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STATEMENT OF

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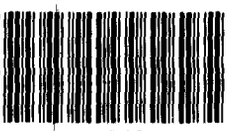
BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ON

EXPANDED HOME HEALTH CARE



MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

We are pleased to be here today to testify on the issue of home health care and S. 234, the proposed Community Home Health Services Act of 1981. In home health care, as defined under Medicare, patients in their homes are given health services by nurses or therapists and personal care services (bathing, grooming, etc.) by aides. S. 234 proposes to expand the coverage of home health services, encourage the establishment of home health programs, and encourage families to provide care for elderly dependents in the home.

The Chairman asked GAO to assist the Committee in examining the likely effects of expanding home health care services. We focused on

--what effect home care services have on patient outcomes;

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--what effect expanded home health care services might have on the number of hospital and nursing home admissions, length of stay and patient discharge; and

--what circumstances might allow home health care to be a cost effective substitute for institutionalization.

Since S. 234 builds on the current home health care system, we first examined some issues or concerns about how this system functions. They are that

--while the use of home health care is expanding, it is still somewhat limited by restrictions on eligibility and service coverage, access problems in some areas, and lack of information on the types of services that are available;

--because of these restrictions, some elderly Americans who need home health care and other community-based services either go without care or seek institutional care as an alternative;

--the way in which home health care services are currently provided needs to be improved because the reimbursement system lacks incentives to minimize costs, the provision of services and funding is fragmented, monitoring service use is difficult and data management is not always effective.

Keeping these concerns in mind, we then looked at the possible effects of expanding home health care services by review-

ing a large number of studies and evaluations that have examined this issue. Although all of these possess at least some methodological flaws, we were able to draw the following conclusions from them:

--Demonstration projects and other research have generally found that expanded community-based services, including home care, attain positive patient outcomes. One of the most critical is that older Americans who receive expanded services in their home may live longer.

--The cost studies we reviewed suggest that home health care can, at a minimum, be cost effective for some groups of people or for some services. For example, reducing patients' length of stay in hospitals would produce savings. While this already occurs to some extent, more can be done.

--However, what the total cost of an expanded system of home care services would be is unclear. Problems of ethics and design in conducting research in this area, mean that conclusive cost effectiveness results for the total population serviced may not be obtainable.

To have a more successful home care system several actions should be taken. Among them are that

--methods should be developed to assure early identification of patients in institutional settings or

before they enter institutions who could and would prefer to receive treatment in their own homes if appropriate home health care services were available;

--incentives should be created so that patients once identified, actually move from institutional settings to alternative care settings when care provided in these settings is cost effective and in accordance with their preferences and their well-being;

--mechanisms are needed to insure that the services provided at home are appropriate to the patients' needs; and

--the adequacy of current reimbursement mechanisms for home health care should be reviewed. We endorse the concept of examining a number of different reimbursement mechanisms through demonstration projects designed to determine if a better reimbursement system can be devised. S. 234 includes a provision for reimbursement demonstrations.

METHODOLOGY

We developed these findings based on a review that combined information collected from interviews with agency officials, experts, and home health care providers with information from site visits and an evaluation synthesis of research in the field. We interviewed Department of Health and Human Services officials,

including those in the Health Care Financing Administration and in the Administration on Aging. We also interviewed health care providers and experts in the home care field. We questioned these people about the general background of the home health care system and its cost effectiveness, its program management and design, and specific details of recently introduced legislation. We combined their answers with what we saw during site visits to 21 home care agencies and programs (listed in appendix I). A number of these were demonstration projects offering expanded services on an experimental basis. We attempted, within our time constraints, to visit a geographically and organizationally diverse set of home care providers.

The major component of our review, however, was a synthesis of existing evaluation studies. The essence of an evaluation synthesis (a method developed by GAO) involves first examining the findings and conclusions of existing evaluations, second, assessing the adequacy of the methods used, and, third, determining, not only the information which is sound and available for policymakers to use, but also the gaps which remain in that information, either because certain questions were not addressed or because the methods were not adequate for addressing them. In reviewing this literature we found a wide range of methodological sophistication among the studies by government agencies, health care providers, and university and contract researchers, as well as our own relevant reports (appendix II lists pertinent GAO reports).

