough social security. Also the same with my State pension, I had to try and stretch it out. I would have reached 63½ in April and this illness happened in January.

There was a period in there that was very difficult and devastating financialwise—also just the illness itself to my husband.

My minister and also the doctor I was working for suggested that I try the Adult Day Care Center where he could stay during the daytime and then I could take him home at night and care for him. A local doctor agreed that he could leave the nursing home for that and we tried it. There was such a dramatic improvement in his condition because of the attention that the Adult Day Care Center gave him, the mental stimulus of other activities, I never worried about him while I was working.

Senator WARNER. They gave him a lot of support?

Mrs. HASTY. Oh, they did.

Senator WARNER. And that brought from within him the ability to recover?

Mrs. HASTY. Yes. You could just see, every week he started to——

Senator WARNER. That was JABA, is that correct?

Mrs. HASTY. JABA and the Adult Day Care Center is under JABA.

Senator WARNER. Which I will be visiting later today.

Mrs. HASTY. The staff, everybody on the staff was so good to him. They have a nurse there all the time to monitor medications of the people who are there.

Then when I reached 63½, I was able to retire and he had improved so much that he was able to stay at home. Now I am working part-time and——

Senator WARNER. He's able to care for himself.

Mrs. HASTY. He's doing fine. He's right there and can talk to you too.

[The prepared statement of Mrs. Hasty follows:]

OLIVETTE P. HASTY

My name is Olivette P. Hasty, I am 65 years old. Two years ago, in January, my husband, Art, had a severe seizure in the middle of the night. We called the Rescue Squad and they took him to the hospital. He was out of his head and had another seizure. the doctor did all he could but told me it would be a long struggle and his mind would never be better than an eight year old's.

After two weeks in the hospital, he had to leave because Medicare would not continue to cover him. He was placed in a nursing home for two weeks. He recovered some, but still could not stay home alone. I was working full time and was not quite 63-1/2 at the time, so I could not get Social Security or my state retirement. I just needed one more month on the job. Our minister suggested the Day Care Center. By then, the bills were piling up. I applied for a 1/2 scholarship and was given one. It was "life saving." That enabled me to keep working until the time to retire. . If I had quit, I would have lost my pension, and, in four months, we would have been broke.

Thanks to the scholarship from JABA, Art spent six weeks at the Day Care Center. With the individual care he got there, he not only got better, but returned to normal. When he left the Center, I retired and am now working part time. The attention he got there was a stimulus to his brain, what he needed. The only improvement I can think of is more funding to support this wonderful service - so that more families could be helped.

Senator WARNER. We'll be glad to hear from you, Mr. Hasty.

STATEMENT OF ARTHUR HASTY, ADULT DAY CARE CLIENT

Mr. HASTY. My name is W. Arthur Hasty. I am 72 years old.

I don't remember much until the ambulance trip to the nursing home. There is no stimulus there, the only thing they do is bathe and feed you. I fell out of bed once and couldn't sleep at night because of the noise of people calling out, "Let me out."

I have recovered and even quit smoking. I'm doing fine, back to normal. The TJADCC [Thomas Jefferson Adult Day Care Center] really saved our "hides."

Senator WARNER. I thank you very much. I want to emphasize two things at this point. One, how grateful we are for these people who are having, what we call, hands on experience to come and publicly testify. That's not an easy thing to do. We respect you and are grateful for your doing that.

The second thing is that clearly from their testimony, we gain the feeling that the home environment is unique and it enables them to, in many instances, recuperate faster with the help of the loved ones.

We are not here to indict or incriminate the professional services which are the fall back. Indeed, the nursing homes provide a very important adjunct to our health care system. What we are trying to show are two things—one, so long as we are able to keep them in the environment where love and affection can be provided by the family, they can get equal or perhaps quicker care; and second, it is more economic.

Mr. Dickinson passed me a note here to compare that the hourly wages for a person who will come to the home—as you said, Ms. Landford, some 30 hours a week—if you compare those costs with what it would cost to put them in a home—I think you stated your own figures—you have a multiple of three, four times more costly in the established facilities as compared to the home care. Would that be correct, Mr. Dickinson, a multiple of those figures?

Mr. DICKINSON. Yes, sir.

Senator WARNER. Any other testimony, Ms. Landford, that you'd like to add?

Mrs. LANDFORD. I'd like to dispute my age.

Senator WARNER. Well, now, my mother never would be precise with that, so we're not going to hold you to that. This is not the application for a driver's license. [Laughter.]

We'll forego that. All I know is that you look very healthy and vigorous, and full of love and affection which I think is worth many times over what medication provides.

For you, Ms. Hasty, an act of courage, both on the part of yourself and your husband. We wish you both well. Anything further you'd like to add?

Mrs. HASTY. No, except that I'm definitely in support of the Adult Day Care Center.

Senator WARNER. Good. We will do what we can in the Congress of the United States to place greater emphasis, as we rewrite the legislation to appropriate the funds, on the ability for families to care for themselves in the home setting.

Mrs. LANDFORD. Is it possible we can have something like home placement for the elderly to go for a weekend or something like that? I don't get no weekends off.

Senator WARNER. Well, what you're saying is perhaps a facility which would take them for a period of 48 to 72 hours to allow the home care system just to let down for a bit?

Mrs. LANDFORD. Yes.

Senator WARNER. You've got an idea there that we should explore. All the rest of us in our lifestyles are looking for 48 or 72 hours to take off and we're approaching one of the glorious weekends in our annual church and calendar this weekend, Easter weekend.

All right, we thank you very much. We'll dismiss the first panel.

Senator WARNER. Now, will you introduce Panel II, Mr. Dickinson?

Mr. DICKINSON. Yes, sir.

We are very pleased to have Mr. Gordon Walker with us this morning. Gordon has been a strong working partner with Senator Warner's office for a number of years. He is a lightning rod in the aging network of Virginia and we appreciate his contribution today and contributions he's made in the past.

We are also highly privileged to have with us Dr. John A. Owen, Jr., of the University of Virginia Medical Center. Dr. Owen, a distinguished Professor of Internal Medicine, is also the incoming President of the Medical Society of Virginia.

In that capacity he will also serve as a new member of the Medical Society of Virginia Review Organization, the federally responsible group which helps to monitor quality of care in the Medicare program for the Commonwealth.

Dr. Owen will describe to us the innovative local VMAPP Program, Voluntary Medicare Assignment Program for Physicians. In this program area, physicians are voluntarily accepting Medicare reimbursement as payment in full for low income beneficiaries identified by VMAPP and JABA. It is a remarkable partnership and a way to make Medicare dollars most valued for those who need the assistance the most.

Senator WARNER. Thank you. If you will kindly come forward and take your places at the witness table.

Mr. DICKINSON. Excuse me, Senator. The third member is Mr. John Holly. Mr. Holly is the Administrator of the Martha Jefferson Hospital in Charlottesville. He will share with us some unique stories of public/private partnership his hospital has entered into with JABA.

Senator WARNER. Dr. Owen, I wonder if you might lead off. I had the privilege of visiting with you, not only this morning, but on many previous occasions. If I might add a personal note—and I add these personal notes only to show you how interested I am in these subjects—my father was a doctor. He graduated from Washington Lee University in 1903 and devoted his life to medicine and the care of people.

He never desired on earth to pile up any monetary benefits for himself. His doctrine was total service to mankind. I only wish that he had lived a little longer. I saw my father last just after I came

home from World War II—I was discharged from the Navy—and he died but a few weeks after I got home.

I have nothing but the greatest affection and admiration for my father and I have tried humbly in my public life to do what I can for the medical profession and those that labor in it. Dr. Owen, you represent to me many of the characteristics my father had in your service to the public. Thank you, sir.

STATEMENT OF JOHN A. OWEN, JR., M.D., PROFESSOR OF INTERNAL MEDICINE, UNIVERSITY OF VIRGINIA HEALTH SCIENCES CENTER

Dr. OWEN. Thank you very much, Senator.

Senator Warner, distinguished guests, thank you for letting me briefly present the story of VMAPP, the Voluntary Medicare Assignment Program for Physicians.

I am John A. Owen, Jr., M.D., Professor of Internal Medicine, University of Virginia and President-elect of the Medical Society of Virginia.

I am the son of a country doctor in Halifax County who graduated from the University of Virginia Medical School in 1903. Like him, I attended Hampden-Sydney College and the University of Virginia, receiving my MD degree in 1948. Since 1960, I have been full-time on the Medical School faculty here and since 1960, I have been an active member of the Albemarle County Medical Society and of the Medical Society of Virginia.

In 1986, I was asked by the President of MSV to head a Committee on Aging, our charge being to work with the Governor's Advisory Board on Aging to develop a potential alternative to any legislation which would require mandatory acceptance of assignment of Medicare benefits by all physicians because we did not want the confrontational animosities that would inevitably entail.

After several discussions, our two groups agreed to initiate a pilot project to see if doctors would be willing to be part of a voluntary program accepting assignment automatically whenever financial need could be verified by a confidential and impartial authority.

From my childhood memories of the Depression, I knew that the medical profession deeply respects the financial problems of patients. From my years in the Albemarle County Medical Society, I knew my colleagues to be decent and sympathetic physicians who were open to new ideas.

At the request of the Committee on Aging, I sought their approval to develop a working agreement with the Jefferson Area Board for Aging. I might add that Mr. Walker and I had already worked together on preparing a directory of physicians in the area for the benefit of his clientele.

Through the American Medical Association, I had learned that voluntary programs were already being developed in Wisconsin, Connecticut, Ohio, and other States. The upshot is that JABA agreed to process its elderly population to establish financial need, which we define annually as income less than 200 percent of the Federal poverty level figures.

Qualifying persons receive a VMAPP card and a list of participating physicians. The Albemarle County Medical Society donates $2,000 per year to JABA to cover the expenses of this service and we polled our members collectively and individually to secure their pledge of participation—that is, they would, without question, accept assignment to any patient who presents a VMAPP card.

The collective vote of the Society was unanimous. The individual acceptance rate was around 93 percent. The program was officially launched on October 1, 1987. I have here a copy of the card which participating physicians are given to display for the information of their patients.

All this was duly reported to the Medical Society of Virginia and through its leadership, other component societies across the State learned of the program and elected to do the same thing. Norfolk and Richmond led the way followed by Arlington, Lynchburg, Fairfax, Northern Virginia, and Danville.

As of 6 months ago, 11 component societies had such programs off and running and it is under active consideration by 9 others. The major population centers are involved, and the rural areas will follow their lead. We continue to be evangelistic about the VMAPP program everywhere.

All this did not take place with effortless ease. We felt it advisable from time to time to brief our key legislators in Richmond in order to secure their support. We visited former Commissioner for Aging, Wilda Ferguson, and former Secretary of Health and Human Resources, Eva Teig, and readily obtained their much-needed and much-appreciated backing.

In short, gentlemen, this is a success story in that everyone involved is happy with VMAPP; and every faction that participated, doctors, patients, Boards for Aging, and the executive and legislative branches of government, has benefitted from it.

Could it be that the secret of success is that it deals with people fairly yet respectfully, recognizing individual needs and individual pride with the tact and courtesy of the old country doctor who knew his patients so well because they were also his friends and neighbors?

Rightly or wrongly, my interpretation is to generalize that the role of government is most effective when it works to bring people together as individuals rather than when it polarizes them into inimical groups.

But finding the way to do this, as Virgil says of the ascent from Avernus, "hoc opus hic labor est."

Thank you.

[The prepared statement of Dr. Owen follows:]

TESTIMONY OF JOHN A. OWEN, JR., M.D.
PROFESSOR OF INTERNAL MEDICINE
UNIVERSITY OF VIRGINIA

UNITED STATES SENATE SPECIAL COMMITTEE ON AGING
CHARLOTTESVILLE, VIRGINIA
APRIL 11, 1990

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From my childhood memories of the Depression I knew that the medical profession deeply respects the financial problems of patients. From my years in the Albemarle County Medical Society, I knew my colleagues to be decent and sympathetic physicians who were open to new ideas. At the request of the MSV Committee on Aging, I sought their approval to develop a working agreement with the Jefferson Area Board for Aging (JABA). Through the American Medical Association (AMA), I had learned that voluntary programs were already being developed in Wisconsin, Ohio and other states.

JABA agreed to process its elderly population to establish financial need, which we defined as income less than 200 percent of the annual Federal poverty level figures. Qualifying persons received a VMAPP card and a list of participating physicians.

The Albemarle County Medical Society donated $2000 per year to JABA to cover the expenses of this service, and polled its members collectively and individually to secure their pledge of participation, i.e. that they would automatically accept assignment on presentation of the VMAPP card. The collective vote was unanimous; the individual acceptance rate was around 93 percent. The program was officially launched on October 1, 1987.

All this was duly reported to the Medical Society of Virginia and through its leadership other component societies learned of the program and elected to do the same thing. Norfolk and Richmond led the way, followed by Arlington, Lynchburg, Fairfax, Northern Virginia and Danville. As of six months ago, 11 component societies had such programs off and running, and it is under active consideration by nine others. The major population centers are involved, and the rural areas will follow their lead. We continue to be evangelistic about the VMAPP program everywhere.

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Senator WARNER. Doctor, just in lay language, explain your observation of the therapeutic effect—I'm not sure I can put it in the proper words but I'm sure you can—of what the unique home setting provides that the institutionalized facilities just are unable to provide?

Dr. OWEN. I think there are many, many things that one could mention and I think Ms. Landford and Ms. Hasty already mentioned some.

First and foremost is the freedom from distraction, from noise, from the sense of being part of a large, continuously active and interesting institution. Second is the fact that care is given by people that you know and recognize as being 100 percent involved in your problems and nobody else's. Third is the comfort of seeing all around you familiar and reassuring sights, sounds, and even smells that tell you that you're home and everything is going to be all right.

Senator WARNER. And that, if you had to translate it, is worth 10 times the drugs and medication that you can purchase often?

Dr. OWEN. Absolutely.

Senator WARNER. And it's all for free. I say all for free, but I mean it's a burden on the caretakers at home, but there's no price tag you can put on it. I suppose the one word to characterize it is, it's just love, isn't it?

Dr. OWEN. Yes.

Senator WARNER. That summarizes it.

Mr. Walker.

