CARE

P.O. Box 3-488
2200 E. 42ND AVE. • ANCHORAGE, ALASKA 99501

January 28, 1980

The Senator Glen Hackney
Chairman- Health, Education, and
Social Services Committee
Alaska State Legislature
Pouch U
Juneau, Alaska 99811

Re: Testimony for Committee Hearings
January 28, 1980
Senate Bills 320, 321, & 322

Dear Senator Hackney:

SB 320 and SB 321

The "medically needy" of the State of Alaska are in great need of the relief that these two bills would provide by broadening income standards. We see, on a frequent basis, dignity being destroyed and families broken as individuals slightly over-income attempt to cope with the increasing costs of catastrophic illness. Legislation providing for the financial gaps in health care has long been needed. We commend the Interim Committee on Services on the Elderly for identifying this as a priority need.

SB 322

We wish to express our strong support for the concept of payment to certain institutions and agencies for Medicaid-eligible persons on the basis of prospectively determined rates. We believe that a "prospective rate" system in the State of Alaska would greatly enhance the quality of care available for a cost-effective dollar. The consequences of this bill are far reaching and of a major importance to the future of health care in this state. Detailed comments on this proposed legislation will be provided to you in the near future. I regret that this is not available to you at this time, but we do want to provide you with accurate and careful consideration on the details of this bill, while at this time expressing our firm conviction that "prospective rates" can be an appropriate solution to a crucial problem.

Respectfully yours,

HEALTH CARE SERVICES - ALASKA, INC.

Donna M. Stephens

Donna M. Stephens, Administrator
Careage House & Nakoyia Health Care Centers

Dick Wilson, Administrator
Careage North Health Care Center

DMS:DW:mlc

DRAFT

POSITION PAPER
ON
SENATE BILL 322
HOUSE BILL 612

"An Act authorizing payment for services provided by certain institutions and agencies to Medicaid-eligible persons on the basis of prospectively determined rates; and providing for an effective date."

Senate Bill 322 and House Bill 612 would require that Medicaid reimbursement for services provided by hospitals, long term care facilities, and home health agencies be based on a prospective determination of reimbursement.

Under the present State and Federal statutory language, such reimbursement is permissive.

The Department of Health and Social Services supports the concept of prospective determination of reimbursement. Major benefits of such a program are:

Could be either prospective/retro

1.) Standardization of Health facilities Reporting and Budgeting.

2.) Centralization of hospital operational data.

pro-prospective

3.) Reimbursement based on budgeted costs instead of historical cost settlements.

4.) Concurrent communication between the Department and health facilities manager.

5.) Billing and Payment simplification based on pre-negotiated reimbursement.

While Senate Bill 322 or House Bill 612 would authorize, if passed, a prospective reimbursement system, however, it does not provide for the implementation of a Unform Reporting Budgeting System which is paramont to the development of an efficient prospective reimbursement system.

After a historical review of prospective reimbursement programs, in other states, it was determined that propective reimbursement requires basic provider education, technically qualified experienced staffing, and a systematic approach to operations.

Historical review also shows that it takes approximately two-three years to develop an effective uniform data base which provides for informed decisions in determining reimbursement.

In accordance with our agreement with the Senate Health Education Social Services committee hearing on January 28, 1980, the following alternative proposal to Senate Bill 322 has been developed.

The development of these alternatives have been in consultation with the Alaska State Hospital Association and Long Term Care Division, Health Service, Incorporated, a Proprietary Nursing Home Corporation in Alaska, and the Department of Health and Social Services.

Alternative #1: Tableing of both bills and the passage following resolution:

BE IT RESOLVED BY THE SENATE:

WHEREAS; The current systems for the payment of services provided by health facilities have become cumbersome, and unnecessarily complicated, and

WHEREAS; The cost of providing care has increased due to the administrative support involved in maintaining these systems, and

WHEREAS; The State costs for monitoring and administrating these cumbersome and complicated systems has increased, and

WHEREAS; The Alaska Legislature, State of Alaska, and the Health Care Industry wishes to limit escalating costs for non-patient related services, and

WHEREAS; A State and Federally approved system for Health Facility Uniform Reporting and Budgeting (S.U.R.) would provide a solution, and

WHEREAS; a uniform system of prospective rate negotiation and reimbursement would assist in reducing non-patient service costs; therefore

BE IT RESOLVED that the Alaska Legislature provide funding for the establishment of an Alaska System for Health Facilities Uniform Reporting and Budgeting using the National Manual on Systems for Uniform Reporting as a guide, and

FURTHER RESOLVED that this system, once developed be accepted by the Federal government and State of Alaska as the system for all health facilities in the State of Alaska; and

FURTHER RESOLVED that the Alaska Legislature establish and fund a committee composed of representatives from the State Department of Health and Social Services, U.S. Department of Health and Welfare, and Alaska State Hospital Association, and Long Term Care Division to develop proposed legislation which would establish a uniform system for prospective rate negotiation and reimbursement in the State of Alaska, and

Fairbanks Memorial Hospital

1650 Cowles St.
FAIRBANKS, ALASKA 99701

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

February 1, 1980

Senator Glen Hackney
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator:

Recently I received a copy of Senate Bill 322 which is an act authorizing payment for services provided by certain institutions and agencies to Medicaid eligible persons on the basis of prospectively determined rates and providing for an effective date.

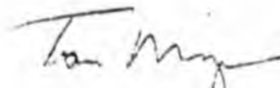
As I am sure you are aware, hopsitals in the State of Alaska are currently being reimbursed on a cost basis as it relates to the Medicaid program. Some hospitals feel that the costs which Medicaid recognizes does not include the full cost of services. Since this mechanism is set up through the Federal Medicaid/Medicare regulations, the state has very little ability to change these.

As my understanding goes, the purpose of a prospective rate determination is for the distinct advantage of having hospitals lower their length of stay and/or occupancy rate. Fairbanks currently has a length of stay of less than four days while the national average is approximately 7.5. In addition, Fairbanks Memorial Hospital currently boasts a bed per thousand ratio of approximately 2.[illegible], whereas the national average is 4.5. These are two main reasons why Senate Bill 322 should not be passed. In addition, the bill is very unclear as to who will determine a "fair rate or reasonable costs of services rendered". It is my impression that what Medicaid is attempting to do is to pay the hospitals less than their actual costs which they are receiving at the present time. In addition, it would be interesting to know the definition of reasonable costs of services which is located in paragraph 070 of the proposed legislation.

We at Fairbanks Memorial Hospital strongly oppose Senate Bill 322 for the reasons listed above and many reasons ~~for which are~~ not outlined here due to lengthy explanations which would be required to explain the prospective reimbursement system.

On another matter we at Fairbanks Memorial Hospital are having severe nursing shortage problems, and since we are the only hospital in the area we have severe staffing problems especially when several of our nursing service personnel are picked for jury duty. We would be interested to see if you, as a legislator, could get the statute amended to exclude registered nurses in addition to teachers, etc. We feel that this is not unreasonable since these professionals play a very key part in the functioning of an acute care hospital.

Sincerely,



Tom Mingen
Administrator

TM/mw

ST. ANN'S NURSING HOME
415 Sixth Street, Juneau, Alaska 99801 (907) 586-3883

February 19, 1980 File

The Honorable Senator Hackney
Senate Chambers
State Capital Building
Juneau, Alaska 99801

RE: Senate Bill No. 322
Prospective Rate-Setting

Dear Senator Hackney:

Thank you for providing St. Ann's Nursing Home this opportunity to express its views on Senate Bill No. 322 relating to prospectively determined rates of reimbursement for care provided to Medicaid-eligible patients.

We readily understand the concern of the legislature concerning ever escalating costs to the taxpayer, and the very urgent need to put a lid on purchases of whatever kind. However, we are also concerned that prospectively determined rate-setting will, of itself, add to the cost push of this inflationary cycle. The Department of Health and Social Services has, in their position paper, given testimony to the need for development of an effective data base to provide information for informed decisions in determining reimbursement, and they show that it takes two to three years to achieve this readiness to start!

In our view, the Senate Bill No. 322 has significant short-comings. It says payment shall be made on the basis of a prospectively determined fair rate for reasonable costs, but fails to say who will determine what the fair rate is. It includes payment for patient care, without defining which of our patients' every-day needs are included in this designation of patient care. It leaves the whole field of determining the details of legislation open, presumably for some regulatory body to determine either with or without consultation of the providers that will be regulated. With such open-ended legilsation, I would hope to see appeal processes spelled out in great detail.

As we at St. Ann's understand the proposal for Prospective Rate-Setting, all costs of patient-care, including the ancillary charges for Physiotherapy and Occupational Therapy, as well as drugs and supplies would be included in the rate

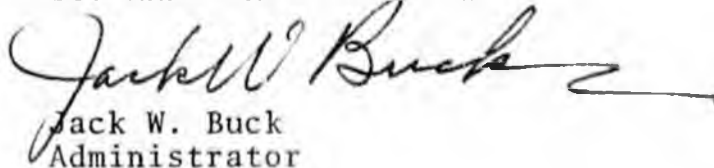
assigned as fair reimbursement. Since the above services are totally unpredictable, there is a clear danger that we would be forced to budget our costs aggressively in order to be sure that we could break even. This would clearly cause a precipitous jump in the cost to the state of doing Medicaid business. The alternative would be to specifically exempt such unpredictable costs and retrospectively reimburse at year-end, a situation that would completely negate the purpose of this bill.

Another possibility does exist, one that any concerned citizen would have to reject out-of-hand, and that is the possibility of reducing the level of care given to the patients by such a margin as to maintain the current cost level. Clearly, no provider is willing to take such measures, and we are convinced the legislature would condemn this method of cost containment.

It is our understanding that an alternative has been proposed that would involve only the free-standing nursing homes. This nursing home does not support that stand. St. Ann's Nursing Home has been in business just two and a quarter years, is still growing, and hopes to attain eighty percent census late this year. It can be seen that prospective costing would be a serious impediment to our doing business, in that we have not yet acquired sufficient data base to forcast with any great deal of accuracy.

We do understand that such a method of budgeting would have immediate advantages to the proprietory sector of the nursing home business. In the proprietory sector, it would be a distinct advantage to be able to show a predictable profit in case of negotiations to borrow funds, or to sell, or even to market stock or securities. Therefore, we offer as yet another alternative, the possibility that the proprietory sector of the Skilled and Intermediate Care Nursing Home industry be subject to prospective rate-setting for a developmental period.