--part-time or intermittent services provided by a home health aide as permitted by regulations,

--medical supplies (other than drugs and medicine including serum and vaccinations) and the use of medical appliances, and

--medical services provided by an intern or a resident enrolled in a teaching program in a hospital affiliated or under contract with a home health care agency.

To be eligible for home health care coverage under Medicare, a person must essentially be confined to his/her residence (homebound), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. The care must have been prescribed by a physician, and the services furnished must be provided by a participating home health agency (either directly or through arrangements with others) in accordance with the physician's treatment plan.

The availability of home health care is somewhat limited and uneven

Despite the growth in home care expenditures several studies estimate an unmet need for home care. For example, in a recent study the Congressional Budget Office (CBO), focused specifically on measuring the potential need and available supply of home health care. This report included estimates that potentially 1.7 to 2.7 million people were in need of expanded home services, but that only 300,000 to 500,000 were being given such services. 4/ GAO studies, although not projectable to the total elderly population,

have indicated that between 10 and 22 percent of the elderly 65 years and older in some areas or cities were not receiving all the homemaker/chore and personal care services they need. 5/

Some of this unmet need may be partly a result of Medicare's home health care coverage. First, Medicare has few incentives to provide chronic care to the elderly. As currently designed this program provides medically related services to individuals with acute care needs on a temporary basis; excluded therefore are elderly who require additional care over a longer time span. Second, several services that are sometimes necessary for monitoring the elderly in their homes are not provided. Many individuals with long term care needs ideally could use a combination of medical, social, economic and mental health services. The services often cited as needed--homemaker/chore, home delivered meals, transportation and respite care--are the services most commonly not covered by Medicare.

In addition to gaps in service coverage and eligibility, fragmentation and lack of coordination among the numerous community-based programs sometimes prevent people from receiving appropriate care. Access to care is also an issue in rural areas where home care services may be in short supply or not be available at all. Lack of information on non-institutional long-term care options also restricts use. For example, GAO reported in 1979 that families lack information on community-based alternatives because they do not have the time to explore the availability of community services and because hospital discharge planners do not

have enough time to assess patients' needs and arrange appropriate placement. 6/

Many elderly may not be receiving care in the most appropriate setting

Another difficulty in the current system is in trying to assure that all health providers--home health care, hospital care, and nursing homes--work together so that a patient receives care in the setting most appropriate to need, individual preference, as well as most reasonable in terms of cost. This does not always occur. Avoidable institutional use includes elderly residing in hospitals or nursing homes who do not need (and in some cases do not desire) the level of care provided, but remain for lack of alternative placement options. Some of these individuals could be released to or could have remained in their homes if community services were available.

Avoidable institutionalization occurs partly because no one has yet adequately defined who should be placed in each care setting. It has already been demonstrated that some people in nursing homes could have remained in their communities with appropriate services. Due to errors in the estimates and problems with assessments it is difficult to identify the actual number of individuals receiving too high a level of care. However, we do know that a problem exists.

Elderly are also unnecessarily residing in acute care hospitals. It has been estimated, for example, that nationally 17,783 people or 6.9 percent of the Medicare and Medicaid patients in acute care hospitals surveyed were awaiting placement elsewhere. 7/

Some of these patients are considered to be potential candidates for home care if the necessary services were made available.

Problems exist in program design and management

Under Medicare, the reimbursement system is relatively open-ended and susceptible to abuse. Moreover, some home care providers lack sophisticated data base management, making review of their operations difficult. Further, fiscal intermediaries do not receive adequate information, nor do they monitor agencies closely enough to insure that the services that are claimed are reimbursable and that the services that are provided go to those most in need.

The reimbursement system, in particular, has been widely criticized as "lacking incentives to providers to be efficient and minimize their costs." 8/ Two problems with it include:

--wide variations in the unit costs of similar services and the related problems in determining whether costs at the higher end of the range are reasonable; and

--problems in determining the allowability of costs claimed and their relationship to patient care. 9/

A report just issued by the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs found that for Medicare's home health care benefit the "current retrospective cost reimbursement system as it applied to not-for-profit agencies, lends itself to fraud, waste and abuse." 10/

The recordkeeping procedures of some providers may not be detailed or sophisticated enough to generate the information that is necessary to determine whether services that have been claimed can be reimbursed. GAO has reported data from the Health Care Financing Administration that shows that "8 percent of the certified home health agencies fail to maintain adequate clinical records." 11/ The report states, further that the documentation fiscal intermediaries receive gives them little or no information on which to base their decisions.