STATEMENT OF GORDON WALKER, DIRECTOR, JEFFERSON AREA BOARD FOR AGING

Mr. WALKER. Good morning, Senator, and distinguished guests. My name is Gordon Walker, Executive Director of Jefferson Area Board for Aging.

We greatly appreciate your visit to Charlottesville and the time you have set aside to learn more about the services and needs of a growing elderly population.

Established in 1975, JABA has provided a wide range of life-sustaining services to the elderly and their family caregivers. Our service area includes Charlottesville and the counties of Albemarle, Greene, Fluvanna, Nelson and Louisa.

In addition to delivering federally sponsored services such as meals, home care, transportation, and care management, we are also pleased to have initiated many model programs, as well. These programs focus intensely on avoiding costly institutional care and the resultant emotional and financial distress to families.

In our early years, JABA depended primarily on Federal funding through the Older Americans Act. In recent years, however, that funding has been reduced dramatically, by over $90,000, while demands for our services have risen sharply.

At the same time though, at every level of government, we are hearing a similar message, seek substantial support from nongovernment sources. Tapping community resources, public and private, in a variety of creative ways, JABA has been able to play a key role in helping thousands of elderly continue living in their

own homes with as much dignity and security as possible, for as long as possible.

These programs which could not exist without tremendous volunteer and financial support from individuals and corporations include:

COOLAID—fans and air conditioners are loaned to frail and handicapped persons who are endangered by summer heat. Cash gifts to this program make it possible to help pay increased electricity bills which many persons could not otherwise afford.

Home Safety—approximately 70,000 elderly persons a year die from falls in their homes and the cost of meeting their health care needs is in the billions. To mitigate this risk, an occupational therapist checks the home for safety factors. Necessary repairs and modifications are made, including access ramps, safety and medical equipment.

Adult day care provides skilled, therapeutic care in a daytime home-away-from-home for persons with Alzheimer's Disease and other impairments that require constant supervision. This program is crucial in avoiding inappropriate institutionalization or giving family caregivers respite to do shopping and other chores and in many cases, keep much needed jobs.

AWARE is an acronym for Assistance with Access to Resources for the Elderly. JABA is working with local businesses to provide information and consultation on aging matters to employees. This program helps employees cut down on diminished job productivity and on personal stress when family issues regarding care for the elderly arise.

Revenues generated through this program will help JABA supplement Federal funding and reach more of the elderly requiring meals and in-home care.

Heretofore, I have described an agency that addresses basic human needs in a resourceful and effective manner. In other words, a community system is in place to meet the ever-increasing demand to assist the elderly and support the family caregiving unit. What is missing, however, is adequate funding to help those who do not have it made in Virginia.

To illustrate this point, I will reference Medicaid's Community Based Waiver Program. Fortunately, Virginia has a very well run program, taking the lead to establish excellent standards of care and fiscal management. The lives of thousands of Virginians have been made better as a result of the waiver's personal care program.

Unfortunately, though, Virginia is quickly reaching a point where, depending on where you live, this program is becoming less and less an alternative to nursing home care. Why is this the case?

Provider reimbursements are too low. As a result, agencies are getting out of the business or are subsidizing the program with non-Medicaid funds. For example, in 1989, JABA had to use over $20,000 of Older Americans Act funds and fund-raising dollars to keep the program afloat.

Second, home care agencies cannot successfully compete with fast food restaurants for a shrinking work force, particularly in low unemployment areas such as the Charlottesville area. Low reimbursement rates translate into low wages for personal care aides.

Oftentimes an aide cannot be found and hence, a person ends up in a nursing home or worse yet, without any care at all. Failure to pay aides, the backbone of any home care system, a respectable wage or fringe benefits, feeds the cycle of poverty. They are likely to face the day when they will not have access to the quality of care they provide others day after day after day.

Third, in my opinion, the program has an emerging urban bias because rural areas lack adequate modes of transportation. Too frequently, we've been unable to place an aide with a person needing care because of the great distances that need to be traveled by old cars on windy, bumpy roads.

Furthermore, the cost of transportation in rural areas is too high for people to benefit from the new community-based program of adult day care services.

These tribulations are not limited to the Medicaid Program. Persons requiring hospice care and other forms of home care remain in hospitals or inappropriately go to nursing homes because nurses aides are unavailable or homes are unsuitable to deliver safe and sanitary care.

Service demands are outstripping available resources. JABA's waiting list of at-risk disadvantaged persons averages 100 or more persons with urgent need, whom we cannot reach because of inadequate funding.

It is not just the elderly who are at risk, but also the large number of family caregivers who valiantly work to meet the burdensome caretaking responsibilities of their spouse or parent.

It is not reasonable nor humane for this country of unsurpassed wealth and peace dividends to ask those needing care to wait for another year to roll around. That is a message they have heard before. Sure, they can wait, they have no choice, but let us not forget that they do so while living in an unsafe house, on an inadequate diet, or without essential health care.

JABA is not asking the Federal, State, or local government to meet this challenge alone. We will continue, though, to advocate for larger government appropriations just as we will take our message to businesses and individuals.

We believe government is in a financial position to offer hope and encouragement. Through no fault of their own, except for the fact that they are still alive, a growing number of people require assistance in the later years of their life.

Money spent now, in the long run, is a cost savings. JABA has shown that operating a home safety program can prevent serious and expensive injury due to a fall and that adult day care can defer and avoid costly institutionalization.

What is being requested of government is what we should ask of ourselves everyday—have our actions been of any use to persons unable to care for themselves?

I'm convinced that we rightfully consider ourselves to be virtuous. We have a similar duty to the unfortunate to be mindful that virtue without action is meaningless. To stem the tide of human suffering requires the active involvement of everyone interested in the welfare of older citizens.

Thank you.

[The prepared statement of Mr. Walker follows:]

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Senator WARNER. Thank you, Mr. Walker.

I note that JABA serves the Charlottesville community and five counties?

Mr. WALKER. Yes, sir.

Senator WARNER. You mentioned you can't reach some areas in those five counties? In other words, the term "serves five counties," connotes that you full serve the five counties, but in fact you might be, in your testimony, inferring that you're only partially able to serve the five counties. Can you help with that?

Mr. WALKER. That's true. We certainly advertise the fact that our services are available in that area. Unfortunately, what occurs all too often is that somebody requiring home care, be they on Medicaid or some other program, lives such a great distance from where you can locate a home care aide that the miles that would be traveled in order for a home care aide to get there are more expensive than the salary you pay the aide. So we are running into situations more and more frequently where you cannot find an aide in a rural area to provide the home care that is necessary to keep a person out of a nursing home.

What is even more unfortunate oftentimes is the fear of going into a nursing home on the part of some people is such that they refuse to go into a nursing home and they end up dying at home without proper care at all.

Senator WARNER. Tell us about the staff, the composition, the type of person that comes and how volunteerism is a part of it, wages—modest though they be—are part of it. Give us some idea of how you put together your staff and how large it is.

Mr. WALKER. The staff itself is 22 full-time classified employees and another 60 to 70 home care/personal care aides.

Senator WARNER. What sort of training should they have?

Mr. WALKER. The latter group receives at least 45 hours of training and are supervised by a nurse. Before anybody receives care from our agency, they receive a full, comprehensive, what we call a multifunctional assessment, meaning that you're looking at what their full requirements are.

Oftentimes, our concern is that people in hospitals may be assessed for what their physiological/psychological needs are, but may be sent home to an environment where you can't even provide home care. We think it is very critical that before you even provide care, that you check out the home and see if the home environment and the family is capable to provide the care that is required.

What I think is happening more and more—particularly, as I mentioned, in the Charlottesville, Northern Virginia, and other areas of the State—is you just don't have a large enough pool of workers to fill these semi-skilled or paraprofessional jobs, so people are going without care.

I think we really need to do something adequately to boost the reimbursement system so these aides can receive adequate reimbursement for the care they are providing. Most of them don't have any health insurance at all. When they need health care, they end up on the indigent care system that the University of Virginia Hospital makes available to them.

As I noted in my testimony, I think it's really unfortunate that they will work 30, 40 years of their lives providing health care and

then when they need it in their 70's or 80's, they probably won't be able to get it.

Senator WARNER. That's quite a dramatic revelation. If you had to list three priorities—one, two, three—what are they that you need to help to better perform your responsibilities and that of your organization?

Mr. WALKER. I'm sure you've never heard of money at the top of the list. [Laughter.]

Let me go beyond money. I think what's needed as well is a coordinated effort. I think you're going to hear about this more during your luncheon meeting today.

I believe we need the Federal, State, and local governments really sitting down and beginning to say, if we're going to offer alternatives to institutionalization, if we're really serious about this, we're going to have to finance those alternatives adequately. We can't just say we're going to throw people out of hospitals but we don't want to put them in nursing homes without adequately financing the community-based programs.

I am encouraged by some of the things that came out of the Pepper Commission. I think the catastrophic cost of providing care is the care in the home, adult day care and nursing home. We need to come up with some kind of reimbursement system for long-term health care.

Senator WARNER. That is a subject to which the Congress will be turning promptly. As you know, we repealed the previous legislation last year because of the concern among many that the costs were being allocated disproportionately to our society and now we've got to start over from point zero and restructure that.

I wonder if both Dr. Owen and yourself could comment a little bit. Supposing I were the operator of a nursing home and hearing about this hearing that we are holding, and the fact that we're trying to put more emphasis on home care, what is their reaction? Is it that we're trying to take business away from them or we're really trying to work in partnership with them to solve a growing problem which they simply don't have the facilities at present to meet? Perhaps at present they do, but in the projected future, they may not.

Dr. OWEN. I'd be very loath to speak for that group, Senator, because I really haven't heard them present their own point of view, so I can't even prescribe it secondhand.

I would guess that at the present time, they are overcrowded——

Senator WARNER. You know that from your personal physician calls, that they are overcrowded and overtaxed generally?

Dr. OWEN. Yes, and understaffed. Incidentally, my patients think the Day Care Center is a wonderful thing. There is a great concern among my patients as to finding the "best" nursing home for their loved one. Unfortunately, the best has a waiting lists of 2 to 3 years.

Mr. WALKER. I would just like to add we don't operate in a vacuum. In fact, we meet once every 2 months with local nursing home administrators and go over these problems. They are having similar problems as far as recruiting an adequate number of aides as well.

The thing that I think most people don't understand is that again, just as in the community-based care system, in a nursing home, it is really your nurses aides who are the people that spend the most time with patients. What's happening is you're getting nurses aides who are having to work two shifts, 16 hours a day. We have had cases of nurses aides who have ended up in a mental hospital broken down from the stress of trying to do two shifts. It is a very, very serious problem.

We know there is going to be a greater need for nursing home care. We feel we have a pretty good relationship with the local nursing homes to identify people who could be discharged to community-based alternatives, and I think as Dr. Owens indicated, there are days in this community and other communities of the State, where you cannot find a nursing home bed close by, so the person may end up 50 to 100 miles away which has them far away from family members, consequently he won't get the visits from family members the way that they should.

The demand for nursing home beds will continue to go up. I don't mean to say that we don't need nursing home beds, but I think the bottom line should be, we should provide care in the most cost effective and most health-promoting environment possible.

I think in too many cases people end up in nursing homes because community-based alternatives aren't adequately financed.

Senator WARNER. We have had a number of hearings in Washington on the subject of nursing home care. That industry in a very responsible way, I think, has come forward to state their case.

It was not possible to include today a panel to give their perspective because our focus essentially is on the growing need for expenditures and budget requirements in the area that you've covered.

Yes, Doctor?

Dr. OWEN. I just wanted to share a thought that occurs to me over and over again. We've been looking at graphs like these that Mr. Dickinson has prepared for 10 or 15 years. We all know that the problem is growing and growing and growing, and yet, by some strange governmental paradox, it's always the Medicare budget and the Social Security budget that is the biggest target for budget cuts.

Senator WARNER. We recognize that, Doctor.

Now, Mr. Holly, you've been very patient in waiting.

STATEMENT OF JOHN HOLLY, PRESIDENT, MARTHA JEFFERSON HOSPITAL, CHARLOTTESVILLE, VA

Mr. HOLLY. Thank you, Senator. I appreciate the opportunity to be with you today. My thanks to your staff, to Mr. Walker and his staff, and all those responsible for today's hearing, and a special thanks to you from the hospital industry for the support that you provide in key legislation and seeing that there is fiscally responsible support of the programs that are so important that we are discussing here today, and for having a very knowledgeable staff so that you can take those important positions before the Senate.

I'd like to share with you a little bit of why I speak with some interest and qualification in this area. I am the President and Chief Executive of Martha Jefferson Hospital, the local community not-for-profit hospital.

We also have, as part of that, a 60-bed home for adults with skilled care facilities. We have a very large home care program which we've talked about and will be talking more about today which includes certified home care services, private duty services and Lifelines, which is an emergency responder system that enables individuals to enjoy the freedom of home and not having to be institutionalized. We have HealthWorks programs which deal with educating those in terms of how they can better take care of themselves and hopefully avoid some of the cost of inpatient care and HealthSource which is a resource library of tapes, videos, and volunteers, many of them older citizens, to help people understand what they will be experiencing.

I have the distinction of being Chairman-elect of the American Hospital Association Governing Council for Aging and Long-term Care Services. I've served on the Council for 6 years and, as you know, we have a very strong interest in what's happening not just in the institutional side of care, but in the continuum of care services outside of the institution.

I am a member of the Virginia Hospital Association Board and serve as the Blue Ridge Regional Policy Council Chairman.

According to the American Hospital Association's statistics nationwide, older adults—which are defined as persons aged 65 and above—account for 34 percent of an average hospital's admissions, and, in our case, about 42 percent; 45 percent of inpatient days—in our case, almost 60 percent; and nearly 50 percent of revenues and we're approximately the same relationship.

The most telling statistic, however, is the percentage of write-offs or contractual allowances that we make for that institutional care. These are charges made, but not collected. For our recent fiscal year ending September 1989, we had over $5 million writeoffs as a community not-for-profit hospital or 26 percent of our charges represented.

This is most disturbing when you realize that we are one of the most cost effective providers in the Commonwealth of Virginia as reflected by the Cost Review Council reports. We are finding it more and more difficult to meet the needs of our aging population, inpatient and outpatient as a result of that.

This graph [1], of which you have a copy with the remarks, I think vividly displays the problem that we face in terms of the amount of money that is being uncompensated on the institutional size which is forcing people into an inadequate support system outside of the institution.