Sincerely,
ST. ANN'S NURSING HOME



Jack W. Buck
Administrator

JWB:ar

Options for State Only Medical Assistance Program
for Medically Needy

DRAFT

I. Who should be eligible for the program?

a. All medically needy (including intact families, single adults, etc.)

b. Select groups:

1. Elderly (need to define cut-off age - 55, 60, 65).

2. Blind.

3. Disabled (need to define degree of disability).

4. Families with children.

DRAFT

A. AFDC-related (at least one parent away from home).

B. All families.

5. Single adults

A. Employable (work requirements?).

B. Unemployable.

II. To what income level should people spend down to?

a. Same as General Relief-Medical.

1. $________ - single.

$________ - couple.

2. Higher level.

III. What kinds and amounts of resources allowed?

a. General Relief-Medical level.

b. Higher or lower level.

c. Special consideration.

1. Home.

IV. What services to cover?

a. Same as General Relief-Medical.

b. Same as General Relief-Medical plus residential care or other home care (adult - foster care; adult - day care).

c. Select services:

1. Hospital.

2. Physician services.

3. Nursing home.

4. Drugs.

5. In-patient psychiatric services.

6. Mental health clinic.

7. Eyeglasses and optometric exams.

8. Hearing ~~adis~~ aids and evaluation.

9. Residential care.

10. In-home services (home health; adult-foster care; adult-day care).

11. Out-patient surgical center.

12. Medically necessary transportation.

V. Legal Mechanism:

~~a. Modify Catastrophic Illness statute (payment after the services).~~

a. Modify Catastrophic Illness statute (payment after the services).

b. Modify General Relief-Medical statutes.

c. Separate new program~~s~~ administered by Public Assistance.

VI. Funding.

a. Open-ended appropriation (supplementals will be honored).

b. Fixed sum "full need" appropriation (supplemental will not be honored).

c. Pilot project or limited funded statewide project.

ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

February 19, 1980

Senator Glenn Hackney
Chairman - Health, Education, and
Social Services Committee
Alaska State Legislature
Pouch U
Juneau, Alaska 99811

Re: Testimony for Committee Hearings
February 1980
Senate Bill 322

Dear Senator Hackney:

Speaking for our association, I wish to elaborate on our position related to S.B. 322/H.B. 612 concerning "prospective reimbursement for hospitals, nursing facilities, intermediate care facilities, etc." Due to the briefness of the bill as it now stands, we cannot effectively comment other than to state that an effective date of July 1, 1980, we feel, is overly optimistic. Other states who presently have prospective reimbursement have implemented their system after several months of preparation, and we recognize the need for similar time in Alaska.

Identification should be clearly made that the primary interest in a prospective reimbursement program in Alaska at this time is most closely aligned with some free-standing nursing facilities rather than hospitals. Health Care Services of Alaska Inc., a proprietary nursing home corporation, has spearheaded the movement because it would address a number of problems they are now faced with under the retrospective system. Due to the nature of long-term care reimbursement (a per diem rate) it more readily identifies with a prospective settlement. It is our recommendation that if a prospective reimbursement program is necessary at this time in Alaska, consideration be given to limiting the program to free-standing nursing homes who wish to participate as a pilot for other health care providers.

The purpose for which such legislation was initiated should be clearly spelled out and a follow-up program to evaluate its effectiveness should be developed at its inception. I have enclosed a report from the State of Colorado showing where a similar program has just been deregulated due to a lack of effectiveness.

Association endorsement for an inclusive prospective reimbursement system for both hospitals and long-term care institutions requires some assurances to the following:

1. That a reporting and budgeting system be established which would provide for uniformity in establishing the reimbursement for Medicare/Medicaid patients throughout the state, taking into consideration geographic and other unique variables.

2. That adequate time prior to implementation be allowed to develop the software, education and appeal processes for an effective program.

3. That the costs associatiated with the change-over in programs not be assessed the institutions participating or their private patients.

4. That allowable reimbursement include all of the necessary costs of operation including: bad debts; charity (mandated by federal law for Hill-Burton hospitals); debt service costs; adequate depreciation and an equity factor allowing for new technology and expansion.

5. That the present Medicare/Medicaid reimbursement program be replaced by the prospective system so as not to add an additional billing requirement.

6. That the determination of rates, i.e. the "rate authority", would be truly a representative body, including providers.

7. That the initial and ongoing cost of the regulatory body not be borne by the providers.

8. That an appeal process be established at the very outset of the program to deal with inequities which may surface and could be substantiated.

9. That the program be monitored by the legislature to determine if the regulatory body is carrying out the intent of the legislation.

10. That the regulations for this program be developed through cooperative efforts between representatives who are providers, working in conjunction with the regulatory agencies.

11. That special consideration be given to institutions providing both acute and long-term care in determining their budgeting and reporting requirements.

12. That reporting requirements be based on a recognized standard in the industry and be as simplified as possible.

Major concerns rest with the fact that many of our hospitals are operating with a limited census, with approximately 85% of their budget accounted for in wages and fixed overhead. Smaller facilities may not have the manpower or financial resources to comply with an immediate prospective program.

A final concern relates to the lack of success in other states in making significant improvement in containing costs through this mechanism. We have been more successful than many who already have a rate commission and prospective budget approval.

If we can be of further service to your committee, please contact our office at your convenience.

Sincerely,

Max Kersbergen
Executive Director

MK/ic

Enclosure

POSITION PAPER/Department of Health & Social Services

ADDENDUM TO POSITION PAPER ON SENATE BILL 322 (Identical to House Bill 612)

"An act authorizing payment for services provided by certain institutions and agencies to Medicaid-eligible persons on the basis of prospectively determined rates; and providing for an effective date."

Senate Bill 322 would require that Medicaid reimbursement for services provided by hospitals, long term care facilities, and home health agencies be based on a prospective method of reimbursement by July 1, 1980.

Under the present State and Federal statutory language, such reimbursement is allowed.

Overview

The current systems and methods of reimbursing health facilities for services to Medicare and Medicaid beneficiaries is retrospective in nature. That is, health facilities are paid for their services based on a cost report submitted after the fact at the end of each facilities fiscal year. The Medicare intermediary (Blue Cross) and The Medicaid intermediary (State Department of Health and Social Services) review these year end cost reports and pay the facilities the lessor of allowable costs or charges. During each year the intermediaries pay the health facilities an interim rate based on the prior year's cost report.

This system of reimbursement was established with the advent of Medicare in the 1960's. It has been revised and added to, over the years so that today it has become very cumbersome, complicated and duplicative. Nationally, the "retrospective" system is considered one of the major causes of the escalation in health care costs as the system lacks incentives to control expenditures. The current system is static and inflexible. Decisions are often made by accountants, based on "generally acceptable accounting principles", rather than on the merits of each individual situation.

In response to this situation, twenty-seven to thirty-four States have instituted a "prospective" system of reimbursement. These prospective systems have taken many forms, each state's structure a little different. However, the philosophic purposes seem to be common "To encourage economy and efficiency to establish a uniform system of reporting and determination of a health facilities future reimbursement."

Department's Position

The Department of Health and Social Services supports the concept of prospective reimbursement. Major benefits of such a program would be:

1.) Standardization of Health Facilities Reporting and Budgeting.

2.) Uniform Collection of hospital operating data for the purpose of determining reasonable rates.

3.) Reimbursement based on current budgeted costs instead of historical cost settlements.

4.) Routine communication between the Department and health facilities managers.

While Senate Bill 322 would authorize, if passed, a prospective reimbursement system, it does not require the implementation of a Uniform Reporting and Budgeting System which is critical to the development of an efficient prospective reimbursement model.

After a historical review of prospective reimbursement programs in other states, it was determined that installation of a prospective system requires basic provider education, technically qualified and experienced cost accounting staff, and a phased approach to implementation.

Based on our analysis of other state's experience with prospective reimbursement, the department recommends a phased approach to the development of a prospective reimbursement system be considered as follows:

1.) The Legislature authorize and fund the development of a State and Federal approved system of health facilities uniform reporting and budgeting. In meetings with the Alaska State Hospital Association, it has been clear that the hospitals and long term care facilities in the State agree that this is a necessary pre-requisite prior to implementing a prospective reimbursement system.

A Uniform Reporting and Budgeting system should be implemented as a first priority. This system should be patterened after the nationally recognized System for Hospital Reporting (SUHR) and the American Health Care Associations, Chart of Accounts. It is

envisioned that this system would be developed with the intention of consolidating in the State of Alaska, all State and Federal Budget and Reporting requirements, ie: Medicare, Medicaid, Alaska Native Health, General Relief Medical, etc.

2.) That a task force be formed composed of representatives of the United States Department of Health, Education and Welfare, Alaska Department of Health and Social Services, and two representatives of the Alaska State Hospital Association. That this task force be charged with publishing a report recommending legislative actions; proposed regulations to support the recommended legislative action and that these recommendations be published prior to the January 1981 legislative session.

A fiscal note and estimated time line for this approach is attached. If this suggested phased approach were used a prospective reimbursement system could be operational by July 1, 1981.

If the legislature simply passes legislation beginning a prospective system effective July 1980, the Department would be in a position of "pushing" a system that has not received adequate health facility education, would impose yet another budgeting and reporting system on health facilities without their support, and would require holding public hearings over a very compressed period of time. This method of implementing a prospective system could result in as much or more time being required to implement a working system as will be required through the Department's suggested method.

The Department supports Senate Bill 322 in concept but would prefer a more phased method of implementing a prospective rate setting system.

Recommended by: Rod Betit March 12, 1980
Rod Betit, Director
Division of Public Assistance

Approved by: Helen D. Beirne 3/12/80
Helen D. Beirne, Commisioner
Department of Health & Social Services

POSITION PAPER
ON
SENATE BILL 322

"An Act authorizing payment for services provided by certain institutions and agencies to Medicaid-eligible persons on the basis of prospectively determined rates; and providing for an effective date."

Senate Bill 322 would require that Medicaid reimbursement for services provided by hospitals, long term care facilities, and home health agencies be based on a prospective determination of rates based on reasonable cost. Under present statutory language, such reimbursement is permissive.

Line 13 of the bill should be amended to add "skilled" between "hospital," and "nursing."

The Department of Health and Social Services supports the concept of a prospective method of determining reasonable rates of reimbursement. A prospective system would provide for an up-front negotiation between the State and the provider before services are provided rather than an after-the-fact review as exists under the present retroactive reimbursement system. Providers, the Department, and the Legislature would know in advance what budgetary limitations exist, how much would be spent, and for what services. Barring major emergency or extreme economic change, cost-settling practices should be eliminated for these categories of service.