EFFECTS OF EXPANDED SERVICES

The inadequacies of the current home care system just described, have been the subject of concern by Congress, the Federal and State governments and others for some time. In response to some of these inadequacies, a number of demonstration projects and other studies have been conducted. Primarily, they have addressed ways to expand and target services, the costs of expanded services, and what services should be provided. In response to this Committee's Chairman, therefore, we reviewed these demonstrations and studies to find out what is known about the effects that expanding home health care would have on patient outcomes; the effects of expanded services on the number of hospital and nursing home admissions, length of stay and patient discharge; and the extent to which expanded home health care can be a cost effective substitute for institutionalization.

Research efforts to examine the effects of expanded services are hindered by methodological concerns

Our efforts to examine these issues were hindered somewhat by methodological concerns we have about the studies and demonstrations. We found few well-designed, controlled studies. We found many case studies (examinations of a single group of recipients), some comparison group studies, and a few randomized control group experiments. Information from well-designed control group experiments is, however, the most useful and has the greatest generalizability, since threats to external validity are minimized. In the studies we reviewed, we also identified a number of methodological problems, including problems of definition, sampling, and client assessment.

Definitional problems

The definitional problems in the home health care area are so all-encompassing that even the definition of "home care" itself is confusing. Thus, comparing various home health care evaluations is difficult because each defines home health care to describe its individual situation. Some evaluations of home care include people in day care centers while others include or exclude homemaker services, home health aide care, or some other specific services. The service mix is often not specified in the report. Therefore, the differences of service mix among different studies make comparisons difficult. Furthermore, there is no consistent definition of a "home health care visit." A visit can be as different as a 10-minute stop by a skilled nurse or a 2-hour health aide visit. In some cases a visit could be a 24-hour live-in nurse service.

Determining costs in different health care settings suffers from methodological problems, too. Many evaluations fail to consider the value or costs of services provided informally by families, or formal support provided by other Federal programs. This failure is critical because services that families and friends provide are similar to those that agencies provide. In an earlier report, GAO stated that families and friends provide more than 50 percent of the services at all impairment levels. The families and friends' portion of home services provided reaches 80 percent at the extremely impaired levels. 12/ Support provided by other Federal programs such as Supplemental Security Income, Title XX, and other Federal benefits, are often not considered when comparing institutional to noninstitutional settings.

Sampling issues

Even the best-planned and implemented evaluations may contain sampling problems. Probably the most common problem that has a seriously adverse effect on validity is attrition; that is, members of the control groups die or move from the study area at a higher rate than members of the treatment group. If control group members die at a higher rate, the experimental group grows proportionately older and more infirm than the control group. Subsequently, the experimental group may use proportionately more services and have a higher per case cost. Attrition becomes more important for studies with longer time frames.

Client assessment issues

A number of evaluations we reviewed also have some drawbacks with respect to client assessment. Each study typically uses its own client assessment forms and categories, making it difficult to compare clients across studies even when the clients seem to have similar disabilities and disease levels. Moreover, client assessments are often performed by the home health care providers, but the reliability of these assessments is questionable. Finally, in a number of studies the hypothetical differences in cost of services provided and subsequent savings between settings are based on physicians or the health providers' estimates. These estimates may be inaccurate.

Current studies provide some helpful information

These methodological problems make interpreting the evaluations difficult. However, in spite of these problems much can be learned from this work. We will now discuss some of the information we were able to derive from these evaluations.

Studies and evalutions we reviewed suggest that increasing home care services can provide improved patient outcomes on some measures. Three outcome measures will be discussed: patient life span, patient contentment and patient functioning levels.

Patients receiving expanded home care live longer

There is evidence that individuals who receive expanded home health care services live longer than those who use the currently available health services. Two evaluations of different long-term

care demonstrations that used an experimental design corroborate this view. Preliminary data from one randomized control and treatment group study showed a statistically longer survival period for recipients of expanded services as compared to a control groups' mortality rate. Over a 24 month period, the treatment group lived longer than the control group. 13/ These findings are supported by a second study, of one year duration, that also reported statistically significant differences between a homemaker, and combined homemaker-day care sample's mortality rate when compared to a control group's. 14/ In both studies, recipients of enriched home care or alternative services lived significantly longer than control groups when traditional services were available.