It is going to be an even greater challenge for all of us with the increasing numbers as reflected in the graphs that you've displayed and the limited resources, human resources, as we've been talking about here the last few minutes.

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[1] See p. 37.

I could spend my entire time talking about the reimbursement system problems, but that's really not why we're here and I'd like to talk about some of the positive things that are happening. We are fortunate to have the University, to have JABA and to have other public institutions and private who are responding to the needs. I'd like to share some of the things that we are able to do as a community hospital.

Older adults' hospital care needs are different than younger persons, as we all know. There is a multiplicity, complexity, and general chronic care requirement that's different. Traditionally, hospitals have been oriented toward acute care with emphasis on inpatient care, specialization and maximum use of high technology—all of that very expensive.

In contrast, the optimum system for seniors would be a comprehensive and integrated system of care that recognizes the chronicity of illness and strives for that functional independence that we have heard earlier testimony on.

There has to be a cost-effective balancing of the patient's need for care with our limited resources, both institutionally, governmentally and private.

At Martha Jefferson Hospital, we consider ourselves an innovative health care provider that due to our community support systems, has been able to take numerous steps to provide for quality patient care and caring services in a more cost effective manner.

Our institution's mission is to provide for the healthcare services of those in our community. We serve a five-county area similar to what JABA said. Charlottesville is a hub of the surrounding counties. We have very broad-based inpatient/outpatient programs with outpatient obviously being the more cost effective to deal with seniors' needs.

Having a physician, as Dr. Owen has testified, is probably the most critical because physicians are oriented not to institutionalization, but to meeting the needs of the patient outside of an institution and only using an institution and its resources when necessary. We have a very strong and increasingly strong physician referral service which attempts to match an individual with a private physician to accomplish that need.

A well informed senior is better able to avoid more costly care needs many times. We have extensive education programs with free lectures monthly, both through our 70 Medical Minutes program where we have physicians speaking on topics to the public and we have other professionals talking about areas of interest and need to individuals in this regard. We also have cosponsored Seniors Health Awareness Days at local churches.

We have the HealthSource resource library that I referenced before which, by the way, needs more support if there are those who have materials that would be beneficial there, to enable people to better understand what they can do to help themselves and what some of our needs are as a community in meeting the needs of older adults. We have an extensive home care program which I won't go into, but I have information for you and your staff in this regard.

One of the most important things that an institution can do, both for the inpatient and outpatient is to be certain that we optimally

use the resources at hand. We have established a Physician Resource Management Committee which I would encourage other institutions to consider establishing.

We have physicians, many of them graduates of our fine local university, who sit down and help us understand how can we optimally meet that patient's needs. There many advances in technology and drug therapies and the like which can reduce one's hospitalization which can aid in the recovery. These individuals sit down monthly and look at a multiplicity of opportunities in this regard.

Senator WARNER. That is most important.

Mr. HOLLY. Indeed, it is. In fact, we can document——

Senator WARNER. So you're teaching people how to do it for themselves, so to speak?

Mr. HOLLY. Absolutely. We can document savings to the patient of over 300 percent in terms of what it might be otherwise.

We started, at the request of those in the community, what we call a billing assistance program. As any of us know who have ever tried to file insurance, this is an extremely complex issue, particularly for seniors who have to deal with Medicare and supplemental insurance. Literally, people will bring the shoe box of bills, they'll come in with great anxiety, and we can assist in that regard to help them get the proper reimbursement for their care and have the proper resources so they can go out and more optimally provide for themselves.

Another very important program that I mentioned, and I'll just comment on briefly in the interest of time, is HealthWorks where there is health promotion, wellness activities, supervised instruction on nutrition, and exercise — two of the most important things we can do to avoid and to minimize the adverse effects that would result in one's institutionalization.

We have the capacity to expand, but we don't have the support to expand. Our system, as we referenced earlier today, is based on one that is not adjusted to the times and the times are extremely outpatient- or ambulatory-oriented, but we are still focused, in large part, on the institutional compensation system.

I think Congress has taken very progressive steps in recognizing a change in the physician reimbursement system and that is going to encourage more of the primary care emphasis and support which will help individuals most.

Community screenings, cholesterol and blood pressure checks, all of those things are important and we encourage people to take advantage of those free offerings of things which will help them identify problems early on, go to their private physician, and avoid the more costly aspects of institutional care.

One of the things that we are very excited about that I would strongly encourage as we consider the Older Americans Act in the year ahead is that we should fund more heavily programs like JABA. It has made a tremendous difference in this community. It has negated the necessity for institutions to do a lot of this. It has worked with our community institutions in accomplishing a lot of this.

We are having a new program which we are calling a "Brown Bag Series" where the Jefferson Area Board for Aging will be sending staff over and educating our staff on the use of community re-

sources to expand options for the elderly. That is very important because, as acute caregivers, we see an episodic exposure to the patient and our people are very empathetic, are known for their care of the individual, but only see them in that acute setting.

This will help us understand their needs outside that setting and will help us to insure that we're doing everything we can to properly educate them to avoid their return to the institution. It will also probably get us some volunteers to go out there and help the other side of the system because these people are in health care because they care about the patient.

I'll conclude with saying what I think some of the opportunities are and that I hope the Senate, through your leadership, will have an opportunity to consider.

There is a need for more Federal and State support of the right programs and services. Examples are JABA, and programs at the University that we are working in cooperative relationship with. They started a Biomedical Ethics program and ethics is an issue we are all going to deal with as we look at that average age of individuals and the ability we have to care for people.

In coordination with that, we are able to educate a large number of people about how we can support the individual, the family, the caregivers, so that we won't face a greater crisis with this in the years ahead.

The University has a fine Geriatrics program which could, should and will, I expect, expand in its application in our local community in terms of a unique model that we can set for the Nation.

There needs to be provision of adequate resources which, again, thankfully you voted in support of this recently in terms of money to train people. We lost some of that training money in the recent past. It's back now; it's made a difference. The nursing schools have people in them. We have opportunity for nursing assistants and I couldn't agree more, the critical caregivers are all the way up the spectrum, the home care aides, the most dramatic and where we have the greatest needs, but we have that need with nurses and other care professionals as well, so the support for those people being trained is important to us all.

Excess capacity is something we hear a lot about, and I'm sure you've heard too much about it more than likely, but there are opportunities there. I think we need to look at creative ways to deal with the supposed excess capacity in institutions and not having to go out and build new long-term care facilities, but rather, utilize facilities which have the ability to be converted and where we might be able to accomplish some of the day care needs and accomplish some of the weekend caregiver relief needs noted earlier.

These all cost money to accomplish, so we need to find some models and try some of those programs.

Liability concern is one that we have not mentioned today, but I think it is critical. It forces a lot of people out of medicine, it forces a lot of unnecessary medicine and forces real problems for the individual in terms of where they receive care and how do we deliver that.

We are fortunate in the Commonwealth that our General Assembly has been progressive. They have taken actions which have lim-

ited that liability and I hope that we will see more of that action at the Federal level as well.

In closing, we hear a lot about how bad our system is. I think today we've head a lot of examples of how good it is, how much better it could be, and I am confident it will be.

Thank you for the opportunity to comment.

[The prepared statement of Mr. Holly follows:]

COMMENTS BY JOHN HOLLY AT SENATOR WARNER'S HEARING APRIL 11, 1990

"Aging - Community Based Care for Older Virginians"

I. Acknowledgments

- o Thanks to Senator Warner, his staff and others responsible for today's hearing on this most important subject to us all.
- o Special thanks to Senator Warner for his clear support of the needs of the elderly including his voting on key legislation to retain the fiscal integrity of the Medicare program and having such a knowledgeable staff on the issues.

II. Qualifications

I consider it a privilege to be before this group today and would like to share with you my relevant "qualifications".

President and Chief Executive of Martha Jefferson Hospital

- 221-bed not-for-profit acute care local community hospital
- 60-bed Home for Adults with skilled care facility known as Martha Jefferson House and Infirmary
- MJH Home Care providing Certified homecare services, private duty services and Lifelines - emergency responder system
- MJH Healthworks providing wellness and preventive care via classes and health screenings
- MJH HealthSource a community education resource library

- o Chairman Elect of the American Hospital Association Governing Council for Aging and Long-Term Care having served 6 years on this body
- o Member of the Virginia Hospital Association Board serving as the Blue Ridge Regional Policy Council Chairman

REMARKS FOR SENATOR WARNER PUBLIC HEARING

According to AHA statistics nationwide, older adults..persons age 65 and above..account for 34% of the average hospitals' admissions (42% at Martha Jefferson Hospital,) 45% inpatient days (59% days Martha Jefferson Hospital,) and nearly 50% of revenues (47% of Martha Jefferson revenues.) The most telling statistic is the percentage of write-offs or contractual allowances for charges made, but not collected from Medicare. For the

fiscal year just ended September 30, 1989, this was $5,012,299 or 26% of Medicare charges. This is most disturbing when one realizes Martha Jefferson Hospital is recognized regionally and on a statewide basis for its highly cost effective quality patient care services. We are finding it more and more difficult to meet the needs of our aging population with such a declining compensation for the services as reflected in this graph.

It is going to be an even greater challenge for us all with the increasing numbers and decreasing resources, financial and human. The impact of the growing numbers of older adults on hospitals and other healthcare providers will be dramatic! I will provide for the Senator's staff some key AHA summaries in this regard, as well as an excellent resource prepared by the Aging & Long Term Care Governing Council.

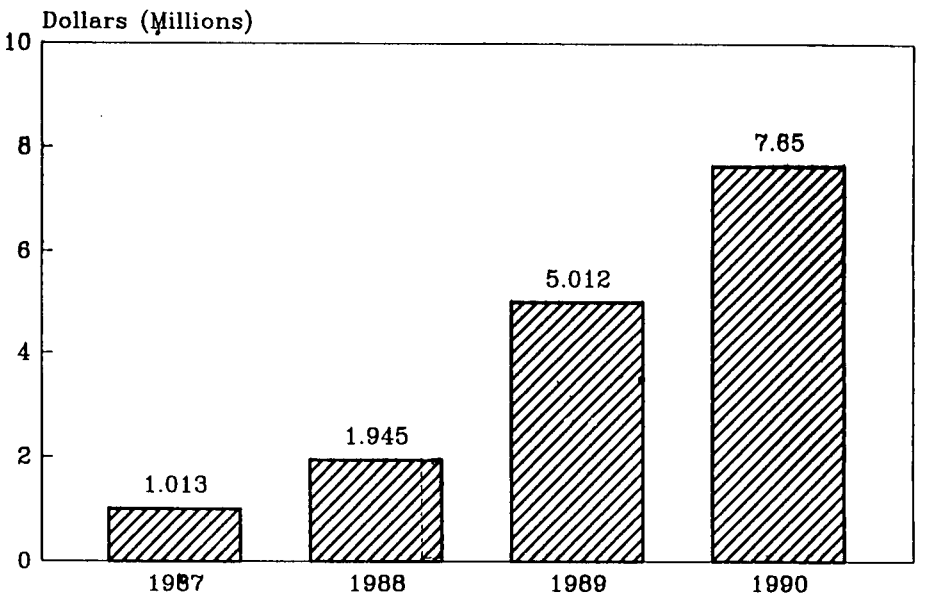
My entire time could be spent on the problems with our reimbursement system, but I'm certain that you are well apprised of these. I'll devote the rest of my remarks to our local services and how they might help serve as a model for other communities.

Older adults' hospital care needs are different than younger persons as evidenced by their multiplicity, complexity and general chronic care requirements. Traditionally, hospitals have been oriented toward acute care with an emphasis on inpatient care, specialization and maximum use of high technology. In contrast, the optimum system for seniors would be a comprehensive and integrated system of care that recognizes the chronicity of illness and strives for functional independence. There must be cost effective balancing of the patient's need for care with our limited financial resources, both institutionally, governmentally and private. At Martha Jefferson Hospital, we consider ourselves an innovative healthcare provider that has taken numerous steps to assure that high quality care is provided in the most effective manner. I'd like to share some examples of this.

Our institution's primary mission is to provide for the provision of quality healthcare services to our community. This takes the form of a very broad base of inpatient and outpatient service programs. The most cost effective way for seniors to receive care is to have a personal physician. We strive to assist this through our Physician Referral Service and outreach programs.

MARTHA JEFFERSON HOSPITAL

Medicare Losses



Contractual Write–offs

A well informed senior is better able to avoid the more costly care needs. We have an extensive education program with free lectures monthly through our 70 Medical Minutes and WomenCare public education programs. We also have cosponsored Seniors Health Awareness Days at local churches via the Senior Center. We also have HealthSource, a resource library where videotapes, journals, and other publications are available for patients to use to assist them in better understanding their care requirements. We also have an extensive HomeCare program that provides a broad array of services, but which is experiencing significant difficulty in obtaining adequate staff and being compensated so that we can offer these services in a less costly setting than a hospital or nursing home.

One of the other important things that our hospital does that others should consider is having a Physician Resource Management Committee which works closely with our Medical Staff through hospital professionals in identifying how we can most cost effectively provide our patient care services. An example of savings that were reported recently in changing antibiotic usage resulted in savings to patients of 300%.

A recent program addition at the request of seniors is "Billing Assistance." This was in response to the extreme complexity of seniors or anyone trying to deal with our Medicare and private insurance reimbursement system. We now provide this service so one can "bring in the shoe box" of bills and be relieved of the anxieties of accounts due and take full advantage of insurance.

One of our most important program offerings is MJH HealthWorks. Individuals can take part in health promotion and wellness activities including supervised instruction on nutrition and exercise. We are expanding our capacity to deal with this through addition of staff and facilities, again which is not being adequately reimbursed since heretofore its direct return has not been as measurable as a test or a surgical procedure. In addition, we have responded to one of the large identified community needs through the annual sponsorship of health screenings including cholesterol testing and blood pressure checks.

A new educational program that we are coordinating with the Jefferson Area Board of Aging is our "Brown Bag Series" where we will have programs offered at the hospital open to all employees on "Use of community resources to expand options for the elderly." This is being offered as part of our efforts to expand our staff's interest and support of such community programs and needs. This also will assist us in assuring that

our staff fully appreciates the total care requirements of an individual and not just that which they see on an episodic short-term basis as an inpatient or as an outpatient.