While this bill would begin to address cost containment in the area of hospitalization and long term care, additional administrative costs would be incurred due to the requirement for contract development and negotiations. Various approaches may be used to implement a prospective reimbursement system. The Department is drafting a detailed explanation of those options and will have additional information on cost, program, and administrative impact.

The Department supports S.B. 322 in concept but must oppose its passage as the Governor's Budget Review Committee has not had an opportunity to approve the additional funding in administrative costs which would be required.

Recommended by: 1/25/80

Rod Betit, Director
Division of Public Assistance
(DATE)

Approved by: 1/25/80

Helen D. Beirne, Commissioner
Department of Health and Social Services
(DATE)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SENATE BILL 322
Title "Prospective Reimbursement for Health Facilities"
Requested by Senate HEWW Committee Date 1/25/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Medical Assistance
BRU, Program, or Subprogram(s) Affected Public Assistance Administration
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	9,485	56,910	28,455			
200 TRAVEL		20,064				
300 CONTRACTUAL		70,000				
400 COMMODITIES		3,000	1,000			
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	9,485	149,974	29,455			

FUNDING (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
GENERAL FUND	4,743	74,987	14,728			
FEDERAL FUNDS	4,742	74,987	14,728			
OTHER (Specify Fund Source)						

POSITIONS

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
FULL TIME						
PART TIME						
TEMPORARY	2	2	2			

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This fiscal note assumes legislation authorization for this program by April, 1980.

The fiscal note provides for beginning activity in late FY 80, a full year operation in FY 81 and a 1/2 year transition to existing audit staff in FY 82.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Rod Betit Date: 3/12/80
Division/Office: Public Assistance PH: 465-3355
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: [signature] Date: 3/12/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Page ____ of ____

Time Schedule for Completion
of Uniform Reporting and
Proposed Prospective Rate Legislation

Budgeting and Uniform Reporting System	May 1980	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan. '81	Feb.	Mar.	Apr.	May	June	July
1. Request for proposal published and support staff hired	→														
2. Contract Awarded	→	→													
3. First Draft Budgeting-reporting forms and system	→	→	→												
4. First Regional Meetings to review Drafts	→	→	→	→											
5. Revise Forms and System	→	→	→	→	→										
6. Final Regional Meetings	→	→	→	→	→	→									
7. Preparation and Completion of Final Forms and System	→	→	→	→	→	→	→								
8. Publish Health Facility manuals and inform providers of implementation	→	→	→	→	→	→	→	→							
9. Implement	→	→	→	→	→	→	→	→	→						
Task Force Activities															
1. Hire of staff support & Task Force Appointment	→														
2. Routine Meetings of Task Force	→	→	→	→	→	→	→	→	→						
3. Meeting with Senate HESS Committee with prposed Legislation	→	→	→	→	→	→	→	→	→	→					
4. Introduction of proposed legislation to esablish a prospective system	→	→	→	→	→	→	→	→	→	→					
5. Implementation of prospective rate setting(if legislation passes)	→	→	→	→	→	→	→	→	→	→	→	→	→	→	

1.) One auditor to assist current state audit staff in development of State's portion of Uniform Budgeting & Reporting, as well as to staff task force in the development of the task froce report.

SR 18= 2517x 2 months x.25% = 6,292
2517x 12 months x .25% 37,755
2517x 6 months x .25% 18,887
$ 62,924

2.) One clerk typist to support the auditor and assist in task force minutes, document distribution etc.

SR 8= 1,277 x 2 months x .25%= [illegible],193
1,277 x 12 months x .25%= 19,155
1,277 x 6 months x .25%= 9,578
$31,926

Travel and Perdiem

1.) Task Force Operations
Eight Meetings of Task Force
in Anchorage (Six persons)
a.) Travel
8 x 6 x $300= 14,400

b.) Perdiem
6 x $59 x 3 days x 8 meetings= 5,664

TOTAL $ 20,064

Contractual

1.) Contract with firm specialized in prospective rate setting system, contract to include two regional meetings with health facilities to review proposed budget-reporting forms and system

$70,000

Commodities

1.) Postage and Printing costs for correspondence and reports 4,000

Introduced: 1/15/80
Referred: Health, Education & Social Services and Finance

our copy

BY THE RULES COMMITTEE BY REQUEST OF THE LEGISLATIVE COUNCIL (for the Interim Committee on Services for the Elderly)

IN THE SENATE

SENATE BILL NO. 322

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act authorizing payment for services provided by certain institutions and agencies to Medicaid-eligible persons on the basis of prospectively determined rates; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 47.07.070 is repealed and re-enacted to read:

Sec. 47.07.070. PAYMENT TO INSTITUTIONAL PROVIDERS. Payment for services provided by hospitals, nursing facilities, intermediate care facilities, inpatient psychiatric facilities, and home health agencies shall be made to the providers of services for Medicaid-eligible persons on the basis of a prospective determination of fair rates for the reasonable costs of services rendered, including

(1) patient care;

(2) charity and credit losses in accordance with regulations of the United States Department of Health and Human Services;

(3) maintenance, improvement and expansion of buildings and equipment;

(4) debt service for amortization of principal and interest payments.

* Sec. 2. AS 47.07.080(1) is repealed.

* Sec. 3. This Act takes effect July 1, 1980.

SB
323

COMMITTEE REPORT
SENATE

1/15/80

FURTHER: Finance

Date: 2/11/80

Mr. President:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had SB 323 making a special appropriation to the Dept. of Health and Social Services for homemaker health aide services; effective date

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

[ ] do pass [ ] do not pass

[✓] do pass with attached amendments(s)

[ ] replace with CS for ______ [ ] same title [ ] new title

and recommends ______

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the ______ Committee

MEMBERS SIGNING DO PASS	MEMBERS HAVING OTHER RECOMMENDATIONS:
Coletta	

CHAIRMAN

do pass

S 60 (Rev. 12/78)

AMENDMENT

OFFERED IN THE SENATE: BY: SENATE HESS

TO: ________ SENATE BILL No. 323

HOUSE BILL No. ________

PAGE: 1 LINE: 7

line 7: change "homemaker" to "homemaker/home"

SB 323 [illegible]

An Act making [illegible] 1979-80 to the Dept. of HSS for homemaker [illegible] services providing [illegible]

Introduced 1-15-80
Logged - 1-15-80
Referred Finance
Comm. Meeting 1-30-80 - 1 ~~[illegible]~~ 2-11-80 - Passed with amendment.
" Action

Passed with amendment.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

POUCH H-05
JUNEAU, ALASKA 99811

REPORT REGARDING SENATE BILL NO. 323

HOMEMAKER HOME HEALTH AIDE SERVICES

Regardless of whether or not there is a single statewide contract or regional/local contracts, the administrative costs as well as the unit cost for a contractor will increase with the addition of home health aide services. The additional unit cost will be approximately $5/unit in an urban area. The additional cost per unit results from the need for:

additional 35 hours of training for home health aides;
licensed nursing supervision of home health aides;
increased supervisory visits and travel;
increase in salary for home health aides.

The present homemaker contractor, Easter Seal Society, receives $9.34 per unit. The contractor anticipates the unit cost for homemaker services to increase to between $12-15/unit for FY 81 since the current unit cost is not adequate. The increase will enable the contractor to have full time regional supervisors and adequate supervisory travel. An additional supervisor is needed in Anchorage. In addition, workmen's compensation costs are approximately $3,500 more than their original estimate.

Currently at $9.34/unit with the FY 80 funding level of $1150.0 there are 123,126 units of service available.

If the unit cost of homemaker services increased to $12/unit at a funding level of $2500.0 there would be 208,333 units of homemaker service available, an increase of 85,207 units or 69% over FY 80.

If home health aide services were added to homemaker service at a unit cost of $12, the additional $5/unit for home health aide service would result in a $17/unit cost for combined homemaker-home health aide services. At a funding level of $2,500.0 there would be 147,058 units of service available, an increase of 23,932 units of service or 19% over FY 80.

The following table shows what the increase in units of service would be at various funding levels.

UNITS OF HOMEMAKER-HOME HEALTH AIDE SERVICE

		# of Units	% of Increase Over Current Year
($17/unit)	$2,500,000	147,058	19%
Funding	$3,000,000	176,470	43%
Levels	$3,500,000	205,882	67%
	$4,000,000	235,294	91%

The current rate of $9.34/unit includes homemaker wages as well as administrative costs which were figured at 30% of the $1150.0. The contractor's administrative costs include:

Travel
Supervisor's salaries
¼ time executive director's salary
Program director's salary
Bookkeeper's salary
Secretary's salary
Fringe benefit 18% (workmen's compensation, E.S.C., employer's FICA, and Blue Cross coverage for full-time employees)

The increased workmen's compensation costs, additional supervisory travel, full-time nursing supervision, and additional training will increase the administrative costs. For comparative purposes, the administrative costs for Alaska Homemaker-Home Health, Inc. were 51%.

During the first year of implementation of a homemaker-home health aide program a great deal of developmental work will need to be done including:

development of program standards based on the standards of the National Council of Homemaker-Home Health Aide Services;
development of a training program based on national standards;
educating medical providers and potential clients regarding home health aide services;
hiring full time nursing supervisors;
developing an adequate supervisory system to meet the needs of rural areas;
developing a unified referral system;
developing a unified case recording system;
developing protocols and agreements with medical providers;
developing a case monitoring system.

Given the number of developmental tasks and the fact that at the present time it is difficult to determine what the actual need and demand for home health aide services are, during the first year a single statewide contractor is preferred. Once a program is developed and fully operational it would be easier to then move to have regional contracts.

It should be noted that with regional or local contracts the administrative costs would increase since each contractor would need to have administrative staff and depending on the area of the state travel costs may be higher, as well as wages. At the present time it is also difficult to determine on a regional basis what the need is for home health aide services. In addition, the more contracts let, the higher the overall administrative costs will be.

The Division would, as a result, prefer to let a single statewide contract for FY 81. In developing the request for proposals, the Division would appreciate the assistance of members of the Interim Committee on Services for the Elderly to ensure input regarding the expectations of the contractor and specific requirements to meet regional needs. In urban areas, for example, it may be practical to have both homemakers and homemaker-home health aides, whereas in rural areas it would be more practical to have homemaker-home health aides.

During the first year, once some of the developmental tasks have been accomplished, various models of decentralization/regionalization can be developed so that quality services with local/regional control can be delivered in a cost effective manner. With input from potential regional/local providers, as well as the Interim Committee, a smooth transition plan could be developed. During FY 81 visits will be made to the various regions and communities of the State to provide information regarding the program and to encourage prospective contractors.