Home care increases patient contentment

There is general agreement that patients receiving home care services are more content and their mental functioning also improves. In the Triage program, clients' perceptions of their health showed marked improvement. Information from the On Lok program and other studies also suggests improvements in the level of contentment.

Evidence on increased patient functioning is inconclusive

Whether home care services actually increase patients' functional abilities is unclear. Some studies report that patients who receive home care improve their functioning; others report the opposite results. The discrepancy can be explained a number

of ways. The population under study is generally chronically ill, with decreased functional abilities. Further, in studies using control or comparison groups members of these groups may die at a proportionately higher rate than members of the experimental groups. To the extent that this occurs the experimental groups therefore will have a higher proportion of the elderly, infirm, and dysfunctional patients, since they live longer.

Results from an evaluation of the functioning of individuals placed under either home health or nursing home care services reported a greater improvement in the home care sample's level of functioning. 15/ Patients treated in the On Lok demonstration also showed some improvement or no change in activities of daily living. 16/ On the other hand, a more recent study using a rigorous design indicated a deterioration in the physical activities of daily living for the experimental group. 17/ This study examined a long term demonstration program in Chicago offering comprehensive services that included physician's visits and chore service. The experimental group, however, was older than the comparison group for this study. This may explain their lower levels of functional abilities.

Can costs be contained if services are expanded?

It seems likely, based on our review, that expanding the types of available home health care services and increasing the numbers of people who would be eligible for this care would increase Federal health expenditures. It has been hypothesized however, that some of the increase would be offset by the

accompanying reductions in institutional costs. We reviewed the research and evaluations to examine whether expanded home care services can be provided cost-effectively and how the appropriate placement of patients can aid this cost reduction or containment.

Home care can reduce hospital length of stay

Studies in the early 1970s used the judgments of physicians and other experts to estimate the number of hospital days that could potentially be saved by making home care services available. Of the nine studies we examined, the estimated average number of hospital days avoided per patient transferred to home services was 13.3 days. These studies reported estimates ranging from an average of 3.5 to 22.6 hospital days saved. 18/ This positive finding is substantiated by more recent and methodologically improved evaluations. For example, a 1976 study using randomly assigned treatment and control groups reported an average length-of-stay reduction of between one and 3.5 days for the experimental group in 5 of 13 diagnostic groups, without compromising clinical outcomes. 19/

Since the Federal government paid 41 percent of the nation's $85.3 billion hospital bill in 1979, any reduction in days paid for would potentially produce savings. 20/

The effects home care has on hospital admission/readmission rates are inconclusive

One way home care could result in hospital cost savings is by reducing the frequency of admissions or readmissions to hospitals. By stabilizing chronic illnesses home care could

theoretically reduce the need for hospital admissions for the elderly. However, whether or not expanded home care services actually reduce patient admissions and readmissions is not clear. Studies that relied on estimating techniques reported a small number of hospital days saved by home care, while studies using more rigorous designs find no savings with home care. Two other studies reported an increase in institutional utilization. We are unable to draw conclusions because of design problems and conflicting findings in these studies.

Findings from some relatively well designed studies (although not without flaws) suggest that community placement has no effect on hospital admission and readmission rates. Preliminary statistics released from a Health Care Financing Administration demonstration project indicate that there was no statistically significant difference in the use of in-patient services between randomly assigned community care recipients and the control group. 21/ Another researcher reported similar results using randomly assigned treatment and control groups. Elderly clients receiving several additional services showed no difference in hospital use when compared to members of a control group receiving traditional services. 22/

Other studies that had randomly assigned treatment and control groups did find that the treatment group was significantly more likely to be institutionalized than the control group. In these studies the observed higher hospital use for the home care sample was attributed to the detection and treatment of illnesses

that otherwise would have gone unreported. 23/ One study termed this phenomenon "social visibility," where at-risk clients come in contact with a service system and are more likely to be encouraged to enter institutions sooner. 24/ Although this may be an area of expanded use of services and increased costs, it could provide care to the elderly who would not otherwise be served.