OPPORTUNITIES AND CONCERNS:

- More Federal and State support should be given to promoting cooperative arrangements between public and community providers - The Robert Wood Johnson Foundation model but with more support coordinated through existing resources, i.e., a geriatric program facilitation through the University of Virginia, JABA, Senior Center, Martha Jefferson Hospital and others as appropriate. We have a model for this now with the University of Virginia Biomedical Ethics program which has enabled us to significantly improve our understanding of this important, yet extremely complex aspect of service provision which dramatically impacts older adults.
- Provision of adequate resources in order to assure that we have capable care givers including nursing assistants, nursing and physician professionals and all associated ancillary personnel. Alternatives exist today for those who traditionally went into healthcare. We are just at the beginning of a major personnel shortage. Adequate funding for training and adequate funding for services provided is essential.
- Recognition of the value of converting the "excess capacity"which we always hear about in hospitals to meet the intermediate and skilled care needs of patients. There is little need to build additional new nursing homes if we are allowed to utilize existing facilities without restrictive regulatory and legislative conditions and inadequate reimbursement.
- Addressing liability concerns via Tort Reform since there is more than adequate documentation on the positive impacts of limitations as enacted by our Virginia General Assembly.
- In closing, we have a great healthcare system that is in transition. There are problems, but also successes. The answer is not in converting to another nation's healthcare system, i.e., Canada because we are dramatically different. I'll also leave with the Senator's staff articles in this regard.

- Thank you for listening and responding.

Additional Material submitted for Record by Mr. John D. Holly :
(Reference Page Two, Prepared Testimony, April 11, 1990)

The Long-Term Care Dilemma

1) **It is critical to take a stance on the long-term care issue. Why?**

   a. The Demographic Imperative

      Over the next 40 years, the population over age 85 will increase fourfold therefore, the need for long-term care services will be great.

   b. It is the Wave of the Future

      Hospitals are in the long-term care business now and more will be involved in long-term care in the future.

      Approximately 1,300 hospitals or 1/4 of AHA member hospitals provide SNF or ICF care; 30% of hospitals provide home health services; 932 hospitals provide respite care; and 422 hospitals provide adult day care. More and more hospitals are diversifying. Those who will not be directly providing long-term care services in the future will have developed relationships with long-term care providers in order to ensure continuity of care and timely discharge.

2) **The Current Long-Term Care System Is Totally Unacceptable**

   a. Unlike acute care, the burden for long-term care falls heavily on persons unlucky enough to need extensive long-term care and on their families.

      - Most long-term care, approximately 70%, is provided by informal caregivers – family and friends of the elderly. This care is being severely threatened due to increases in the proportion of women working, the divorce rate, the mobility of the populations as well as the decrease in family size.

      - The cost of nursing home care is approximately $25,000 per year. 51% of this cost comes from out of pocket expenses borne by the elderly themselves.

      - In addition to the financial cost, the emotional cost of not remaining in the home for those institutionalized is immense.

      - Medicaid, available to those who impoverish themselves, pays 48% of the national nursing home cost.

      - The cost of relying upon Medicaid, not quantifiable, are tremendous. The major cost is associated with loss of dignity and impoverishment. In 1988, individuals were not eligible for Medicaid if they had more than $1,900 in assets, not counting the value of the home. In some cases, Medicaid eligibility rules leave the spouse impoverished as well.

   b. Public costs are great

      Approximately 75% of Medicaid expenditures are used to finance long-term care. Poor families with children now compete with the disabled for limited Medicaid funding.

   c. The dependence on out-of-pocket spending and Medicaid for long-term care financing perpetuates a two-class system of long-term care, especially with respect to nursing home care. This exacerbates concern about quality of care.

   d. Access is limited – waiting lists for nursing homes is common since Medicaid patients and those who need high tech care have difficulty accessing the care they need.

   e. Form follows financing. Financing is more available for nursing home care then home care or other types of community-based services, therefore these services are limited in supply. Despite the strong preference of the elderly to remain in their own homes as long as possible, only 25 percent of the disabled elderly receive any paid in-home services.

   f. The current long-term care system is a mess. It is highly fragmented, each program has its own eligibility requirements, benefit coverage, provider regulations, administrative structure and service delivery mechanisms. It is almost impossible for even those most knowledgeable about health care, i.e. health care professionals, to locate the care we need for our family and friends and to attempt to ensure it is coordinated. Those less knowledgeable about health care are at a complete loss.

3) **Legislation in Long-Term Care Must Move in 1990.**

In 1990, the Pepper Commission and and the Advisory Council on Social Security will issue reports on long-term care. Other major players who are drafting major health policy proposals include the Washington Business Group, the National Association of Manufacturers and the ALF-CIO. A detailed bill addressing the long-term care issue is critical.

THE LONG-TERM CARE SYSTEM

An Overview

The long-term care industry is in a state of flux—at a time when the population in need of long-term care services is increasing at a tremendous rate. This turmoil will affect us all—as most of us will either need long-term care services or will be caring for or affected by those who are chronically ill. Action is needed now to eliminate the fragmentation of the system and to minimize the burdens borne by the chronically ill and their caregivers by bolstering the system of services that can support the sustained provision of care.

The long-term care industry is experiencing turbulent times for a number of reasons. Most obvious is the demographic shift toward an older population. In 1900, 4% of the population was age 65 or over. Currently about 12.7% of the population is over the age of 65. By the year 2030, 65 million people will be over age 65—representing 21% of the total population. Moreover, the fastest growing segment of this population is the group over age 85; these are the people who suffer the highest incidence of chronic disabling disease, and who will increasingly require long-term care and supportive services. Because of this growth, long-term care units and facilities, as well as non-institutional settings such as adult day care centers, are being increasingly burdened.

Long-term care providers are caught in a struggle between trying to comply with significant changes in regulations while facing inadequate reimbursement rates. Furthermore, there are few alternative financing options for the chronically ill and elderly to access in paying for long-term care (both institutional care and community-based services); making costs associated with long term care services a burden borne predominately by those who need the services and their caregivers.

General Recommendations

Long-term care services must be both accessible and available to all those who need such care. This means that consumers must be able to locate and receive the services they need and providers must be able to provide effective, high-quality services to meet these needs. These goals will only be attained by concerted efforts from both private and public sectors.

Benefit Problems

Long-term care is not just a nursing home issue. At a given time, only 5% of Americans are in a nursing home. For every 1 person 65 years and older living in a nursing home, there are nearly 4 people living in the community requiring some form of long-term care. Thus, long-term care encompasses a wide array of services offered in a variety of settings by an number of organizations. These services could be institutionally-based, such as skilled nursing home care, or they could be community-based, such as adult day care services, homemaker and personal chore services, home-delivered meal services, and respite care.

Hospitals, as well as other providers, are affected by the demographic changes and the increase in need for chronic care and supportive services. Hospitals involvement in the provision of long-term care services has increased over the last few years. In 1987, 1,042 hospitals provided skilled nursing facility care, 598 hospitals provided other institutional long-term care services, 724 hospitals provided respite care services, and 372 hospitals provided adult day care services.

The financing options available to older Americans to fund long-term care services are few, and those that exist are often inadequate—leaving gaps in coverage. When a chronic illness causes deterioration to the point of requiring long-term care services, most older Americans find that the long-term care services they need are not covered by Medicare, nor by other public programs or private "Medigap" insurance. These older individuals and their families discover for the first time that long-term care services are hard to find, and when they do find the services, they are often forced to pay large out-of-pocket costs for such care. When nursing home care is required, many elderly individuals "spend-down" to the poverty level, impoverishing themselves to the point of being eligible for Medicaid assistance.

Medicare expenditures for long-term care generally have been small; in fiscal year 1985, Medicare's contribution to nursing home care was less than 2% of total public and private spending for such care. Medicare, designed to address acute care needs, covers some skilled nursing care, for a limited number of days, and home health care for patients that meet certain criteria. Medicare payments for home health care was only 25% of total spending on home health care in 1985.

Medicaid, developed to provide assistance to certain low income persons, has become the primary source of public funds for long-term care. Medicaid pays 48% of the nation's nursing home costs. Medicaid also covers limited community-based services for certain eligible elderly individuals.

Private long-term care insurance, which covers intermediate and lower levels of nursing home care and some alternative services, has grown in the past few years. Whereas there were only about 12 companies offering long-term care insurance five years ago, today there are over 100 companies selling this product. While the current generation of policies still do not cover some long-term care services, the coverage is better than what has traditionally been available through private and public sector financing.

In addition, though the cost of premiums for long-term care insurance may seem high, it is expected to decline as more people purchase the insurance, and at a younger age (e.g. age 55). Premium costs reflect the fact that the majority of policies are currently purchased by retirees rather than a younger cohort, and by individuals rather than through groups. Policies sold to a younger population, to those who are at a reduced risk of imminent need for long-term care, would cost less than current policies and would eventually lower the cost for all long-term care insurance. Similarly, group policies would spread the risk among many people, and would result in lower premiums.

Unfortunately, while the need for long-term care insurance is great, many older adults are still unaware of the fact that Medicare does not cover long-term care services or that Medicaid, which covers some long-term care services, can be accessed only through depleting assets to the poverty level. Therefore, many individuals do not investigate private long-term care insurance options.

Currently most of the costs of long-term care are being borne by the elderly themselves and their families. Out-of-pocket payment for nursing home care by the elderly and their families represents nearly 50% of all payment made for this care. In addition, of the non-institutionalized elderly, more than 70% rely exclusively on unpaid sources of care (i.e. family and friends). Children of elderly parents represent the largest single source of care, with daughters and daughters-in-law being the most likely family member providing this care.

Recommendations Concerning Benefits

The responsibility for financing long-term care services should be shared by both the private and public sectors. Public policy should encourage individuals, to the extent that they are able, to provide for their own long-term care. But out-of-pocket costs must be sensitive to variations in ability to pay.

Any comprehensive private or public sector insurance package should attempt to cover a wide spectrum of long-term care services, both institutional and non-institutional in nature. Such packages should also support the provision of informal long-term care services by family and friends and encourage, where possible, the use of less costly services. The development of financing alternatives must be coupled with education on the potential need for and costs associated with long-term care and the coverage available through private and public financing mechanisms.

Senator WARNER. Thank you very much. It's been a very helpful contribution.

I think we will all now take a 3 to 5 minute stretch and then proceed with our last panel.

[Recess.]

Senator WARNER. We will proceed with our last panel. We are very grateful to Governor Wilder and his Administration for coming forth today with our first witness, the Honorable Howard M. Cullum, Secretary of Health and Human Resources, Commonwealth of Virginia. Second, we have Mrs. Thelma Bland, Commissioner on Aging, Department for the Aging; and third, Mr. Bruce Kozlowski, Director, Department of Medical Assistance Services, Commonwealth of Virginia.

We thank you for joining us today and we thank the Governor for his interest in these programs.

STATEMENT OF HON. HOWARD M. CULLUM, SECRETARY OF HEALTH AND HUMAN RESOURCES, COMMONWEALTH OF VIRGINIA

Mr. CULLUM. Thank you, Senator Warner. I'd like to thank you, your staff and Mr. Walker and his staff for the arrangements today and giving us the opportunity to provide comments on behalf of the Commonwealth.

For me, it is an honor to serve in Governor Wilder's Cabinet as Secretary of Health and Human Resources, and the aging program is one of many that is in the secretariat, as you know.

First of all, just to cover services for older Virginians, I'll speak first about the philosophy that we have had and I think the AAA have had in State government—to serve elderly Virginians in their own communities and in their own homes; to be able to assist family caregivers as a priority.

It has become evident already in the hearing today that assistance to the family caregiver is going to be an essential component, hopefully, of reauthorization.

Senator WARNER. Would you concur in my observation and that of the witnesses that it is more cost effective?

Mr. CULLUM. Yes, sir.

Senator WARNER. In other words, as we see a growing shortage of funds, we are trying to apply those funds where they can, in turn, provide the greatest care for the greatest number of individuals, and given the limited number of dollars, if we can spread them over—to the extent we can—the home care concept, we reach more persons?

Mr. CULLUM. Yes, sir. That is pretty widely agreed on, I think, as the approach that ought to occur.

Senator WARNER. So from the standpoint of the Commonwealth of Virginia, the Governor and his budget, I think he would likewise favor emphasis, as you said just now, being placed on this plan?

Mr. CULLUM. Right, that has been the direction from the Administration, the previous Administration and also the General Assembly, to move in the community care approach which Ms. Bland and Mr. Kozlowski will speak to.

To talk about the service system, it is a partnership of State and local public agencies with the voluntary, nonprofit community and the private sectors. Services to the elderly are multiagency and public/private partnerships.

Funding, the realities of money, as you hear all the time in Washington, is a combination of Federal, State and local funds with private pay, donated funds and insurance. I think that the Federal Government, which is frequently criticized for not doing enough in a lot of areas or too much in some, a lot of times there is not adequate representation or recognition that the Federal Medicare money, health care, the match for Medicaid, the Social Security, a lot of the housing programs, shows there already is a tremendous heavy Federal investment for the elderly above and beyond the Older Americans Act.

Somehow, when you focus just on that one act and that piece of money, you get a distorted view of what the commitment has been. I think there has been a significant Federal commitment.

The major Virginia agencies serving the aging—Social Services, mental health assistance services, also housing development, the Governor's Employment and Training Department are the types of major agencies that provide the services or financing and set policy at the State level. At the local level, you have the AAA's, the area agencies on aging and local social services, the community services board, local health, local housing, and it is a state/local partnership as far as the service delivery.

A couple of the Virginia highlights, the service has been in home-services. As spoken to today, there has been a growing movement in support for the adult day care that I think we are going to see more of where the caretaker of the past is going to be working and unable to, in a lot of cases, economically leave in many cases, years and years of employment and service and critical income to be able to stay home and support someone, even if that is desirable.

I think the development of adult day care is going to continue. There has been mention here of respite care. Already we've put in $1 million of new money for respite care projects through the local health departments focused on the elderly and especially persons with Alzheimer's. There are respite programs around the State run by a variety of agencies and it has been, I think for the actual family caregiver, one of the key ingredients to be able to withstand the strain of months and months, and in some cases, years of hands-on service.

Next is nursing home care. There has been some discussion of nursing home care. Virginia has over 25,000 beds. There are 2,500 beds opened in the last year or so and there are 2,000 more beds still to come on-line. Even though we support the folks in community care, there are a large number of nursing home beds. I think the Commonwealth spends over $330 million of State and Federal money a year which is 50/50 Federal and State for that nursing home care.