The Division, while favoring regionalization and decentralization, would like to ensure that a quality homemaker-home health aide service program is developed which addresses both urban and rural needs and which includes adequate training and supervision to ensure that clients receive quality service.

The Division supports allowing physicians or certified home health care agencies to make direct referrals to the contractor for home health aide services. Anyone, of course, who wanted homemaker-home health aide services and was able to pay for the service could go directly to the contractor for service as is now possible with homemaker service.

HOME HEALTH AIDE SERVICES

The following information is to provide the reader with an understanding of home health aide services.

Objectives of Home Health Aide Services:

1. Providing physical and emotional relief for a family member who has been caring for the patient.

2. Maintaining the patient at home, if that is the best plan for the patient and conforms with the medical overall plan for the patient/family.
3. Hastening rehabilitation and independence through concentrated service.
4. Stabilizing a situation until the family can make a better plan.
5. Enabling a family member to continue employment.
6. Reducing the length of frequency of nursing visits.
7. Making a patient more comfortable during terminal illness.
8. Perform functions which could be carried out by a family member if one were available.

Examples of Home Health Aide Services:

Under the supervision of the professional nurse gives health related personal care to the convalescent, disabled or chronically ill patient.

The professional nurse, by virture of her license to practice, is legally responsible for the non-professional worker she supervises.

Care for the patient's hair including shampoo
Change patient's bed linen
Rub patient's back
Help the patient with a bed bath
Help the patient wash hands and face
Care for fingernails
Care for patient's feet-skin and nails
Offer and remove bedpan and/or urinal
Turn the patient
Help the patient with oral hygiene
Help the patient with transfer activities
Encourage the patient's participation in active exercises
Monitor, with supervision, certain drugs and treatments
Perform dressing changes.

Examples of Homemaker Service:

Homemakers provide housekeeping and personal care services which are not health related and do not require the supervision of a health professional.

Home Management

a. light general cleaning

    1. Vacuuming
    2. Making beds
    3. Washing reachable windows

b. washing dishes

c. chopping wood

d. shoveling snow

e. keeping kitchen and bathrooms clean and orderly

f. Marketing for food supplies and other simple errands

g. planning and preparing nutritious, varied meals, fitting them into the cultural and economic standards of the family

h. serving meals

i. preparation of infant formulas and special diets

j. light washing, ironing, and mending of personal clothing and linens

k. listing of needed supplies

l. assisting members of the family, both young and adult, to learn household routines and skills

m. transportation.

Personal Care

a. Ambulation - walking the client

   1. Purpose must be to get someplace - NOT for exercise

   2. NO gait problems associated with specific health problems, e.g., stroke

b. Transfers - lifting/moving the client

   1. homemaker must be trained

   2. standby assistance only - no major lifting

c. Bathing

   1. standby assistance into bathtub/shower only

   2. may bathe in bed

   3. no acute medical or skin problems, no major lifting

d. Grooming

1. may wash hair - no giving of permanents
2. <u>no cutting of toenails</u>
3. may shave
4. no cleaning of ears
5. may clean dentures, brush teeth for oral hygiene
6. may cut fingernails if no nail problems.

<u>Responsibilities of the Nursing Supervisor in Home Health Aide Program</u>

1. Responsible for home health aide care given to all patients in her district.
2. Assesses need for home health aide service. All personal care to be performed by home health aides should have been first given by the nurse.
3. Interprets home health service to family.
4. Accompanies the home health aide on her first visit to the patient's home introduces home health aide to family. Demonstrates personal care to be given. Discusses and plans with home health aide for housekeeping and meal planning and preparation to be done.
5. Conferences on a scheduled basis with home health aide at least once a month.
6. Evaluates use of service, need for continuing service, plans for termination of service.
7. Visit at least once per month. At first it may be necessary to visit more frequently, every day or every week may be indicated in unusual or difficult situations. The need for each specific patient and home health aide will determine frequency of visits by the nursing supervisor.
8. Notify patient if home health aide is unable to visit on assigned day. Does patient's personal care, if necessary, especially if home health aide misses more than one assigned day.

<u>NOTE</u>: A means of adjusting this for rural areas will have to be developed.

Federal Funding

Home health aide services, when they are provided by a home health agency, are covered by Medicaid and Medicare. The eligiblity requirements of these programs are restrictive and, as a result, many people in need of home health care are not eligible to receive services under these programs. Homemaker-home health aide services can be provided under Title XX. Personal care services can be provided under Title XIX for eligible individuals. It would require an amendment to AS 47.07.030 which lists categories of services covered under Medicaid. It would also require the appropriation of additional funds.

Current Services Available

At the present time home-health aide services are available in Anchorage through the Anchorage Home Health Agency. Home health aide services are provided as a part of their home health care program which includes skilled nursing services, rehabilitative services (physical therapy, speech therapy and occupational therapy) and home health aide services. Home health aide services began in June, 1978. The cost per unit for home health care is $108.67. Their FY 80 budget is $400,000. Approximately 13%, or $52,000, is for home health aide services at a unit cost of $15.00. The number of units is 3466.

National Council on Homemaker-Home Health Aide Services

The Division has contacted the National Council for materials to assist the Division in the planning of homemaker-home health aide services. Upon receipt of these materials we will be able to more adequately address more specific questions.

Report Prepared By:

Elizabeth Muktarian
Social Services Program Coordinator
Division of Social Services

Approved By: [signature] DATE: 1/8/80
Art Holmberg, Director
Division of Social Services

CARE

P.O. Box 3-488
2200 E. 42ND AVE. • ANCHORAGE, ALASKA 99501

January 30, 1980

The Senator Glenn Hackney
Chairman - Health, Education, and
Social Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Testimony for Committee
Hearings - January 30, 1980
Senate Bills 323, and 325

Dear Senator Hackney:

SB 323

Homemaker Home Health aides are greatly needed through out the State of Alaska to complete the continuim of care in the health care system, allowing more persons to remain in their own homes and communities as long as possible. Although some studies show that supporting persons with chronic illness in the home can be as expensive as institutionalization, we must also recognize that as long as home support is feasibly possible, the quality of life for the individual is usually greatly enhanced. The cost-concept ratio must certainly be explored as we in the State of Alaska develop a philosophy of care for our ill, elderly, and handicapped citizens. Please remember that national statistics show that only 5% of those over 65 ever require long term institutionalization. As the percentage of persons in our population over 65 grows, we must have support services such as Homemaker Health Aide systems in place and functioning. Now is the time to act.

This bill also brings to mind several questions that, in our opinion, should be addressed:

1) What provisions should be made to ensure in the administration of this appropriation that supervision of the health component will be made?

2) What specifically is a Homemaker Health Aide Service and how does it differ both in funding and concept from the currently existing Home Health agencies and Easter Seal Homemaker's functions?

3) Is $2,500,000 an appropriate amount for the appropriation and how will it be distributed through out the State?

SB 325

Again, we wish to express our support of the concept of the State providing assistance to the elderly to increase the quality of life by mechanisms that allow our elders to live independently as long as possible. Our Social Workers have found that more senior citizen housing such as is available in Anchorage at the Chugach View Apartments, in Chugiak at the Chugiak Senior Citizen's Center, and in Fairbanks at the Golden Towers would be of great assistance in our discharge planning efforts. We also have identified a need for subsidized housing for the handicapped individual under 60 and would like to see this bill amended to take those persons into consideration.

There are currently many models through out the nation for "Senior Citizen Housing" from totally independent apartments or condominiums in one structure to units with common eating areas and meals provided along with recreational opportunities and health supervision. We, therefore, also recommend that the bill be amended to indicate the Legislature's intent of what exactly "Senior Citizen Housing" means.

Senate bills 323 and 325 compliment each other. For your information, we have attached one concept of the continuum need in long term care.

If we can be of further assistance in providing information, please do not hesitate to contact us.

Sincerely,

HEALTH CARE SERVICES - ALASKA, INC.

Donna M. Stephens

Donna M. Stephens, Administrator
Careage House & Nakoyia Health Care Centers

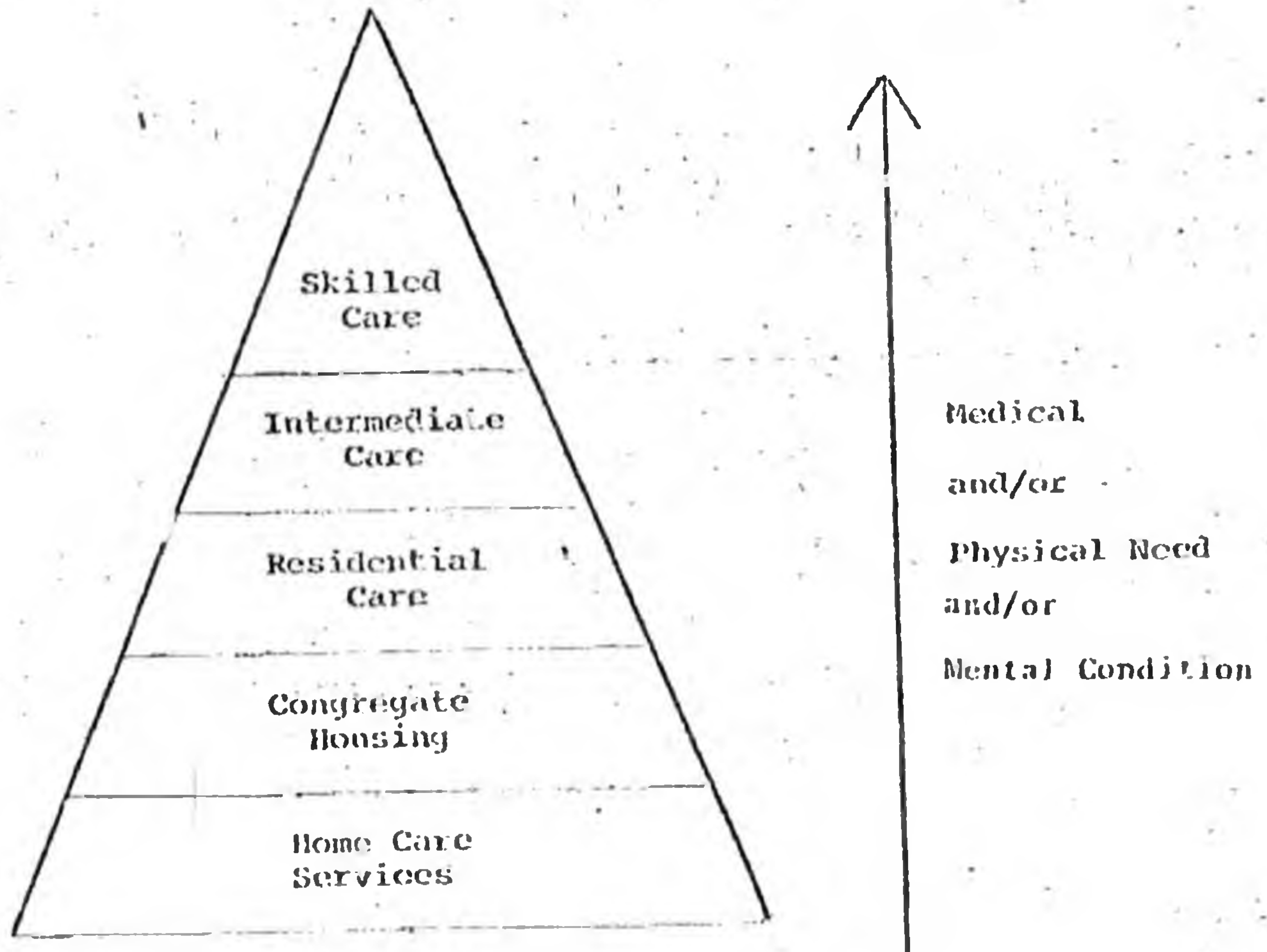
Dick Wilson

Dick Wilson, Administrator
Careage North Health Care Center

DMS:DW:mlc
Attach.