The effects of home care on hospital backup are unknown

Hospital backup is a special case of appropriate placement. This refers to patients in acute care hospitals awaiting transfer to chronic care settings. These patients are referred to as occupying "administratively necessary day beds". Annual surveys of New York hospitals indicate that this problem is severe and getting worse. In 1979 there were 3,961 Medicare/Medicaid patients awaiting alternative placement; in 1980, there were 4,424. The average wait for these patients increased from 53 days in 1979 to over 74 days in 1980, a 40 percent increase in one year. 25/

A number of people have hypothesized that availability of home care services can provide alternative placement for backed-up patients. However, little work has been done to test this hypothesis and whether the type(s) of patients backed-up in hospitals are candidates for discharge to home care is unknown. From the patient descriptions provided in two studies, it is difficult to tell if these patients were inappropriate hospital placements. We still do not know if, or to what extent, expanded home care can reduce hospital back-up. However, this may be a promising area for future work.

Additional work on alternatives to hospitalization is needed

One area for potential cost savings has received little attention or research. Some hospitalized patients, not classified as backed up may be likely candidates for returning home early. These patients, such as those needing minimal care and monitoring, could be discharged early to recuperate in their homes if appropriate home health services are available. Due to the high cost of hospital care, some savings may consequently be realized by any early discharge. The problem in implementing this approach, however, is that no adequate methodology for identifying such patients currently exists. One recent study of home health care concluded that even under Medicare there is little agreement in the field as to what kind of discharge service is required for elderly persons who are possible candidates for home health care. It noted that currently "hospitalized patients (are) dependent upon a very uncoordinated, and in some instances even haphazard system identifying their need." 26/

Reduced placement in nursing homes suggests little or no cost savings

It has not been demonstrated conclusively that home care services can reduce the number of days the elderly would otherwise spend in a nursing home. While some studies reported reduced nursing home use for the treatment group, it is difficult to attribute the observed difference between the treatment and comparison group to the program due to methodological problems.

Cost-saving is not necessarily achieved as indicated in two studies reporting fewer nursing home days for a randomized treatment sample but higher total costs for the extended services. 27/

Such findings may be explained partly by the relative costs of home health care and nursing home care services. Nursing home rates, specifically if paid by Medicaid, are fairly low while home care rates are often as expensive or more expensive depending upon the home services used. Estimates of the cost of a day of nursing home care in 1979 ranged from $21 to $56 per day. 28/ Due to the number and frequency of services a home care recipient needs, costs for this care may often exceed these rates on a daily basis.

The uncertainty about differences in the cost of serving someone in the community versus in a nursing home was raised in a recent Department of Health and Human Services study. A review of research which assessed candidates for care in either setting seemed to indicate that for slightly impaired people alternatives other than nursing homes are more economical, but that for severely impaired people the opposite is true. They noted, however, that what is not yet known is "exactly where the breakeven point occurs, and how to determine for which individuals and subpopulations which particular services and settings are cost-effective." 29/

CONCLUSIONS

Despite a large number of home health care evaluations and demonstration projects our knowledge of the effects of expanding home care is still limited. While we see improvements in some patient outcomes such as longer lives and increased contentment,

the results for other outcome measures such as physical functioning are still uncertain. Similarly, we find that some home health care costs may be offset by reducing patients' length of stay in hospitals as already occurs to some extent. However, more can be done. The cost effectiveness of home care as a substitute for nursing home care is unknown. The total effect of expanding home health care services on health costs is not known, and it may never be known.

We can fill some of the current information gaps by

--examining appropriate placement to try to determine what patient or illness characteristics are most economically and effectively dealt with with in each chronic care setting.

--developing methods for early identification of patients who can avoid institutionalization by receiving home health care or are likely candidates for early discharge.

--developing mechanisms to insure that services are provided to patients who are most in need and that the services provided actually match these needs.

--examining through demonstration programs if improved reimbursement mechanisms can be developed.

This concludes our statement. We would be pleased to explain any part of it or to answer any questions you may have.