From a State budget perspective——

Senator WARNER. That $330, is that the State's contribution or the combined contribution?

Mr. CULLUM. That's the combined.

Senator WARNER. Combined contribution.

Mr. CULLUM. So that is split in half. There is a significant amount of money that already is in the nursing home industry.

Next is general medical care. I think what you've heard about in Medicare and some of the things that happen, a tremendous need for health care for the elderly and there are some significant projects such as what Dr. Owen mentioned and other persons to deal with that general medical care.

Unfortunately, we have many areas in the Commonwealth where there is a significant lack of primary care providers so that people end up in the hospital. That is one area at which we are looking at the State level in the sense of more scholarships and other programs that were, in fact, added by the Legislature to the budget to deal with developing more physicians, especially family practice physicians in the future. We are putting significant money into transportation.

The State does operate five geriatric centers on the grounds of State mental hospitals. We have around 800 elderly persons in there who need psychiatric care in addition to other health needs.

There have been Alzheimer's projects at some of the State hospitals and some of the communities.

Housing, I think one of the areas we've talked about is in-home, care and we've talked about nursing home. There also is in Virginia, as in all the States, some kind of board and care homes for elderly disabled. In Virginia there is over 22,000 beds in homes for adults, the label we give, and about 15,000 of those people are elderly. Many of them are getting more and more frail, went in the home in acceptable physical health and as they age out in place in that home for adult, are going to need some degree of support and care to minimize the placement into nursing homes if that is at all possible.

There are, obviously, through Title III of the Older Americans Act, nutrition centers. I think from a program perspective in Virginia and across the country, we know what the continuum service is for the elderly as far as in-home and support to the family and the nursing home and hospital care, when that is necessary.

I think there is pretty strong agreement on the continuum, we know those pieces and putting it together and managing it well in a cost-effective way and having adequate funds is always the issue.

One point on coordination, at the State level, we have the State Long Term Care Council which I, as Secretary, chair with nine State agencies. There are throughout Virginia local long-term care coordinating committees working to tie the various agencies together in the services that they have.

One final point on coordination and what's happened in Richmond. There is a Commission on Health Care for all Virginians which really is going to start its third year and they are looking at the uninsured in the way of health care and they are looking at long-term care.

The General Assembly put in $3 million in this biennium for case management projects so we can look at several models around the State of what is the best way to get contact, make the linkage and manage that variety of care that the elderly are going to need in the future.

Just an idea of money, the health and human resources piece that deals with health care, mental health care, a tremendous amount of which goes to the elderly, is about $3.5 billion of funds. We put, for instance, over $100 million, into indigent care at UVA, at MCV, for their uncompensated care that Mr. Holly mentioned. Obviously that is an increasing concern to the hospitals and the State to make sure the hospitals are viable.

One of the concerns we do have statewide is some of the rural area hospitals are having difficulty making ends meet, as financing policies change and some of them are on the brink of going under, according to recent cost information.

Just one final point is that the Department for Aging in fiscal year 1986, put in 7.5 percent of the funds that went from the State/Federal controlled money into the Virginia Department and the 25 local AAA's. For fiscal year 1990, that is now 25 percent State money because the Federal money has grown in real dollars only about $2 million over the last 5 years.

Hopefully part of the ultimate review of this is going to give serious consideration to adequate funding levels from the Federal perspective. The increase in this particular program averaging about 2-percent total a year has just not kept up with the growing demand you're seeing.

My last page here talks about future policy and funding issues. I think you heard eloquently from your staff and from others and are well aware of the demographics of this. It is labeled in many cases the "Demographic Time Bomb" of elderly people or people who are going to get old, especially the old old, the 80 and above. It is going to have a significant Social Security impact; it is going to impact on this whole service delivery system. If the AAA leadership believes they are strapped now, looking ahead 10 years, there is going to be a significant increase.

There is, as I mentioned earlier, going to be a significant change in the status of the caregivers. The caregivers are typically women. They are, in many cases, going to have tremendous pressure on them to care for that elderly relative in the future.

There also is going to be the issue, as we mentioned earlier, of long-term care, that private insurance capacity vis-a-vis public financing. One of the major areas is developing and financing expanded community capacity.

I think there is general agreement in the nursing home community that they support the growth of community care but everyone realizes there are some people, due to medical reasons and care reasons, who are going to need nursing home care.

The nursing home operator's concern is, as the years go on, it will be similar to the parallel we've had in the State mental hospitals the people left or the people going there have acute needs where they are going to be needing higher staff/patient ratios. They are not going to have easy people to deal with.

[The prepared statement of Mr. Cullum follows:]

Senate Special Committee on Aging

Field Hearing on

"Aging In Place: Community Based Care for Older Virginians"

Conducted by

The Honorable John W. Warner

Presentation by:

Howard M. Cullum

Secretary of Health and Human Resources

Commonwealth of Virginia

Commonwealth of Virginia

Services for Older Virginians

Philosophy:	Serve Elderly Virginians in Their Own Communities and In Their Own Homes; Assist Family Care Givers as a Priority.
Service System:	Partnership of State and Local Public Agencies with the Voluntary Non-Profit Community and Private Sectors.
Funding:	Combination of Federal, State and Local Tax Funds with Private Pay, Donated and Insurance Monies.

Public Sector:

Major Virginia Agencies	Local Governments
Aging	Area Agencies on Aging
Social Services	Local Social Services
Mental Health, Mental - Retardation and Substance Abuse Services	Community Services Boards
Health	Local Health Departments
Medical Assistance Services	----

Current Virginia Highlights:

- In-Home Services
- Adult Day Care
- Respite Care
- Nursing Home Care
- General Medical Care
- Transportation
- Mental Health Geriatric Centers
- Alzheimer's Projects
- Housing
- Nutrition Centers

Coordination

- State Long Term Care Council
- Local Long Term Care Coordinating Committees

- Commission on Health Care for All Virginians
  - -- Uninsured
  - -- Long Term Care

Future Policy and Funding Issues:

- Demographics
- Long Term Care
  - -- Private Insurance
  - -- Public Financing
- Developing and Financing Expanded Community Capacity
  - -- Family Support Services
- Family Responsibility
- Income Maintenance
- Health Care
- Housing
- Transportation
- Biomedical Technology and Medical Ethics
- Gerontology Research

Senator WARNER. That is a very important point that you raise on the assumption that the home care can handle a lot of the less serious cases, that means a greater percentage of the serious patients will be in the nursing facilities putting an added burden on their staff. I am glad you stressed that; I had not thought of that.

Mr. CULLUM. The term that is used is the acuity level, the care level of the people in the homes is going to be significantly higher 10 years from now because we will have screened out hopefully with a lot of good community programs.

There is an issue on family support services that really is a theme you are well aware of. What does it take to support the family? The reality of it is when someone says, if it's cheaper to do it in the community, why don't we just quickly do it?

The concern that everyone has at the Federal, State and local financing level is no one wants to do anything that is going to make a major change in the fact that most people try to care for people themselves at home. So to say everyone is going to be through publicly financed care, puts a price tag that neither the Federal Government or State government can deal with.

We want to be able to supplement and support the families without removing the current practice in most cases but the reality is many people are in situations that are untenable, they go on month after month in care.

There needs to be a revisiting of the issue of family responsibility, a reassessment of who will pay, looking at the Federal policy in Medicaid and others about what are the transfer of assets rules. If one lives long enough in a nursing home, most people will spend down and go onto Medicaid. What is going to be the future public policy about family responsibility in this country?

Income maintenance area, I think you know as a Senator, the issue of inadequate Social Security level and increase is something that is the hot button political issue every year. One of the major things that has to be remembered is the way that people can take best care of themselves is to have an adequate income to be able to buy the care.

Senator WARNER. On that point, I'd like to say that some of the proposals that have been put forward in the Congress this year talk about freezing the COLA's on Social Security, in other words, not allowing for an increase in these relatively small sums of money to keep pace with inflation.

This Senator has rejected out of hand any proposal which freezes those COLA's. Unfortunately, when we look at means to bring about greater balancing—I say greater balancing, we've yet to achieve any balancing of the Federal budget system, but always somehow someone steps up and wants to take away the COLA's on Social Security. Then there are also proposals to reduce the funding of Social Security.

I was in the Congress at a time when we had less than 60 days before Social Security was going to go bankrupt. Fortunately, we had a commission that came forward and worked out a formula, the Congress accepted that formula and now the Social Security system is strong.

I think we should have a minimum of a year's reserves of funding in that system before we even think about any adjustments in the amount of tax now on Social Security.

Mr. CULLUM. I think, Senator, everyone who deals with the elderly, the fact of adequate income, there is a major public policy decision that will have to be made of where future priorities will go as far as dollars to those who are less able to care for themselves.

Just the issue of health care, housing, transportation, I think that as mentioned by Mr. Walker and others, the critical link that transportation plays to have a service available.

Biomedical technology and medical ethics, which was mentioned before. There is a greater capacity and will be an increasing capacity from a medical perspective to care for people and the issue of quality of life is going to be raised in the next decade. Who is going to make those decisions, family care providers, medical profession.

The last point is gerontology research. Hopefully, there will be continued emphasis on research into the elderly. I think there has not been enough attention, as has been mentioned already, but the issue of human resource development, who are the staff that are going to be the caregivers, the professionals in the future as we look at those numbers that go up? It is going to take a planned effort.

In closing, I would like to thank you for the opportunity to share the State overview. We look for joint planning and we look at these priorities and we'd like to build on the private sector, community, church, and family and the volunteer commitment that has been there to serve the elderly.

We will provide you with formal input from the Commonwealth prior to the reauthorization as you proceed so that it is very clear what the Administration's perspective is. We do recognize the Federal budget constraints and the hard decisions ahead. I don't think we are Pollyannish about the difficult budget decisions that will have to be faced, not only at the Federal, but at the State level. We look forward to that partnership in the years ahead.

Thank you very much.

Senator WARNER. Mr. Secretary, Virginia is fortunate to have a person of your quality and background to step forward and offer themselves in public service and I'm glad that Virginians have received the reassurance—I don't think it was necessary—that the Wilder Administration will continue to build on the record of his predecessor in caring for the growing aging population in this State.

Mr. CULLUM. Thank you, Senator. We will look forward to working with you.

Senator WARNER. Now, Ms. Bland. I had the privilege of visiting with the U.S. Commissioner of Aging. I think she's a personal friend of yours. Am I correct on that?

Ms. BLAND. Dr. Berry, yes.

Senator WARNER. We are happy to have you here.

STATEMENT OF THELMA BLAND, COMMISSIONER ON AGING, COMMONWEALTH OF VIRGINIA

Ms. BLAND. Senator, first, let me thank you for the opportunity to present information to you on the vital needs of older Virginians. I am very pleased with the excellent job that the JABA staff has done in assisting you with setting up the hearing.

I feel totally obligated to comment and to note to you the number of older persons that we have present. I think it is important to recognize that they are here to speak for themselves about the needs that they have.

One of the things that I'd like to take a few minutes to do is to present some information on issues that we have discussed in the Virginia aging network relative to the reauthorization of the Older Americans Act.

As we have heard this morning, we have seen changing numbers of older persons and we also have a changing need. We have to continue to look at the need to increase our community-based services.

The Older Americans Act was authorized 25 years ago and naturally we need to look at some of the updates that we need to the Act. I'd just like to take a few minutes to point out some of those this morning.

Secretary Cullum has indicated that at some future time as we continue the process toward reauthorization of that Act, that Virginia will submit to you our formal recommendations for amendments to the Act.

One of the things I think we've heard this morning is the nature of the flexibility of the area agencies on aging to provide services to the people over aged 60. We have 25 such agencies throughout the State. One of the things we'd like to see done as the Act is reauthorized is that we reaffirm the original goal of that Act so that we will see some increasing funds provided to community-based services.

Mrs. Landford spoke about respite care services this morning. Certainly that is a big need. Right now, we have Titles of the Older Americans Act that specify we'll spend certain percentages on what we refer to as our nutrition program, our meals program, we also have a community-based services program, a home delivered meals program for those persons who are disabled and cannot visit the congregate site.

The thing we'd like to point out is that both programs are equally important and we need to continue to keep those healthy Virginians healthy, but we need to make sure that we provide priority services to those persons who are disabled and who are frail.

One of the things that we'd like to see considered as the Act is reauthorized is that the titles continue to be kept distinct so that we can have some flexibility from State to State in providing services in areas that are most needed.

Second, one of the things that has been mentioned this morning is the use of volunteers. We have a large number of older persons who volunteer themselves. We'd like to see some concern given to some specification in the Act regarding the use of senior volunteers, a so-called Senior Corps, a group of older persons who assist

the frail elderly themselves so that we can have more volunteer opportunities within our area agencies.

Senator WARNER. Could you be a bit more specific? I think that's a key part of this new authorization. How do we recognize those people? How do we compensate for them? As we say in the Congress of the United States, what perquisites of office should they be given for their services?

Ms. BLAND. Very high recognition. Volunteers don't want to be compensated for the services they give. They give it because most of them state that they get more out of it than the people they provide volunteer services to. However, they do need to be coordinated, there needs to be funds to get those volunteers where they need to be in the community, funds for transportation, those types of things, funds to coordinate. We have some existing senior volunteer opportunities through ACTION. There is some concern that those volunteer programs could be better coordinated through the Administration on Aging, through Dr. Berry's department, so that you don't have fragmentation and we can use those volunteers in a more coordinated manner.

Senator WARNER. I'm glad you raised that.

Ms. BLAND. We've heard continued evidence this morning that we need to have our Act introduce the concept of elder care. Everyone is very familiar when you say child day care, everyone knows exactly what that is. We now have a growing number of families providing care for their parents and we need to recognize that. The aging process does not just begin at age 60 and we need to integrate it with our other programs as we are currently doing in Virginia. So we need some mention in the Act about the whole concept of elder care.

Also, in the Act we added a new title in 1987, Title III-D, which recognized the fact that we do have a growing number of older persons who are frail, so we'd like to see some consideration given to keeping that title intact and looking at the need for some increase in those funds for the frail elderly.

There is also a need for us to look at cost sharing, the whole idea that our area agencies can provide services but in order to do so we may want to have the flexibility to look at having clients share in the costs of some of the services when they can afford to do so.