FIGURE 1.

THE LONG TERM CARE CONTINUUM



POSITION PAPER/Department of Health & Social Services

POSITION PAPER

SENATE BILL NO. 323
(Identical to H.B. 616)

2,500,000
1,150,000
1350

"An Act making a special appropriation to the Department of Health and Social Services for homemaker health aide services; and providing for an effective date."

The Department of Health and Social Services supports in concept the addition of home health aide services under the Division of Social Services. In the FY 81 budget the Governor has included an additional $303.5 over the FY 80 funding level of $1150.0 for homemaker services. The Department can support additional services up to that level of funding.

Home health aides provide personal care services such as bathing, assistance with transfer activities, assistance with ambulation, and assistance with passive exercises. These services alone would have an impact on reducing unnecessary institutionalization of disabled and chronically ill Alaskans. The impact would be more substantial if home health aide services were a component of a comprehensive home health care program ranging from skilled nursing to homemaker-home health aide services.

Currently the availability of home health services in Alaska is limited. The Division of Public Health has a limited amount of money available for skilled nursing home health services in Juneau and Fairbanks. Payment for home health care is also available under Medicare (Title XVIII) and Medicaid (Title XIX). The home health care available under these federal programs include home health aide services and are limited to medicaid and medicare eligible individuals. The eligibility requirements of these programs are restrictive and, as a result, many people in need of home health care are not able to receive needed services. They may be ineligible due to age, income or a disability which does not fall within the federal requirements.

If the Department developed either a homemaker-home health aide service or a comprehensive home health care program, this program would include the present homemakers who, after additional training, would be capable of providing health aide services under supervision of medical/nursing professionals. In order to implement a new program, much developmental work would need to be accomplished during Fiscal Year 1981. The contractor would need to set up a safe home health delivery service which includes, on a continuing basis, training and professional supervision. The addition of a home health component would result in a higher unit cost during the development phase and increase ongoing administrative costs.

Clarification is needed regarding interim committee intent with respect to eligibility for home health services. Currently, homemaker service is provided to all Alaskans based on need and service availability, regardless of age or income, under the Division of Social Services' child protection and adult protection programs.

Clarification is also needed regarding any interim committee intent with respect to contract limitations, i.e., whether or not regional contracts are mandatory. This information will assist the Department in preparing a request for proposals and in determining the allowable administrative costs for contractors. The Department recommends that this not be a requirement for FY 81.

Although the Bill authorizes a $2500.0 appropriation, the Department's understanding is that the interim committee intent is for an additional $1046.5 over the Governor's FY 81 budget request for homemaker services. The Governor's FY 81 budget request contains $1453.5 for homemaker service in the Division of Social Services.

The Department would like clarification regarding interim committee intent with respect to the use of additional funds. It is anticipated that the unit cost of homemaker services will increase in FY 81.

The Department views the addition of home health care services as a means of further assisting Alaskan citizens to receive the services they need in the least restrictive setting possible, as well as reducing the cost of unnecessary institutionalization.

RECOMMENDED BY: Art Holmberg DATE: 1-28-80
Art Holmberg, Director
Division of Social Services

APPROVED BY: Helen D. Beirne DATE: 1-28-80
Helen D. Beirne, Commissioner
Department of Health and Social Services

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No. 323
Title special appropriation to DHSS/DSS for homemaker home health aide services
Requested by Senate HESS Date January 25, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected Social Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES	0	0	58.5	64.9	70.7	77.1
200 TRAVEL	0	0	6.6	7.3	8.1	9.0
300 CONTRACTUAL	0	0	3.4	3.7	4.0	4.4
400 COMMODITIES	0	0	.8	.9	1.0	1.1
500 EQUIPMENT	0	0	2.5	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
	0	0	0	0	0	0
TOTAL	0	0	71.8	76.8	83.8	91.6

FUNDING (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
GENERAL FUND	0	0	71.8	76.8	83.8	91.6
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0

POSITIONS

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
FULL TIME	0	0	2	2	2	2
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

A. Assumption

1. Both positions budgeted for 12 months.

2. A 9% inflation rate for line items 100, 300 and 400.
   A 10.8% inflation rate for line item 200.

IV. DATE January 25, 1980 PREPARED BY Art Holmberg Art Holmberg
AGENCY Division of Social Services
PHONE 465-3170

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Reviewed by Michael Ordono
Division of Mgt & Budget
DHSS 1/25/80

33-001 (Rev. 12/78)

Senate Bill No. 323 FISCAL NOTE Continuation

TITLE: "An Act making a special appropriation to the Department of Health and Social Services and Social Services for homemaker health aide services; and providing for an effective date."

III. ANALYSIS (Continuation)

Coordinator for the homemaker-home health aide service would be responsible for:

- the development and maintenance of program policy
- coordination of homemaker-home health aide service with other services and programs
- establishing and maintaining standard of service
- technical assistance
- preparation of program requirements, contract preparation, contract monitoring and program evaluation
- collection analysis and interpretation of statistical data.

At the present time the responsibility for the management of the homemaker contract is being shared by several staff. The addition of a home health aide component would result in the need for a single central office position to establish standards of service, work with the contractor to develop a uniform referral system, record keeping system and establish monitoring guidelines.

Clerk Typist III

The additional work resulting from the new program component would double the present authorization level thus resulting in twice the paper flow, therefore, a clerk typist is needed.

Program Summary

1. New Positions

Range 18 - 6 mos @ $2,465 =		$14,790
6 mos @ $2,640 =		$15,840
		$30,630
fringe benefits @ 25.5% =		$ 7,810
		$38,440
Clerk Typist III - Range 8		
6 mos @ $1,277 =		$ 7,662
6 mos @ $1,393 =		$ 8,358
		$16,020
fringe benefits @ 25.5% =		$ 4,085
		$20,105
	TOTAL	$58,545

2. Other Expenses

Travel - for fiscal and program monitoring

2 Trips to Bethel	468 x 2 =	$936
Anchorage	255 x 2 =	$510
Fairbanks	301 x 2 =	$602
Nome	443 x 2 =	$886
Ketchikan	140 x 2 =	$252
		$3214
Plus $2,216 for travel to villages for spot reviews		$2216
		$5430
Per Diem 3 days per trip for 2 trips to 5 regions plus 1 day to six villages		$6,630

TITLE: "An Act making a special appropriation to the Department of Health and Social Services and Social Services for homemaker health aide services; and providing for an effective date."

III. ANALYSIS (Continuation)

Space Leased 200 Sq. Ft. @ $1.42 for 2 positions. 282 x 122 = $3,384

Commodities 400 per yr. per position + 9% inflation.

FY 81 Only

Equipment - 2 desks
2 chairs
1 typewriter
1 bookcase

A BILL RELATING TO IN-HOME SERVICES

I. PREAMBLE:

It is the right of every individual to live his life in circumstances which enable him to make the fullest use of his capacities. This right is protected when the society in which he lives provides those safeguards which ensure his basic economic security in a decent environment, and the services which are necessary to promote his physical, mental and emotional health. These services are only effective when they are available in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health.

In-home services are a major component in this system. They ensure appropriate utilization of all other components in the system; they utilize the home and the family as a valuable resource; they prevent the unnecessary displacement of persons which occurs when services are lacking; they guarantee the right of the individual to remain in the place of his choice. In the absence of in-home services, no system may be considered either comprehensive or effective. They must, therefore, be an integral part of this system and top state priority must be given to the development of a rational system of comprehensive in-home services for the whole population.

The state policy must provide:

* that in-home services which are comprehensive will be available, accessible and acceptable to every member of the population who needs them;

* that they will be available without restrictions as to diagnosis, race, religion, ethnic origin, age or sex;

* that they will be based on the needs of the consumer rather than the provider;

* that they will be provided without financial barriers;

* that they will be provided in circumstances which guarantee high quality;

* that they will be provided without barriers between health and social services, but as a coordinated blend which promotes and supports optimum health in the broadest sense;

* that they will be based upon a philosophy which recognizes the right of the individual to participate with professionals in making decisions about the place, type,

and extent of care and services he needs and receives.

II. DEFINITIONS:

(1) The term "in-home services" is meant to describe an array of services which can be brought into the home, singly or in combination, and which can be adapted to meet the needs of persons in all age groups, in all diagnostic categories, and in all economic and psychosocial situations when such services can be used therapeutically, or to prevent or arrest illness and disability, to supplement limited function and to protect and support those whose capacities for optimum development, function and participation in family and community life are threatened.

In-home services include, but are not limited to, the following:

* skilled nursing services as ordered by a physician;
* physical, occupational and speech therapy as ordered by a physician;
* personal care services as recommended by a physician or registered nurse;
* homemaker-home health aide as recommended by a professional person;
* chore services, friendly visits, escort services, shopping assistance, telephone reassurance, home repairs and maintenance, and nutrition services.