HOME CARE AGENCIES AND PROGRAMS

VISITED OR CONTACTED

San Francisco Home Health Services, Inc., San Francisco, California

Mt. Zion Hospital and Medical Center, San Francisco, California

California Association for Health Services at Home, Arcadia, California

Los Angeles Visiting Nurse Association, Los Angeles, California

Senior Health Care Program, Harborview Medical Center, Seattle, Washington

Seattle Visiting Nurse Association, Seattle, Washington

University of Washington Institute on Aging, Seattle, Washington

Chelsea Village Program, New York, New York

Long-Term Home Health Care Program, Metropolitan Jewish Geriatric Center, Brooklyn, New York

Visiting Nurse Association of Boston, Boston, Massachusetts

Community Long-Term Care Project, Spartanburg, South Carolina

Alternative Health Services Project, Atlanta, Georgia

Upjohn of Georgia, Atlanta, Georgia

Ketona Program, Jefferson County Department of Health, Birmingham, Alabama

Community Nursing Services of Salt Lake City, Salt Lake City, Utah

Holy Cross Hospital of Salt Lake City, Salt Lake City, Utah

Denver Upjohn, Denver, Colorado

Triage, Inc., Plainville, Connecticut (NV) 1/

Monroe County Long Term Care Program, Inc., Rochester, New York (NV)

Pittsburgh South Hills Home Health Systems, Pittsburgh, Pennsylvania (NV)

1/NV: Interviews conducted and extensive information collected, but project site not visited.

APPENDIX II

SUMMARY OF GAO REPORTS ISSUED ON MATTERS RELATED TO IN-HOME SERVICES

Report title	Date of issue
Returning The Mentally Disturbed To The Community: Government Needs To Do More (HRD-81-152A)	January 7, 1977
The Well-Being Of Older People In Cleveland, Ohio (HRD-77-70)	April 19, 1977
Home Health--The Need For A National Policy To Better Provide For The Elderly (HRD-78-19)	December 30, 1977
State Programs For Delivering Title XX Social Services To Supplemental Security Income Beneficiaries Can Be Improved (HRD-79-59)	April 11, 1979
Home Health Care Services-- Tighter Fiscal Controls Needed (HRD-79-17)	May 15, 1979
Conditions Of Older People: National Information System Needed (HRD-79-95)	September 20, 1979
Conditions And Needs Of People 75 Years Old And Older (HRD-80-70)	October 15, 1979
Entering A Nursing Home: Costly Implications For Medicaid And The Elderly (PAD-80-12)	November 26, 1979
Evaluation Of The Health Care Financing Administration's Proposed Home Health Care Reimbursement Limits 1/ (HRD-80-84) (HRD-80-85)	May 8, 1980

1/Letter report to the Honorable Bob Packwood and the Honorable Sam M. Gibbons.

ISSUES CONCERNING THE CURRENT HOME HEALTH CARE SYSTEM

Our examination of some of the issues relating to how the current home health care system functions, primarily focused on Medicare's coverage of home health care. While the Federal government also funds in-home health or health related services through Medicaid, Title XX of the Social Security Act, and Title III of the Older Americans Act, the largest expenditure is under Medicare.

Medicare's coverage of home health care represents one of the fastest growing health expenditures for the Federal government. It is estimated that in FY82 $1.146 billion will be spent on Medicare benefit payments for home health services. 1/ This is an increase of about 300 percent over the $287 million spent in FY76. 2/ The number of Medicare home health visits has also increased from 8.1 million in 1974 to 17.3 million in 1978. 3/

Medicare, authorized by Title XVIII of the Social Security Act (42 U.SC. 1395), provides a broad health insurance program for most persons aged 65 and over and some disabled persons. Home health services under Medicare, as defined by the Social Security Act include:

--part-time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse,

--physical, occupational, or speech therapy,

--medical social services provided under the direction of a physician,

Report title	Date of issue
Comparison Of Data On Older People In Three Rural And Urban Locations 2/ (HRD-80-83)	May 23, 1980
Medicare Home Health Services: A Difficult Program To Control (HRD-81-155)	September 25, 1981

2/Letter report to Chairman, Federal Council on Aging.

NOTES

1/ K. Reiss, Federal Programs That Finance Home Health Care Services (Washington, D.C.: Congressional Research Service, March 1981), p. 3.

2/ Medicare Home Health Services: A Difficult Program to Control, U.S. General Accounting Office, HRD-81-155, September 25, 1981, p. 1.