A lot of families don't know about resources available. If they can be put in touch with the resources, then they could afford to pay for the services, so first of all, identifying the resources, we need to be concerned about that.

That brings me to the last issue I'd like to mention briefly, the whole idea of the provision of direct services by our area agencies on aging. The Act does not prohibit it but it does not encourage it. As you've heard this morning, people in the community depend on many services. We may not have other agencies available to provide the services, so some flexibility there would be very helpful as the Act is reauthorized.

From there, I'd like to just take a few minutes to reemphasize the things that we've heard from some of our other presentors about the increased need for community-based services. I am very pleased that you have used our chart because it does show the dramatic increase that we have had in the older population.

For the Virginia Aging Network our community-based services consist of three main areas. We are dealing with the in-home services where we have the workers to go into the home and provide the services. Dr. Owen mentioned how much his patients like the adult day care center here in Charlottesville.

In the prepared presentation that I've given you, there is a chart that shows that in Virginia, we only have 33 such sites, such day care centers. Those 33 centers only serve some 834 persons, so one of our needs in the State is for——

Senator WARNER. What percentage do you think are cared for with the 33? Can you give us some idea of what's in place today and under ideal conditions, what should be in place? Is that a doubling of that number?

Ms. BLAND. Really most of our localities don't have it. It is a priority need throughout the State. We would be pleased to be able to increase by any percentage, it would be very helpful. Given the number that we now have, any increase would be helpful. Recognizing our funding limitations, we wouldn't be able to double, but we would like to at least increase what we have.

Senator WARNER. Thank you very much for your contribution.

Ms. BLAND. Thank you.

[The prepared statement of Mrs. Bland follows:]

PRIORITY SERVICES

FOR OLDER VIRGINIANS

A PRESENTATION TO
THE HONORABLE JOHN WARNER
U.S. SENATOR FROM VIRGINIA

APRIL 11, 1990

VIRGINIA DEPARTMENT FOR THE AGING
Thelma E. Bland
Commissioner

PRIORITY SERVICES FOR OLDER VIRGINIANS

- HOME BASED SERVICES
  Homemaker/Personal Care
  Home Care/Companion
  Adult Day Care
- HOME DELIVERED MEALS
- TRANSPORTATION

Thank you for the opportunity to present information on the most critical needs of Virginia's elderly. The priority services needed by Virginia's older persons , both now and in the next decade, are **in-home services, home-delivered meals and transportation.**

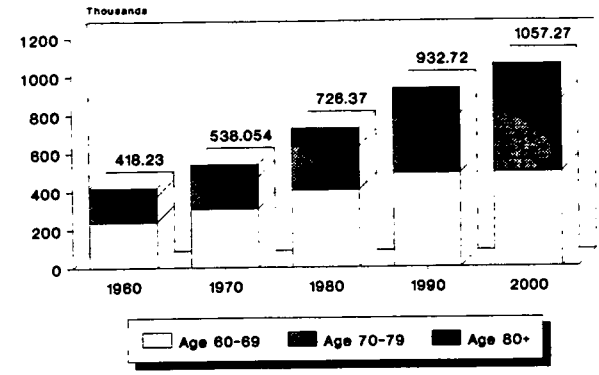
These community-based services are essential to older Virginians, to their families and to the Commonwealth. Community-based services allow older Virginians to remain independent in their own homes and communities for as long as possible.

The next chart shows the dramatic growth in the elderly population of Virginia in the last half of this century. We are fast approaching a time when there will be one million older Virginians.

The chart shows a 91% increase in the number of "old old" Virginians, those age 80 or over, between 1980 and 2000. Statistically, we know these individuals are the group most at risk of losing their independence and subsequently using more formal and expensive services from government and other sources.

Virginia's Elderly Population

A 91% rise in age 80+, 1980-2000



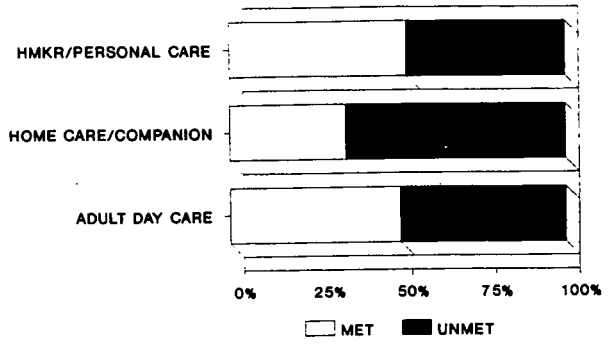
Source: VA Data Center

Community-based services are critical to preserving a desirable quality of life for older Virginians. Older persons prefer to remain in their own homes, to be as independent as possible, and to avoid unnecessary placement in nursing homes. Community-based services make this possible.

Community-based services are targeted both to those elderly without adequate family support and to those whose family members need respite from their caregiving. These services complement what family support is available. They supplement family help, but don't replace it.

Community-based services are usually "last resort" services, targeted to individuals who have few other resources to help themselves. The typical client is an older woman, living alone, on limited income but above the poverty line ($6,280 for one person). Many of the recipients of these services do not qualify for other government programs nor can they afford to pay for all the services they need.

SERVICES IN THE HOME
*Level of Assessed Unmet Need**



*Assessments by AAA case managers

In-home services are the most critical community-based services. In-home services include:

Homemaker/Personal Care Services -
supportive activities for older frail clients such as assistance with bathing, going to the bathroom, meal provision, housekeeping.

Home Care/Companion Services -
light housekeeping, meal preparation and errands for older dependent adults.

Adult Day Care Services -
regular daytime supervision and care for frail and at-risk older adults in a group setting.

We have documented needs from our Area Agencies on Aging for $5,447,808 per year to provide in-home services. This figure is not a projection. It

is based on people who have been assessed by a professional case manager as needing these services. It is the cost for serving older people who are now on waiting lists or receiving only a small portion of the services they need.The anticipated demand for in-home services during the 1990-92 biennium is more than 1.6 million hours of service.

The growth of the older population, coupled with recent changes in the federal Medicare program which required hospitals to discharge older patients earlier, has resulted in greater numbers of frail older Virginians needing more care at home. They are living in their homes but with chronic ailments and severe limitations in their abilities to carry out the basic activities of daily living.

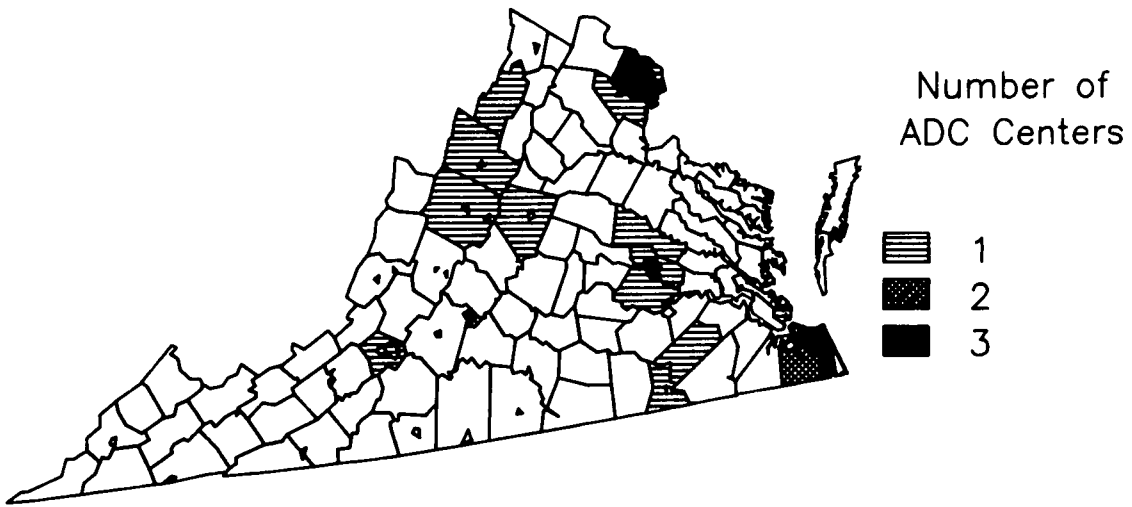
Many elderly, such as Alzheimer's victims, simply cannot live safely alone. But often their families are workers who cannot afford to give up a salary to stay at home. Adult day care is one answer and the need is growing rapidly. Yet there are only 33 adult day care centers in Virginia, able to serve 834 persons. The following map shows where these centers are located and how many are in each locality. Even the most populous urban areas have a short supply and most rural counties have none. West of Salem, there is no licensed adult day care at all.

The shortage of services for the homebound puts tremendous pressure on them and their families to accept institutionalization, but given a choice, most people would prefer to receive services in their home rather than move into a nursing home or other long-term care facility. National studies indicate that those individuals who are able to receive services in their own homes rate their quality of life higher than those who are institutionalized. Further, a study conducted by Virginia's Long-Term Care Council in 1985 found that **in most cases it was also less expensive for the taxpayer to provide services in the older person's home than to pay the state's share of Medicaid nursing home charges.**

The Department for the Aging and Virginia's Area Agencies on Aging support a coordinated and comprehensive system of long-term care. Improved in-home services form the foundation for such a system.

33 ADULT DAY CARE CENTERS IN VIRGINIA

Total Capacity of 834 Clients



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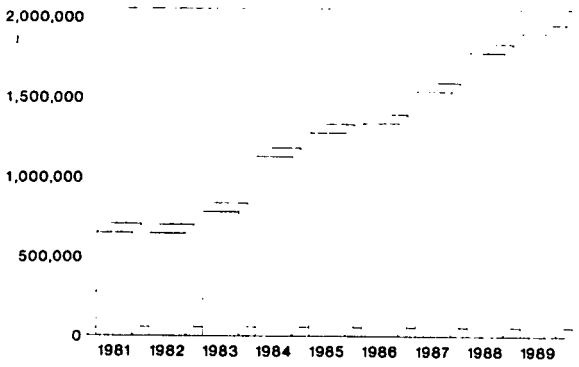
Home Delivered Meals Served
Increased by 300% in the 80's



Source: VDA

Home delivered meals clients are typically frail persons over the age of 70 who are homebound and who are physically and often financially unable to prepare adequate meals. They also lack the help of family and friends who could prepare their meals. We need, right now, $2,482,240 per year to provide home delivered meals to clients who have a documented need for the service. Our waiting lists for home delivered meals are long and growing.

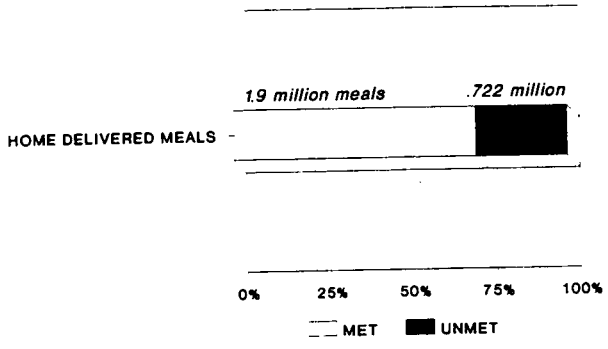
Home delivered meal programs are specifically designed to meet the following objectives:

o Assist with improving and maintaining the nutritional health of individuals recuperating from an acute illness or whose health has deteriorated due in part from poor nutritional intake;

o Provide a daytime check on the older person to insure their well being and safety; and

o Provide a supportive service which assists in promoting the continued personal independence of older Virginians.

HOME DELIVERED MEALS
*Level of Assessed Unmet Need**



*Assessments by AAA case managers

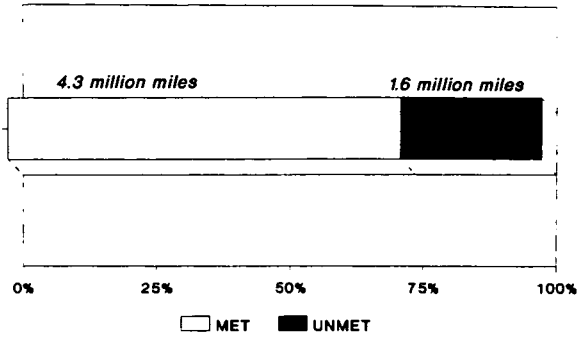
Eligibility for home delivered meals is determined only after a careful assessment of individual need and after other informal supports are exhausted. Home delivered meal programs operated through the state's Area Agencies on Aging are actively coordinated with similar community programs such as Meals on Wheels. Together these two programs attempt to meet the growing need for this service on the part of older Virginians.

The priority of home delivered meal programs has substantially increased over the past several years. This is due, in part, to the aging of our population, the spiraling costs of institutional care (primarily nursing home care) and increased efforts to maintain persons in the community as opposed to other levels of care.

Home delivered meals prevent a deterioration of nutritional status (malnutrition, induced dementia, etc.) on the part of the elderly and allow better access to needed services.

This service promotes the continued independence of older Virginians and assists their efforts in remaining in a community setting for as long as this is appropriate and possible.

TRANSPORTATION FOR THE ELDERLY
the link between seniors and services



Source: VDA

The third crucial community based service is **transportation**, provided largely to low and middle-income older Virginians. Many are frail and cannot drive. Public transportation is often their only way to get to needed health, social, and nutritional services.

Activities which younger people often take for granted - grocery shopping, visiting with friends, keeping a routine doctor's appointment, going to the coin laundry - are impossible for many older persons who cannot afford an automobile, can no longer operate an automobile, and do not live within walking distance of public transportation. Most areas of the Commonwealth have no public transportation system (see map). Transportation services are especially important to older persons in the rural areas of Virginia.

Without transportation to reach health services, the elderly may face deteriorating health which requires a higher level of care, often provided at state expense. Another major problem of the elderly is poor nutrition, which often results from their physical frailty, low income and isolation. Transportation provides a link to the meals, support, and services available at senior nutrition sites.