III. RECOMMENDATIONS:

(1) The FY 81 budget for Homemakers Services under the Department of Health and Social Services be increased from the current $1.15 million to $2.5 million with the following intent:

* the department shall double the amount of hours available for client service;
* the department shall contact with one organization to provide administration of the grant with provision for subcontracts to regional or local providers;
* the department shall provide for full-time (40 hrs/week) supervisors at an increased salary;
* the department shall allow local providers the option of homemaker-home health aide service according to standards set by the National Council of Homemaker-Home Health Aide Services, Inc.
* the department shall provide funds enough for a minimum of 40 hours of

training for homemakers, and 60 hours of training for homemaker-home health aides.

(2) The Department of Health and Social Services be instructed to take the necessary steps to include "personal care services" as an available coverage option under Medicaid.

(3) The State of Alaska be instructed to take the necessary steps to require that voluntary and commercial insurance plans include coverage of comprehensive in-home services.

SB 323

NATIONAL COUNCIL
for Homemaker-Home Health Aide Services, Inc.
A non-profit national standard-setting organization

67 Irving Place, New York, N.Y. 10003 (212) 674-4990

MIDPOINT REPORT

Advocacy Project

MIDPOINT REPORT

ADVOCACY PROJECT

National Council
for
Homemaker-Home Health Aide Services, Inc.

MARCH 1, 1979

Introduction

The National Council for Homemaker-Home Health Aide Services, Inc. was awarded a three year grant from the Administration on Aging early in 1977 to refine an "advocacy model" for application at the state level. The advocacy model operates by marshalling a state's and community's resources via technical assistance from the National Council to develop comprehensive, integrated, and coordinated in-home services, using volunteer leadership in concert with professionals. Volunteers and professionals act as advocates for further steps. This model will be disseminated throughout the country for states to use in establishing in-home services of good quality.

The advocacy approach to service development is demonstrated each year in one community in each of two states in one D/HEW region. A National Advocacy Advisory Committee, which provides the guidance of this project, recommends the selection of each year's region and states. They arrive at this decision after Project staff visit several regions and states to meet with department representatives of aging, health, social services, and health planning. The National Advocacy Advisory Committee is made up of representatives of governmental departments related to home care, national consumer groups, citizen organizations, and direct service providers. In all, six states and three regions will be involved in the Administration on Aging demonstration over the three year period. Additional regions, states, and communities will be involved through funds made available by Exxon, United States Steel, and American Telephone & Telegraph corporations. A diversity of statewide models is being developed with technical assistance from the National Council and will be disseminated to states throughout the country. Accomplishing this will advance the nation towards the goal of having homemaker-home health aide and other home care services of good quality widely available for the functionally dependent elderly, families, and the ill and handicapped of all ages.

There are several steps in the development of the advocacy model in each state and region, and these occur over varying periods of time, depending on local conditions. In general, however, the following steps may be taken as representative of the model development for all states and regions.

Steps in Model Development

Lead Agency is Chosen

Project staff work closely with a lead state agency, an assigned in-home services staff person and a core committee of state staff related to aging, health, social services, and health planning. They help form a state advisory committee on home care which brings the public and private sectors together with the executive and legislative branches of government. Together they select a demonstration community and develop a strategy for the statewide development of home care services, using a community as a model.

Community is Selected

This community is selected in each state to demonstrate to state and regional staff how to develop and expand a homemaker-home health aide service system. The service developed thus integrates health and social services and is coordinated with other services in a continuum of in-home care for all age groups in the community.

Advocacy Team is Formed

A three member advocacy team is formed for each "advocacy" community. They act to stimulate interest in in-home services in their community. The team is lead by a volunteer, a citizen-at-large. This advocate is assisted by a professional and another volunteer or professional. They work with state and community advisory committees and with regional, state, and National Council staff to develop and coordinate homemaker-home health aide service activities. After selection the teams attend a special National Council sponsored advocacy orientation and statewide seminar on these services. The National Council arranges for $5,000 in start-up funds provided by the Exxon Corporation for each community funded under the Administration on Aging grant, and gives guidance in the development of the proposals for the use of these funds.

Technical Assistance Given by the National Council

The technical assistance provided by the National Council to the D/HEW "advocacy" regions, states, and communities consists of a series of training sessions on the development and management of in-home care services. The assistance also includes on-site, telephone, and mail consultation, and copies of written and audiovisual materials. Each year the lead regional agency convenes a one day meeting of regional, and state staff representing aging, health, social services, and health planning from all states in the region. The National Council provides information on the basics of quality in-home services, issues facing the field, and use of the advocacy model. This meeting lays the groundwork for the expansion of home care services in the region.

Management Institute is Held

A five day management institute is held by the end of the second six months for new administrators of home care services from the states within the region. Through its regional activities, the National Council has an impact on the development of home care in all the states within the region. Training sessions draw on expertise from other states within the region, providing lateral technical assistance which is well received by both state and local participants.

Summary

Developing and expanding home care services that are comprehensive and coordinated is a slow process. Careful groundwork must be laid, new relationships developed and traditional mistrust overcome on all levels. Project staff often act as facilitators in this process, bringing together various departments and agencies around the same table to talk and to learn together. As neutral parties, staff members help them pool knowledge and reach consensus on needed action.

Such is the typical progression of activities in a region, state, and community selected for creation of an advocacy model. What follows is a report on the progress of activities in the regions selected through February 1979. The first two of these were Region IV*and VII**. In addition, is information on other states and communities with whom Project staff have worked with funding from corporate sources. These reports are cast in a common capsule format, and each contains information on:

-- the Need articulated by the region, state, or community;

-- a review of Changes brought about through intervention of the advocacy model;

-- the Status of meeting that need in each region, state, or community; and

-- a catalog of the Agents of those changes.

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* Kentucky, Mississippi, Tennessee, Georgia, Florida, North Carolina, South Carolina, and Alabama

** Missouri, Nebraska, Iowa, and Kansas

Region IV

Site visits were made by Project staff to Regions III, IV, V, VI, and VIII; and to the states of Wisconsin, Indiana, Arkansas, Kentucky, and Mississippi. After careful review, Region IV and the states of Kentucky and Mississippi were selected for special attention the first year. With the help of the regional director of aging, Project staff then held an orientation meeting on home care in Atlanta. It was attended by 45 professionals from the fields of aging, social services, health, and health planning departments in the region. Discussion focused on trends and issues in home care and on strategies to overcome barriers to the development of comprehensive home care. In addition, the participants identified needs for additional local and state funds, for coordination of state and local home care services, the importance of integrating the funding of homemaker-home health aide service, the need for standardization of eligibility criteria for service, and the importance of decreasing the hostility of hospitals and nursing homes toward the idea of home care.

A management institute was held at the University of Georgia, organized by Project staff. Thirty-five new administrators of home care services attended the meeting; state Title XX directors identified and selected participants with help from health and aging administration staff.

Further, the Regional Director of the Administration on Aging has initiated discussion with health systems agencies on the integration of home care in their planning; and has assigned one of his own staff members the task of developing interagency agreements on integration of home care services in their own planning efforts. Such integration was presented as part of the national effort toward initiating cost-cutting innovative procedures.

A model statewide training program for homemakers, supervisors and case managers was set up in Georgia, using Title XX training funds. Georgia hopes soon to bring their homemaker program into the Accreditation Program of the National Council. This homemaker program has expanded from 60 homemaker-home health aides in 27 counties in 1975 to 193 in 106 counties in 1979; by 1980, all of the counties in the state will be covered.

Accelerating this growth trend will be the special attention paid to Birmingham, Alabama. This site has been selected by the National Council's Advocacy Project staff as the one in which the attempt to help expand and coordinate homemaker-home health aide services will be made, using grant funds received from the United States Steel Foundation.

As a result of the efforts reported above, some concrete consequences of intervention by the Advocacy Project have been reported out at seminars held by the National Council in Mississippi and Kentucky. These include more effective proposal writing, more effective use by agencies of multiple funding sources, greater expansion rates for integrated programs of services, and more attention paid to the details involved in the contracting for services. Technical help provided by National Council staff has thus been effectively used to enhance the impact of homemaker-home health aide services on regionwide planning of home care as part of a coordinated series of support activities for individuals and families in need.

Kentucky

Need: To use what is learned in the demonstration community to facilitate statewide development of in-home services through Operation Independence; to identify all sources of available in-home services funds, and to develop a plan for allocating in-home service dollars; to develop definitions and guidelines for the purchase of services; and to plan for data collection.

Changes:

- Project Independence, a state funded project providing an array of in-home services as an alternative to institutional care whenever possible, has been extended to two additional area planning and development districts, both of which have requested National Council technical assistance.

- The adoption of regulations for the licensure of homemaker and other in-home services was delayed pending adoption of state guidelines.

- The Secretary for Human Resources appointed a technical advisory group to develop regulations; members include a representation from the Purchase area and Ms. Fanny Dorsey, a member of the Federal Council on Aging.

- Representatives of the state citizens advisory committees chose the expansion of in-home services as their number one priority.

Status: It is hoped that state support will be increased for the integration of homemaker and home health aide, especially because of the support of the new Secretary for Human Resources. He is considering institutionalizing Project Independence statewide. The in-home services task force is ranking in-home services by categories such as aging, children and the developmentally disabled. Preliminary talks are under way for the development of a statewide approach to homemaker-home health aide and supervisory training.

Agents: The Secretary for Human Resources created an in-home service task force drawn from related state agencies and citizen statewide advisory committees.

COMMUNITY: Purchase Area

Need: To locate multiple funding sources that will maintain and expand home care as Project Independence funds are reduced to the district; and to integrate the homemaker and home health aide tasks by contract with county health departments.

Changes:

- The medical screening team has helped gain support of local physicians for home care.

- A conference on the array of in-home services helped to educate the community and state in-home services task force.

- Fifty-two workers from West Kentucky Allied Services and the Bureau of Social Services, along with their supervisors, were trained as homemaker-home health aides. This has resulted in improved case assessments, plans of care, and more effective, efficient, and cost-effective work in the homes.

- Bureau of Social Service workers have increased requests for health assessments.

- A nurse from a home health agency is supervising West Kentucky Allied Services homemaker-home health aides in one county -- one step toward integration.

Status: Negotiations are underway between county health departments to contract with West Kentucky Allied Services so that Medicare and Medicaid, rather than Project Independence, funds cover the personal care tasks of the aides in eligible cases. This approach, plus tapping other third-party funding sources, is particularly crucial since Project Independence funds will be cut back further next year as this program is spread across the state.

Agents: The advocacy team in the Purchase district was led by a prominent local resident and assisted by a nurse. The latter is a member of the medical screening team for the West Kentucky Allied Services homemaker program and the public relations director of the planning district. These persons helped expand a subcommittee of the planning district's aging committee. West Kentucky Allied Services, the agency which delivers in-home services for this Project Independence community, was chosen to develop an aide training program.