3/ Ibid, p. 6.

4/ Long-Term Care for the Elderly and Disabled (Washington, D.C.: Congressional Budget Office, August 1977), p. x.

5/ Improved Knowledge Base Would Be Helpful in Reaching Policy Decisions on Providing Long-Term In-Home Services for the Elderly, U.S. General Accounting Office, HRD, forthcoming, p. i.

6/ Entering a Nursing Home: Costly Implications for Medicaid and the Elderly, U.S. General Accounting Office, PAD-80-12, November 26, 1979, p. 64.

7/ American Association of Professional Standards Review Organizations, "Long-Term Care One-Day Census" (September 4, 1980), p. 4.

8/ Response to the Senate Permanent Subcommittee on Abuse in the Home Health Care Industry, U.S. General Accounting Office, HRD-81-84, April 24, 1981, p. 1.

9/ Ibid.

10/U.S. Senate, Home Health Care Fraud and Abuse, Report of the Committee on Governmental Affairs, Permanent Subcommittee on Investigations, October 19, 1981, p. 43.

11/Medicare Home Health Services, p. 31.

12/Home Health: The Need for a National Policy to Better Provide for the Elderly, U.S. General Accounting Office, HRD-78-19, December 30, 1977, p. 17.

13/Personal communication on September, 1981 updating the paper by F. A. Skellie, G. M. Mobley, and R. E. Coan, entitled "Cost Effectiveness of Community Based Long Term Care: Current Findings of Georgia's Alternative Health Services Report," presented to the Annual Meeting of the American Public Health Association, Detroit, Michigan, October 19-23, 1980, table 2.

14/W .G. Weissert, T. T. H. Wan, and B. B. Lirieratos, "Effects and Costs of Day Care and Homemaker Services for the Chronically Ill: A Randomized Experiment," U.S. Department of Health, Education, and Welfare, 1979, pp. 27-29.

15/S. L. Hughes, Evaluation of a Comprehensive, Long Term Home Care Program for Chronically Impaired Elderly (Evanston, Northwestern University, 1981), p. 45, citing a 1978 study by Janet B. Mitchell entitled "Patient Outcomes in Alternative Long Term Care Settings."

16/M. Stassen and J. Holahan, A Comparative Analysis of Long Term Care Demonstrations and Evaluations (Washington, D.C.: The Urban Institute, September 1980), p. 110.

17/Hughes, p. 3.

18/Compilation of results from Michigan Blue Cross, 1976; Berger, 1971; Schutchfield et al. 1971: Rawlinson, 1972; Associated Hospital Service of New York, 1972; Connecticut Blue Cross, 1975; Good Samaritan Hospital, Cincinnati, Ohio, 1976; Denver VNA, 1976a; and Denver VNA, 1976b--as reported in T. Hammond, "Home Health Care Cost Effectiveness: An Overview of the Literature," Public Health Reports, Vol. 94 (August 1979), p. 2.

19/L. W. Gerson and F. E. Berry, "Psycho-Social Effects of Home Care: Results of a Randomized Controlled Trial," International Journal of Epidemiology, Vol. 5 (1976), pp. 162-63.

20/M. S. Freedland and C. E. Schneider, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," Health Care Financing Review (Winter 1981), p. 106.

21/See Skellie, Mobley, and Coan, table 1.

22/Weissert, Wan, and Livieratos, pp. 27-29.

23/B. Hicks et al., "Triage Experiment in Coordinated Care for the Elderly," American Journal of Public Health, Vol. 71, (September 1981), p. 998, in Hammond, p. 310.

24/M. Bleckner, M. Bloom, and M. Neilson, "A Research and Demonstration Project of Protective Services," Social Casework (October 1971), p. 495.

25/American Association of Professional Standards Review Organizations, p. 7.

26/Office of Service Delivery Assessment, In-Home Services to the Elderly--A Service Delivery Assessment, U.S. Department of Health and Human Services, Office of Inspector-General, September 1981 (Draft), p. 9.

27/Skellie, Mobley, and Coan, p. 8, and Wiessert, Wan, and Livieratos, pp. 28-30.

28/Unpublished data, U.S. General Accounting Office, September 1981.

29/Working Papers on Long-Term Care, U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, October 1981, p. 103.