Virginia's 25 local Area Agencies on Aging are usually the key human services transportation provider in their area, providing nearly 5,000,000 miles of service. Transportation allows older persons to:

- **participate in senior center activities and attend community nutrition programs, where they receive a nutritious meal, learn about health promotion and wellness, gain access to needed services and benefits, and maintain a strong network of supportive friends.**

- **keep medical appointments with their physicians, and other health professionals, and to receive needed therapy and treatment such as dialysis.**

- **visit the grocery store and pharmacy.**

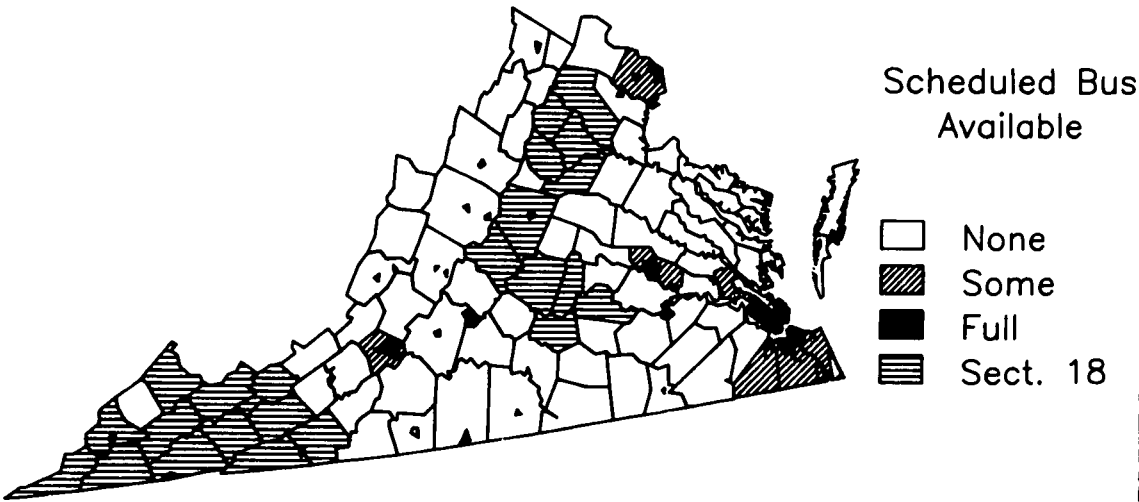
- **apply for social services and other public benefits.**

The Area Agencies have documented the need and demand for an additional 509,449 trips per year at a cost of $1,757,545. Many older Virginians are not able to see their physician, obtain needed medication or receive adequate nutrition without more transportation services.

In conclusion, I want re-emphasize that these are critical and essential services which are, in the long-run, a less expensive alternative to institutional care. Our Virginia Area Agencies on Aging are providing these services efficiently and effectively. The problem is a rapidly growing population of frail elderly and their need for help to finish out their lives in their own homes, with independence and dignity. The solution is not simply more money, but without additional funding, no solution will be effective.

PUBLIC BUS AVAILABILITY

Scheduled at least Daily; Commuter service excluded



STATEMENT OF BRUCE U. KOZLOWSKI, DIRECTOR, DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, COMMONWEALTH OF VIRGINIA

Mr. KOZLOWSKI. Senator, distinguished guests, I am Bruce Kozlowski, Director, Department of Medical Assistance Services. I am very pleased to have the opportunity to talk to you today about the Virginia Medical Assistance Program and the role it plays in providing services to the elderly and disabled.

Title 19, Medicaid, is a 50/50 funded program between the Federal Government and the Commonwealth. It provides services to about 360,000 of Virginia's poorest of the poor.

The Health Care Financing Administration, we frequently jest, makes 99 percent of the rules even though they provide only 50 percent of the funding; but it is a cooperative relationship and it has provided needed services throughout the Commonwealth.

Virginia spends about $1.3 billion a year on Medicaid and over 60 percent of that money is for elderly and disabled citizens.

I am here specifically today to talk about waivers. Waivers really are a complex request to the Secretary of Health and Human Services in Washington to allow us to waive Federal regulations so we can meet specific service needs of our client population.

Regrettably waivers can take 9 months to a year before they are approved. Frequently when they are approved, they are approved with restrictions as to the number of persons that can be served under the waiver, and that number is frequently below what is the defined need.

One thing that we do need is greater State flexibility to meet the unique health care needs of the citizens of each of the various jurisdictions in this country. Although we recognize the ongoing need of institutional services, the Commonwealth's focus very definitely has been and will continue to be on community-based care, mainly because it provides improved quality of life in the company of friends and family.

Infrequently the services that are provided in the community can be provided at a much lower cost and therefore, we can care for more citizens.

Senator WARNER. I judge there is complete unanimity of that viewpoint among this panel and you're probably in as good a position as anyone to make those assessments?

Mr. KOZLOWSKI. Very definitely.

Senator WARNER. And greater emphasis should be put on this segment of the funding as we work on the reauthorization of the Older Americans Act?

Mr. KOZLOWSKI. Definitely.

Senator WARNER. You, as a State, and the other 49 States, will begin to help the Congress as to how to revise this Act and rewrite certain portions of it to give that emphasis?

Mr. KOZLOWSKI. We will vigorously take every opportunity.

Programs in support of the family and community-based care, I assure you, are the focus for the 1990s in the Commonwealth.

I offer to you that things are not exactly perfect in Virginia but we do have much to be proud of. Since you did ask me and give me

the opportunity, I'll do a little bragging about the Commonwealth for a few minutes.

Senator WARNER. Lay a little foundation and tell us how long you've been in these various positions and what is your career so that you can make a judgment.

Mr. KOZLOWSKI. Okay. I've been involved in medical assistance for 20 years. I watched it grow from its birthing stages back in the late 1960's, early 1970's, and have been in the Commonwealth since 1982.

Senator WARNER. You are well-qualified to give us an opinion.

Mr. KOZLOWSKI. Thank you.

Senator WARNER. We appreciate your services that you've rendered to mankind.

Mr. KOZLOWSKI. The Commonwealth has led the country in the creation of a preadmission screening program in which we take all persons who are at risk of institutionalization, long-term care, and we screen them to see if they can be cared for in the community setting as an alternative.

That is a very positive program because without screening, most folks would not be aware that there was an alternative to the institution.

We also led the Nation in the creation of a long term care information and monitoring system in which we track all the elderly citizens who are in some type of institution or community-based service. We track them for the duration, we look at improvements in health service, declines in health service and we use this information for program planning in a very broad stage and, more importantly, for individual planning of care for the individual citizen.

I can anecdotally, as you've taken the opportunity, indicate to you the importance of community based care. My mother passed away last year as a diabetic on dialysis. We were very dependent on community-based care to provide for her the quality of life that she so desired. I'm very definitely a great supporter of this alternative service.

I also want to respond to a question you asked earlier and that is, does the nursing home industry support community-based care in Virginia? I can offer to you as one who works very closely with them, they have been a very strong supporter of community-based care services, continue to be and it's been a good working relationship.

If I can briefly for benefit of the audience, just cover with you some of the community-based care waivered programs that we have in Virginia. We started in 1982 with personal care services designed to provide home-based personal care to elderly and disabled who are determined to be at risk of nursing home placement.

We provide services like bathing, feeding, dressing, toileting, mobility, we do some minimal housekeeping, meal preparation, shopping, bowel and bladder programs, wound care, et cetera.

Currently, we have some 2,972 Virginians being cared for in this program. Our annual savings that we have historically, and will again this year, for the single program are about $23 million. Senator, you all share in half of that.

Another program which I feel very good about, especially in the amount of support that's been given today in testimony, is our cre-

ation this last year of an adult day care health program funded under Medicaid. This is a very new program designed to provide personal care services in a congregate, daytime setting so that family who are required to work can do so and still provide care for their loved ones. Again, the same regimen of services as I mentioned previously are provided in this setting.

We project this year to have about 72 individuals in adult day care and our projected savings from this program is about $700,000.

Respite care, possibly the greatest need that we have in this country. Respite care is a program to provide some relief to family members or friends who are providing intensive care to persons to remain within their homes. Everybody needs a break sometime, if only to just have a holiday, to go to a wedding, to go to a funeral.

This is a very new program. It went into effect in July 1989. We project about 60 people will be cared for this year in this program with a projected savings through this program of about $600,000 per year.

I will speak about a program for children because it will soon carry on to adults. These are individuals who are machine-dependent. We started with a ventilator-dependent program for children in 1988. I offer that we serve about 11 children in that program right now. Our savings per year by keeping them in their home is about $1,700,000.

We have expanded the waiver to cover technology-assisted children and we are moving to an adult program, given the substantial savings that have been accrued. The technology-assisted children program only started in March of this year. We anticipate here about 60 individuals, total savings combined for the two programs of about $5 million a year.

One waiver currently being developed is a home- and community-based waiver for persons with mental retardation. We have an anticipated implementation date of January 1, 1991. We are going through the whole morass at this point in time of the Federal requests and reviews.

It is a challenge and we will be providing services to include training, assistance, and supervision to enable individuals to maintain or improve the health, development, and physical condition, assistance, training, and performance of activities of daily living, training in intellectual sensory, motor and effective social development in consultation with caregivers and implementation of an individual program plan and case management services.

We anticipate the savings as a result of this program serving about 960 Virginians to be about $30 million a year, very substantial.

We are also developing home- and community-based services for persons with AIDS. AIDS knows no age boundary. I have the pleasure of serving on the AIDS Subcommittee in the Commonwealth. We are going into our third year. It is an ongoing learning experience.

The AIDS waiver program will provide a broader range of services during those periods of time in which they become debilitated and require care, preferably with that care being provided in a community setting.

Lastly, to mention as the Secretary said earlier, a new project of case management for elderly clients for which the Medicaid program will participate both in administration and in funding.

We do again appreciate the opportunity to provide this information to you and the work that you have done in improving care to the elderly and disabled of this country.

[The prepared statement of Mr. Kozlowski follows:]

BRUCE U. KOZLOWSKI

DIRECTOR, DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

COMMONWEALTH OF VIRGINIA

APRIL 11, 1990

PREPARED DATA AND INFORMATION

SUBMITTED FOR

U.S. SENATE SPECIAL COMMITTEE ON AGING

CHARLOTTESVILLE, VIRGINIA

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

COMMUNITY BASED WAIVERS

PERSONAL CARE SERVICES

- Instituted in 1982
- Designed to provide home based personal care services to elderly and disabled individuals who were determined to be at risk of nursing home placement
- Covered services include assistance with activities of daily living (bathing, feeding, dressing, toileting, mobility, etc.), minimal housekeeping services and meal preparation, shopping, bowel and bladder programs, routine wound care, range of motion exercises, supervision. Services are limited to those activities that can be safely performed by a nurse aide.
- Currently enrolled providers (3/90) - 145
- Currently enrolled recipients (3/90) - 2,972
- Number served fiscal year to date (3/90) - 4,131
- Cost savings for fiscal year 89 - $22,690,403
- In FY 89 20.5% of individuals prescreened as needing long term care were able to remain in the community setting and received personal care services

ADULT DAY HEALTH CARE

- Instituted July, 1989
- Designed to provide personal care services in a congregate daytime setting to elderly and disabled individuals who are determined to be at risk of nursing home placement
- Covered services include assistance with activities of daily living, nursing care, coordination of physician ordered rehabilitation services (physical therapy, occupational therapy, and speech-pathology therapy), nutrition (one meal a day must be provided), emergency transportation to or from the center, care coordination, and recreational/socialization activities
- Current enrolled providers (3/90) - 13
- Current enrolled recipients (3/90) - 8
- Projected number of enrolled recipients in FY 90 - 72
- Projected cost savings in FY 90 - $743,760

RESPITE CARE

- Instituted in July 1989
- Designed to provide personal care and nursing services in the home on a temporary basis to elderly or disabled individuals who are at risk of nursing home placement when the live-in caregiver requires a temporary relief or respite
- Covered services include assistance with activities of daily living, minimal housekeeping services and meal preparation, supervision, bowel and bladder programs, range of motion exercises, routine wound care, skilled nursing services that can be provided by a licensed practical nurse, registered nurse supervision
- Current enrolled providers (3/90) - 38
- Current enrolled recipients (3/90) - 1
- Projected number of recipients for FY 90 - 60
- Projected cost savings for FY 90 - $621,120

VENTILATOR-DEPENDENT CHILDREN

- Instituted in December, 1988
- Designed to provide skilled nursing services in the home to children under the age of 21 who are ventilator dependent and at risk of continued stay in a hospital, nursing facility or other long-term-care facility
- Covered services include private duty nurses, durable medical equipment including apnea monitors, medical supplies, and respite care
- Current enrolled providers (3/90) - 8
- Current enrolled recipients (3/90) - 11
- Cost savings for FY 89 - $1,731,924

WAIVER REQUESTS AWAITING HCFA APPROVAL

TECHNOLOGY ASSISTED CHILDREN (Expansion of Waiver for Ventilator Dependent Children)

- Request submitted March 2, 1990
- Designed to provide private duty nursing in the home to children under the age of 21 who are chronically ill or severely impaired and require mechanical ventilation at least part of the day or prolonged intravenous administration of nutritional substances or drugs or have daily dependence on other device-based respiratory or nutritional support and who are at risk of admission or prolonged stay in a hospital, nursing facility or other long-term care facility
- Covered services include private duty nursing, respite care, and medical supplies and equipment not otherwise available under the State Plan for Medical Assistance
- Projected number of enrolled providers - 15
- Projected number of enrolled recipients - 60 *
- Projected cost savings - $4,791,900 *

* Includes ventilator dependent children

WAIVERS CURRENTLY BEING DEVELOPED

HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH MENTAL RETARDATION

- Anticipated date of submission to HCFA - April, 1990
- Anticipated date of implementation - January 1, 1991
- Designed to provide training, residential support, day support, and case management to mentally retarded individuals who are at risk of institutionalization
- Covered services will include training, assistance and supervision to enable the individual to maintain or improve his/her health, development and physical condition (monitoring of health status, medication and need for medical assistance), assistance and training in performing activities of daily living, training and use of community resources (shopping, transportation, social and recreational events), training in intellectual, sensory, motor and affective social development, consultation for caregivers in implementation of an individual program plan, and case management services

HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH MENTAL RETARDATION (continued)

- Projected number of providers - 40
- Projected number of recipients '91 - 960
  (Includes 220 who are required transfers from nursing facilities under OBRA 87 requirements)
- Projected cost savings - $30,296,640

HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH AIDS

- Anticipated date of submission to HCFA - August, 1990
- Anticipated date of implementation - January 1, 1991
- Will be designed to provide case management, personal care services, and private duty nursing to adults and children diagnosed with HIV and who are at risk of institutionalization
- Covered services will include case management, assistance with activities of daily living, minimal housekeeping services and meal preparation, shopping, day health care services in a congregate setting, nutrition counseling, respite care, and private duty nursing
- Projected number of enrolled providers is difficult to determine at this point. Those providers who currently provide services under the other waivered services would be part of the pool of potential providers as well as other home health agencies and providers of community based services.
- Projected number of enrolled recipients in FY 91 - 619
- No cost savings have been projected for this waiver. It is being developed to impact on the quality of life for those individuals who have been diagnosed as having AIDS and to coordinate and enhance efficient access to services.