Mississippi

Need: To expand homemaker-home health aide service statewide; develop interagency agreements between health, social services, and aging departments; and encourage the integration of homemaker and home health aide tasks on the community level.

Changes:

- Home care has become a high priority in state and area agency on aging plans.

- A Management training team has been formed for aging programs in AAA's; all attended Project training sessions.

- CETA homemakers are working throughout the state under the Welfare Department's Helping Hands program.

- An Appalachian Regional Commission grant was awarded to Choctaw County to initiate in-home services for aging.

Status: Interagency agreements have been delayed because of top staff changes in the Welfare Department. Fiscal restraints have led to an increased emphasis on volunteer in-home service programs such as friendly visitors. It is hoped the Title XX office will increase the number of Title XX contracts with non-profit agencies and develop state standards for such contracts. There has been a growth in the number of Medicare-only home health agencies throughout the state.

Agents: A state advisory committee composed of citizens appointed by the governor and with the leadership of the Mississippi Council on Aging initiated project work. Representatives from Title XX, Medicaid, Medicare, the Mississippi Council on Aging, and Project staff oriented this committee to in-home services in Mississippi.

COMMUNITY: Lee County

Need: To expand in all counties in the Trace AAA quality, well coordinated, and efficient homemaker-home health aide services with health and social services integrated using multiple funding sources, beginning in Lee County.

Changes:

- Title III, Appalachian Regional Commission, and United Way funds have been used to expand service.

- A Title XX contract was renegotiated.

- Contract discussions are almost completed with two certified home health agencies for Medicare to cover home health aide tasks.

Status: The funding base of the agency needs to be expanded further. This can be accomplished when the regional planning district, which is separate from the AAA, is persuaded of the value of increasing programs for the aging, particularly in-home services.

Agents: The advocacy team, led by a recently retired executive and assisted by the AAA planner and a black community leader, formed the community committee. This committee includes, in addition to related human service agencies, the local newspaper publisher and representatives from the medical center, extension service, AARP, board of supervisors, and community development. Methodist Senior Services, part of a non-profit retirement complex, was selected as the auspice for the homemaker-home health aide program.

Region VII

Region VII was selected for Advocacy efforts for the second year after review of a number of locations.

Two states were selected in Region VII: Missour' and Nebraska. Within these states, two communities were also selected: the Meramec Area and Morrill County.

The Advocacy effort in Region VII was enhanced by the initiative taken by the Director of the region's Administration on Aging to develop a continuum of care of older people. It was obvious that homemaker-home health aide services, a key element in this continuum, needed expansion in this underserved area.

To aide in this effort, the National Council has brought in technical assistance laterally; that is, from neighboring Plains states. This was in addition to technical assistance from the Project staff.

The regional AoA staff helped by arranging for a progress report by staff of the Nebraska and Missouri programs, and by National Council staff, at the Mid-America Congress on Aging, held in Kansas City on February 21-23. This liaison has been maintained. The area's AoA staff keep other regional offices informed of project activities, attend meetings like the Nebraska state seminar, and plan visits to one of the demonstration communities. In this way, it is felt, they can increase the capacity of the regional office to provide leadership for the development of home care services.

Missouri

Need: To provide technical assistance in coordinating funding to allow for integration of funding sources; to identify and obtain new funding sources including a state appropriation; to expand services in rural areas; and to develop state standards.

Changes:

- Information on funding and legislation was provided to the Missouri State Health Commission at its request.
- National Council reviewed the Division of Family Services' standards for in-home services at its request.
- The 1978 Silver Haired Legislature has set the appropriation of state funds for home care as high priority.
- Publicity on the state thrust for home care has appeared in a number of statewide health and social service newsletters.

Status: The concept of the integration of the homemaker and home health aide tasks, seen as a priority item of the state health department, needs to be accepted in local health departments throughout the state. Homemaker service is purchased primarily at a flat rate throughout the state. This rate does not meet expenses and may be increased. Twenty-five percent of these Title XX contracts are with proprietary agencies. Home health aide coverage in some rural areas looks better on paper than in practice and needs to be expanded.

Agents: The state agencies on aging and home health have taken the leadership statewide with close involvement of Title XX personnel. The Office on Aging is the lead state agency, using the state home health consultant "loaned" from the health department. The state advisory committee includes, in addition to related state agencies, representatives from the St. Louis Alliance for Home Health Services, Upjohn, Visiting Nurse Association of Greater St. Louis, a retired Blue Cross executive, HSAs, and Catholic Charities of Kansas City and St. Joseph.

COMMUNITY: Meramec Area

Need: To expand and coordinate home care services as part of a continuum of care, integrating health and social services, with close cooperation of the home health agency, homemaker agency, and Senior Companion Program as part of an arr y of in-home services.

Changes:

- A community committee, chaired by the Advocate, met and agreed to formulate an action plan to:
  . add a social worker to enhance the home health agency, hospital discharge planning, nursing home services, and case management of the homemaker agency;

- increase the maximum number of Title XX purchase of service hours from 40 to 60 per client as a demonstration;

- develop central intake using trained RSVP workers with professional back-up;

- explore contractual arrangements between the home health and homemaker agencies with expanded training for selected homemakers as homemaker-home health aides;

- expand community education to overcome present misunderstandings about in-home services and to gain support for expansion and coordination through talks, the media, and word of mouth;

- expand the community committee with representatives from local volunteer health organizations, fire and sheriff departments, and churches and schools.

Status: It may be difficult to hire a Master's level social worker in this rural area. It is hoped that a recent graduate from the University of Missouri School of Social Work might be located. The state advisory committee will be helpful in obtaining permission to experiment by adding case management capability to the Senior Services Council and by increasing the number of hours. The state representative from the American Cancer Society on the state advisory committee was helpful in suggesting additional community committee representatives.

Agents: The advocacy team is headed by a community leader whose late husband chaired the Governor's Council on Aging. He had been instrumental in obtaining funding to begin home care services in this multicounty area in south central Missouri. She is assisted by the President of Missouri's Homemaker Council and a registered nurse from the Phelps County Health Department. The committee, with strong representation from the country health departments, is soon to be expanded to assure more citizen and consumer interests.

Nebraska

Need: To advocate for the expansion of in-home services as part of Nebraska's continuum of care initiative, identifying gaps and effecting changes in rules and regulations on statutes, and facilitating funding and greater coordination; to develop measurable standards; to provide public information; and to develop a statewide approach to homemaker-home health aide training.

Changes:

- Project staff spoke at the quarterly meeting of the Nebraska Home Health Care Association at its invitation, discussing homemaker services as part of a community home care system and the necessity for multiple funding sources, especially in rural areas.

- Project staff provided technical assistance to Holdrege in Phelps County to help plan the development of a homemaker-home health aide service. Both a nonprofit retirement center which includes an intermediate care facility and the local hospital have expressed interest in delivering the service.

Status: The National Council is eager to demonstrate the value of training for homemakers and chore workers, and of placing them on staff with appropriate benefits and wages. The role of intermediate care and skilled nursing facilities (ICF and SNF's) in the delivery of home care needs to be defined (particularly in light of Nebraska's goal to reduce the number of nursing beds) and the reluctance of physicians to use home care needs to be overcome.

Agents: The Nebraska Commission on Aging assigned a staff member (the coordinator of research, planning, and evaluation) who has taken the leadership to form and expand a state advisory committee. The home health association, nursing home and hospital associations, AMA Auxiliary, Commission on the Status of Women, and the University of Nebraska Medical Center representatives will all be invited to serve on this committee and/or on subcommittees.

COMMUNITY: Morrill County

Need: To develop a homemaker-home health aide service that meets the needs of all age groups and is available to all economic groups, then to expand to additional counties in the Panhandle and serve as a model for the rest of the state.

Changes:

- Community organization work is well underway with plans to contract with a nearby hospital-based certified home health agency.

- The superintendent of schools has offered the use of school space for training of homemaker-home health aides. He has also offered to add the concept of home care to health education classes in the upper grades and to be a vehicle for publicizing the work of the advocacy team and community committee.

Status: The county welfare department, soon to have new leadership; the area agency on aging, which was instrumental in bringing the project to Morrill County; and the certified home health agency in nearby Scottsbluff -- all will be involved more closely as the community plans its activities. A staff member from the regional public welfare office with Medicaid responsibility has been very supportive to Project work, as have the director of the HSA subarea and staff of the local ICF. Project staff will provide technical assistance to them in locating both public and voluntary sources of funds and set up a community-based nonprofit agency.

Agents: The advocacy team is lead by a community leader active on the hospital board and assisted by another community leader and an employee of the local ICF. The community committee in this western Panhandle county of 5000 has drawn support from the hospital, several ministers, the health systems agency, and the superintendent of schools.

OTHER ACTIVITIES

As indicated above, the Advocacy Project staff has continued the activities initiated under the Clark Foundation grant efforts to find and develop opportunities for community based advocacy models. It has also continued to seek corporate funding for targets of special opportunity in communities of special concern to the funding corporations.

These activities are useful on two grounds. The first is that even the earliest localities in which the Advocacy Project staff intervened are given the benefit of the latest experience and newest wisdom the Project has accumulated in its work across the nation; in a similar way, all of the Advocacy communities and states are kept equally well informed as the staff cycles its visits as opportunity arises to do so. The second is that localities are identified with special properties that add to the special knowledge needed to deal with non-standard problems and organizational difficulties, or variants on other experience in urban settings; this latter has been the case, for example, in Pittsburgh.

The distillation of experience and expertise is also disseminated through newly prepared audiovisual materials, the development of curricula for training, the creation of a "how-to" manual for advocacy, development of a new brochure for consumers of services, encouraging newspaper accounts of Project work, promotion of the Project's Program Development and Consultation Unit, and holding of national management institutes. In the following, we outline these activities.

Region III

The National Council has been able to provide technical assistance to Region III because it is providing technical assistance to Pittsburgh and Delaware through corporate funding sources. The Director of the Administration on Aging in Region III has emphasized the need for planning for long term care in concert with HSAs and Title XX agencies for the frail elderly. The Advocacy Project Director was invited to outline the role of homemaker-home health aide service in long term care at an Administration on Aging meeting. She followed an analysis by Dr. Steve Brody of the University of Pennsylvania School of Medicine of Region III HSAs' plans related both to long term health and other health needs of the elderly.