Senator WARNER. Thank you very much.

Is there anything further that either of the witnesses on this panel might wish to contribute to the hearing?

[No response.]

Senator WARNER. We thank you, not only for your testimony, but for your attendance throughout this hearing and your willingness to be our wrap up panel. I express my appreciation and gratefulness on behalf of all Virginians for your public service. Thank you very much.

It is a bit unusual but the Chair would entertain anyone from the audience who might wish to contribute based on their own specific knowledge or what they might have learned today. Does anyone desire to come forward?

Mr. BARD. Senator Warner, I should like to make a few remarks since I'm getting in that area between the yellow and the red border up there myself. I am personally interested in this home health care.

Senator WARNER. We'll be glad to hear you. Would you kindly sit at that chair where the microphones are and identify yourself, just by name. You needn't give your age. We've decided in the committee hearing, we won't——

Mr. BARD. Well, I'm right up there where I'll be a different statistic next year.

STATEMENT OF ROBERT T. BARD, PRIVATE CITIZEN

Mr. BARD. My name is Robert T. Bard. I live in Nelson County and I came into Virginia some 23 years ago for the physiography of the area, so I join in with the native Virginians to enjoy this location.

I've always been a volunteer, even before I retired but I've been retired now for some 17 years and most of my efforts is plowing back into the community some of the things that I've enjoyed from society.

Senator WARNER. What was your work before your retirement?

Mr. BARD. I was an engineer in the U.S. Army and also a registered professional engineer. I served 33 years in the service and before that, I worked in California in public utilities.

It's always been a desire of mine to what does the person do when they become in the same state that they were when they came into this world? They need assistance. I've always looked at a philosophy from Lord Tennyson's division of Sir Lorenthal who gives himself with his alms, feeds three, himself, his hungry neighbor, and me, meaning our Lord Savior. But the greatest thing Tennyson brought, you benefit yourself. This is a terrific thing to me.

As far as the comments about this business of volunteerism that I hear frequently this morning, I would like to see in this Aging Act also a provision for those people who have retired and are willing to give, some way that they can get some type of recognition through the same type of tax breaks that we get for earned income deficiencies.

We are just right now in the process of processing our income returns and we realize that there is a factor in sort of reducing your tax contribution because of your low income but I think it could be

considered in this, some type of a tax break where the people who give of themselves get more than the 12 cents a mile that they get for using their vehicle.

I realize that you can't compensate them for their time, but there could be some type of an hourly contribution that they get through these agencies like JABA, which I work for, I help with MARCCA, I help with educational programs and things of that nature.

I am not looking at it myself but I know that there are people with less income than I have that could contribute if they got some little bit more tax break so that they could afford to spend their time away from taking care of themselves and helping others.

I appreciate the opportunity to make these remarks.

Senator WARNER. That is a very constructive observation. I assure you that I will look into that.

Mr. BARD. I know with the contacts that are here, there is an awful lot of caregiving people out in this community if they could be reached through a publicity program of this type—sweat equity if you want to call it that. I put something in and I get something back.

Senator WARNER. You started with Tennyson and we'll conclude with you.

Mr. BARD. Thank you.

Senator WARNER. I might add that my mother was a great disciple of Tennyson and her volume of Tennyson rests on my dining room table where she placed it many years ago.

Mr. BARD. It's a great inspiration.

Senator WARNER. Indeed it is.

Are there others who wish to come forward? Mr. Marshall. I think you should come down and properly identify yourself.

STATEMENT OF FORREST MARSHALL, JR., PRIVATE CITIZEN

Mr. MARSHALL. First of all, I've known you for many years and you know where I'm coming from.

Senator WARNER. You should first give your name and the fact that you've lived in this community for many years.

Mr. MARSHALL. I was born and raised in Charlottesville, VA. I happen to have built the first nursing home that was in Charlottesville, VA. I've been practicing pharmacy in this area for 31 years.

One thing that I haven't heard this morning is quality. That concerns me more than anything else. I've been taking care of elderly people and a lot of poor people for many years.

Senator WARNER. That's in your capacity as a pharmacist?

Mr. MARSHALL. As a pharmacist and operating the nursing home.

When we have rules and regulations put on us that we, in my profession and the medical profession—I know doctors and dentists have the same problem—I'm required by the rules and regulations of the State of Virginia and the Federal Government to dispense the cheapest medication available to patients that are on social services.

They are not getting the best medications and they are not getting the best medical care. They are not here this morning because they can't afford——

Senator WARNER. You mean the fact that we impose the cheapest requirement often precludes you giving them somewhat more costly medication which would be more beneficial for their specific ailment?

Mr. MARSHALL. To cite an example, I have one patient who lives in Gordonsville who is on Medicare Extended Plus and another patient who is on the PRM with the State of Virginia where I was required to dispense a drug called Wauphren Sodium, which is a generic form of Qumadin which is a blood thinner. The patient's count went out of sight, he came very close to dying because of having to use this medication and this medication was approved by the Food and Drug Administration, so therefore, the State of Virginia says that it is a good drug, I am required to use this drug.

It is not. I'm not saying that all generics are bad drugs. The vast majority of them are good drugs, but there aren't professional people sitting on the boards and commissions and the Federal Government on the State level to make the decisions that are necessary when these rules and regulations are handed down.

Consequently, I have four people that are coming in front of me that can't buy this drug, Wauphren Sodium with their funds but are literally forced to do without grocery money or other money to obtain this particular drug because it is a matter of life and death in their cases.

This goes on every day and it's not just in drugs, it's in medical equipment that you're having to buy, it is in nursing home care. I built the city's nursing home 25 years ago. The first 3 years, we near went broke and fought tooth and nail to keep it open.

Medicare and Medicaid came in, I filled up overnight. I got rid of it in 5 years, we sold it. I was scared to death. If the Federal Government had dropped the funding of it, it would have closed.

There are many nursing homes available in Charlottesville. There is a nursing home or extended care facility or an adult home, whatever you want to call them. In Charlottesville, we are very fortunate that most people are getting decent medical care because we are a medical center. In southwest Virginia, they aren't.

Senator WARNER. Let me just ask this question. We, in Washington, have had a series of hearings on generic drugs and those subjects are another part of the work we perform as a committee, but the central theme we are pursuing this hearing is whether or not people can care for themselves in the home with some support from State and Federal through agencies such as JABA and the community hospital we heard about.

Do you believe that is a viable concept and should receive more support?

Mr. MARSHALL. Oh, yes. It's going to take a great deal more money but it's also going to take a lot of supervision of how the money is spent.

Senator WARNER. It would provide a greater extension of health care for the same dollar?

Mr. MARSHALL. That's correct.

Senator WARNER. That's good. That's very helpful. We thank you, Mr. Marshall.

Anyone else? Yes, sir.

Mr. MILLER. Thank you, Senator Warner.

STATEMENT OF JACK MILLER, PRIVATE CITIZEN

Mr. MILLER. Senator Warner and distinguished guests, I'm Jack Miller and I am a resident of Greene County.

An article—I have a few of them but the one I brought with me has to do with the Mary Hughes' letter to the editor and I think it is very germane to the hearing you're having here now—has to do with the retirees Social Security being used as part of their government pensions. I think it is very, very serious.

I am retired from the military, retired civil servant, and a disabled VA. I paid taxes for 17 years and drew less retirement pay as a Master Sergeant than State employees in this State drew retirement pay but yet we paid it.

My disability check—because I know you're on the Armed Services Committee—I've followed your career since you were Assistant Secretary of the Navy and I retired from the Navy.

I think as people get older, and I think you have a sincere concern in this area——

Senator WARNER. I'm not too far behind. I'm still pursuing my career but I'm not too far behind.

Mr. MILLER. I'm aware of that. Our citizens as they grow older need all the compassion that we can give them.

Senator WARNER. I share in that view. As to the article itself, I'd like to have that incorporated as a part of the record, if you'd give that to the recorder and we thank you very much.

[The newspaper article follows:]

VIRGINIA VICTIMIZING RETIREES AGAIN BY TAXING SOCIAL SECURITY INCOME

[THE CHARLOTTESVILLE DAILY PROGRESS, APR. 9, 1990]

Ray Garland brought out some good points in his column on taxes in The Daily Progress on March 25 ("Really Want To Help? Halt The Sales Tax!"). But I am surprised and dismayed that he failed to challenge the use of Social Security as part of the $12,000 exemption that the new retirement bill provides retirees, which passed during the 1990 General Assembly and now awaits the governor's signature.

A tax rule states that "no state can tax any part of Social Security," and Virginia has conformed to that rule in past years. For Social Security to be brought into focus with the $12,000 exemption is a deceptive maneuver to shield the fact that it will be used to defray part of the financial burden of the state. This absolutely is taxing Social Security.

For 47 years, the state illegally taxed military and federal civilian retirees' retirement incomes, while exempting state and local retirees' retirement incomes; but in March 1989, the Supreme Court order brought an end to that inequity. Now this!

Perhaps the time has come to remove food from the state sales tax, but not as a trade-off to retirement income.

It is difficult to understand how Garland can think the 1990 Assembly Republicans disgraced themselves because they tried to prevent Social Security from being taxed by the state, and if amends are in the offing, they are due the retirees by the state.

Virginia has been in the national spotlight since L. Douglas Wilder was elected and sworn in as our governor, and you can be sure his administration will be under microscopic scrutiny, nationally and worldwide. He has worked hard preparing himself, is well-qualified and deserves all the rewards associated with the governorship. For Virginia to possibly become the first state to tax Social Security would be a distinction he would not welcome and an act that could destroy him politically. Since the retirement bill is a money bill, what better time for the governor to exercise the

prerogative available to him—the use of the line-item veto?—Mary E. Hughes, Kents Store.

Senator WARNER. I assure you that the Congress is going to look at the subject of the use of the Social Security Fund as an offset to certain budget calculations that we perform. That troubles me greatly and it's one that we are going to look at and look at carefully.

I want to assure you and all others that rely in part on Social Security that that fund is financially stable and this Senator is going to continue to vote to keep the current tax structure until we have a time when we have complete assurance that we could make some adjustments but in my opinion it has not come yet, and furthermore, to see that the COLA's are provided for Social Security recipients so they can cope with inflation.

Thank you, sir.

Mr. MILLER. We are of different parties, but you represent us very well.

Senator WARNER. Thank you very much.

There was another hand, right here?

STATEMENT OF BETTY NEWELL, PRIVATE CITIZEN

Ms. NEWELL. Good afternoon, Senator Warner. Thank you for the opportunity to share some concerns with you.

My name is Betty Newell. For the past 20 years, I've been involved in employment as well as a volunteer in various health and human services, specifically in health care administration and public transportation, as a volunteer quite a bit of time in health planning. My most recent employment as director for a home health agency until about a month ago. Currently I'm here strictly as a volunteer. At present, I'm the Region 1 Director for the Virginia Association for Home Care and serve on that board for home care providers. Also I'm a member of the JABA Advisory Board. I certainly congratulate them for assisting you in being here today.

I would like to address what I see as some of the major issues to consider in concerns with aging as well as the reauthorization for the Older Americans Act.

One of the concerns I have, I agree very strongly with Gordon Walker and some of the other folks who have spoken for the need for better coordination of services. We've heard a lot of good things about some services that are available to the elderly in Virginia as well as the rest of the country, but our current system, in my opinion, is I don't know if you want to call it a nightmare or a maze.

It is very difficult for health care providers to figure out what's available, who qualifies for what, a lot of eligibility requirements are nightmares in reimbursement. It prohibits a lot of people from getting in the business; it makes a lot of people leave the business at a time certainly you shouldn't have people leaving it.

I think a good analogy would be I remember as a child going to see a clown with all these little pockets on a clown suit and I think that's how I see our present health care resources. The funding is in a lot of different little pockets and you spend more time figuring out who qualifies for what and figuring out paperwork than you do in providing services.

I know my nursing staff would spend more time documenting what they had done so that we could bill, which quite often was denied for services than they did actually with hands on patient care.

Senator WARNER. You mean the paperwork?

Ms. NEWELL. Absolutely. A good example, to bill for home help, you bill once a month for home health services, you may have to send as many as 10 or 15 different pieces of supporting documentation for one bill. That is absurd.

There has been some improvement, I think, with the Health Care Financing Administration.

Senator WARNER. Do you know whether that requirement rests with the State or the Federal Government?

Ms. NEWELL. It's the Federal requirement.

Senator WARNER. It's the Federal requirement?

Ms. NEWELL. Yes, sir. The Health Care Financing Administration and the fiscal intermediaries that they use have, I think, absolutely absurd reimbursement requirements. It takes a lot of time that should be going to patient care. That's one of the reasons I think you have nurses burning out. They want to do patient care, not fill out forms.

Senator WARNER. Let me just interrupt for a minute. I want to hear further from you but I must say that I'm expected 20 minutes ago at the adult care center to see and visit with those folks, but we'd like to have a few more of your points.

Ms. NEWELL. I can summarize them and say we've heard a lot about transportation and housing, meals programs and so forth and packs on health care, and I would just encourage you. In some things I've been involved in, I was told there were no legislative barriers at the Federal level that prohibit full coordination and I disagree very strongly, there are many barriers.

I would suggest strongly you address those as you reauthorize legislation to encourage cooperation and better use of resources because there are not going to be a lot more resources available.

Senator WARNER. We thank you.

I regret that I have made this appointment, not that I'm going but that I don't have additional time to hear from others. Should we have a successive hearing, I will provide greater time for audience participation. I'm pleased that we have had a large audience throughout the day and I thank you for taking from your time, your work and family life, to come and join.

Should you wish to write me on these questions, I've identified my office the nearest one being Roanoke or Washington, please do so.

I'd also like to thank Mr. Nick Altree, who resides here in Charlottesville. He is on my staff and provided very helpful assistance to both Mr. Dickinson, my principal assistant today, and others.

Thank you very much. God bless.

[Whereupon, at 12:18 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

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