American Telephone & Telegraph Corporation funding is making possible the Advocacy Project's technical assistance to the "community" of the State of Delaware during 1979. The local advocacy team, still in formation, is headed by a community leader who has been closely involved with the YWCA and United Way. Assisted by a state staff member from Social Services for Families and Adults, she is seeking a citizen leader from one of the two southern counties to round out the team. The development and expansion of integrated homemaker-home health aide services, coordinated with other in-home services, and the adoption of state standards for homemaker-home health aide services, are objectives in Delaware.

United States Steel Foundation funding will enable the Advocacy Project to provide technical assistance to Pittsburgh/Allegheny County, which has a high concentration of United States Steel employees. The threatened closing of a Pittsburgh long term care hospital and the ensuing debate brought the issue of home care to the fore in this city. A 60-member task force on long term care for the elderly with a subcommittee on in-home services has been formed with a charge to develop a plan within six months. The Project role will dovetail with this initiative to develop and expand a coordinated system of home care and integrated homemaker-home health service. The Project work here is enhanced by the sponsorship of the Health & Welfare Planning Council. A countywide homemaker-home health aide training program initiative may be explored in this urban setting.

Region IX

Sun City in Arizona has been selected as an American Telephone & Telegraph Corporation funded community. It will serve as a model for the development of home care of good quality for retirment communities both in Arizona and throughout the nation. Boswell Hospital will expand its home care program to include homemaker-home health aide service to this community of over 40,000 older people. Sun City West is under construction with a projected population of over 80,000 people over 50. Project staff met with state and AAA staff and with state legislative leaders to discuss the development and expansion of home care services of good quality in the state. The possibility of a training contract with the Arizona Aging Department is under active exploration.

Following a presentation on homemaker-home health aide service at a quarterly meeting of the National Indian Council on Aging, the Navajo Indian Services to the Aging has requested the National Council's technical assistance to develop their homemaker-home health aide service and to locate funding sources.

"Clark" Communities Update

The National Council's Advocacy Project was initially funded for two years by The Edna McConnell Clark Foundation, beginning in 1975. Eight communities developed 14 programs, including a statewide program, and were helped to develop homemaker-home health aide services. These experiences were invaluable in refining the local community advocacy model and demonstrated the necessity for advocacy on the state level which strengthens local service development. Project staff continue to keep in touch with many of these communities.

Considerable progress has been made in the last three and a half years. The "Clark" phase experiences were invaluable in refining the local community advocacy model subsequently adapted for statewide use. Project staff provided technical assistance to these communities and conducted seminars in most of the states in which the Clark communities were located. These activities strengthened local actions and encouraged sharing with other communities and state staff the communities' experiences. A statewide approach has been made possible in some of these states, involving both provider agencies and state staff.

The Home Services Project, a project of a senior center in Sunnyside, Queens, New York City, was the impetus toward involvement of the Community Council of Greater New York and the New York City Department of Aging in the investigation and improvement of the home attendant program in New York City. Volunteers in the senior center have been trained to check on home care clients between the nurse's and social worker's supervisory visits. Efforts are underway at the state and city levels to structure this program more safely including having the attendants become employees of an agency.

Directors of the Anderson County/Tennessee, the Tulsa/Oklahoma and Linn-Benton/Oregon programs are active in the development of state standards for homemaker-home health aide services. The latter two programs have now come through the National Council's Approval Program successfully and are in conformity with basic national standards.

The amount of homemaker-home health aide service and the expansion of service areas has increased considerably in the "Clark" communities. Expansion has come through new funding sources which broaden the base of support, and through the integration of the health and social service funding sources by contracts with health and social service departments. New funding sources include local county funding, community development, Title III, Title XX, CETA and state funds, and local fund raising such as Bingo games events for clients not eligible for public funds. Explorations are underway in several communities to expand service for hospice and cancer care patients. In Oregon, service is now available in 29 of 36 counties -- up from 11 counties in 1975, thanks to increased state funding. Project Independence, which received technical assistance from Advocacy Project staff, has been a model for the country. The homemaker program in Tulsa has grown so much it was necessary to bring in a director experienced in more sophisticated management techniques.

Ohio's Commission, with Project help, instituted a statewide training program for homemaker-home health aides working under its Aide to Independent Living Program. The State Vocational Education System conducts the training. The curriculum of the advocacy agency in Delaware was the model. The Sunnyside training program, which was initiated through the New York City Board of Education, is the model for a citywide proposal for training aides in vocational schools throughout the City.

Several participants in the National Council training sessions have moved on to other positions in the home care field, spreading their expertise to agencies in other parts of the country.

Other Project Activities

New written and audiovisual materials, and new curricular for training, are being developed and refined. A training module on aide supervision and case management is near completion and will be tested and evaluated this year. A "how-to" guide for advocates is in draft form and is being tested by second year advocacy teams and states. Someone I Can Trust..., a consumer's guide to quality care in homemaker-home health aide services has been published.

Recent articles about the Project have appeared in the National Association of Counties newspaper and in Geriatric and Residential Care, a monthly newsletter. These resulted in many inquiries for information about the Advocacy Project and for requests for help in the development of home care services.

National Council staff provided information to Lou Cottin (a national syndicated columnist who writes on aging) about homemaker-home health aide services and standards and the Advocacy Project for his book, Elders in Rebellion, to be published in the fall.

Inquiries about the National Council's Program and Consultation Unit continue to come in. Negotiations have been completed with four area agencies on aging in Michigan to provide training for supervisors of homemaker-home health aides.

Project staff conducted a National Management Institute for Administrators of Homemaker-Home Health Aide Services at Mills College in Oakland, California. Tuition was charged for this five day management institute which was structured to meet the management and service delivery needs of both new and experienced administrators. Registration was limited to 70 participants, 35 in each group. The program covered such areas as planning, organizing and directing work; techniques of organizational change; financial management; proposal writing; time management; expansion through new uses of services; service evaluation; data collection use and interpretation; marketing; effective communication; wage and salary administration; and public policy and legislation. Continuing education units (CEU's) were granted by the University of California at San Jose. Thirty hours of continuing education for nurses were also negotiated for Institute attendance.

OBSERVATIONS AT MIDPOINT

We are now at the midpoint of the Administration on Aging's three year grant to the National Council to fund an Advocacy Project for homemaker-home health aide services throughout the nation. We have accumulated a fair amount of experience during the first year and a half of work with Regions IV and VII. This experience plus that gained in the several years of work in communities before the Administration's grant leads to some observations that can be made that others may find helpful. Some of these are candidates for formal recommendations to be made at the termination of the Administration's grant.

First, we are convinced that it is an appropriate role for aging offices on regional, state, and community levels to act as catalyst in convening staff of health and social services and discussing home care and long term care for the aging. We caution that comprehensive home care services should be the goal, since home care development is needed also for groups other than the aged. In fact, should area agencies on aging become direct deliverers of homemaker-home health aide services, they should draw upon several funding sources and assure comprehensiveness and availability to other age groups. This is particularly important in rural areas and in small towns, where it simply is not cost effective to erect services for one group alone. The thrust toward comprehensive care can also blunt the perception of some that aging offices tend to be age-divisive in their strong advocacy of services for older people.

Second, we are convinced that it is an appropriate role for regional offices to convene state level meetings with the purpose of developing standards for services; most states want to develop home care services of good quality and will accept help in achieving this goal. The regional office can then arrange for technical assistance, both from the National Council and from other states. The National Council is considered "nonthreatening" because it is nongovernmental and it relates to both health and social services.

Third, we have learned through experience that it takes both exposure and learning for community health and social service agencies to understand their need for each other in providing comprehensive services; each tends to perceive home care through its own eyes, to the detriment of the other. When the idea that: one person can be trained generically to perform both environmental and personal care tasks; mechanisms can be developed for nursing and social worker supervision when appropriate; and the need for skilled nursing care does not decrease when home health aide tasks are contracted out -- when these ideas are communicated clearly, the integration of homemaker-home health aide services comes about. The experience in the Purchase area has shown that with appropriate training and supervision, more home care service can be delivered for the same amount of money. This message must also be carried to consumer groups and taxpayers, though it is granted that it is a complex and difficult message to convey simply. Yet, it is indisputable that improved training and supervison, plus the coordination and integration of services, can lead to the delivery of safe, effective, yet cost effective home care services. Indeed, the need for advocacy of this message is imperative at every level, from the consumer to the regional and national levels. The National Council seeks to convey this message through its Advocacy Project, and thus can help to mobilize in-home services to meet this vital and growing need of the nation.

Fourth, we have become increasingly confident that it is cost effective for states and communities to request technical assistance from the National Council, rather than to create home care systems unaware of what has worked and not worked elsewhere. In the Advocacy Project, we have dealt with a wide variety of communities, states, and regions. We are aware of and sensitive to the questions of turf, of levels of awareness, of pitfalls, of coordinating and articulating mechanisms and procedures that work. Moreover, we are able to tailor this information to the particular public and particular situation in a given locality. Taken together, these advantages tend to enhance the likelihood that viable and enduring home care systems can be created and sustain themselves within reasonable periods of time.

Fifth, we have become aware of the fact that, supplementing these manifest functions and advantages of the Advocacy Project, we are serving an important but little recognized latent function -- namely, the creation of a way of thinking about homemaker-home health aide services, about the creation of such services from the parts of the health systems now extant, about the creation of standards and the implications of their application in practice. Since we carry a consistent message to many parts of the country, with consistent standards of performance, we are helping to create a national climate or posture toward uniform quality levels in the delivery of homemaker-home health aide services. In a sense, we are the carriers of a de facto, rather than a de jure, application of standards of service. Moreover, we carry these uniform definitions and practice standards with a fine sense of adaptation necessary to match local conditions and situations. In the long run, it may be found that this is one of our most important functions.

Sixth, and finally, by testing the realities faced by individuals and groups in the communities, states, and regions in which we work, we are able to interpret the national needs in ways not accessible easily to fixed field offices and stationary staff. This "pollinating" function serves two purposes. The first is to bring the message of common difficulties in delivering services on the local level to central staff, not only at the National Council, but to governmental and other national agencies. The second is our increasing awareness of the need for documentation to fill in gaps in the literature. We have touched upon (in "Other Activities") our involvement in the creation of literature of the field. We continue to be alert to the need for further literature -- in training aides, in helping administrators cope with organizational difficulties, in informing the several publics that agencies serve.

In conclusion, it is our hope that the reader will have gathered some sense of the excitement we feel at the scope, depth, and variety of problems and solutions we have tested for the provision of homemaker-home health aide services throughout the nation. In the coming decades, the importance of such services in keeping the costs of national health maintenance care in line, in improving the quality of life of our citizens, and in extending a humane and knowing hand to those most in need of it -- all with benefit from the most careful yet enthusiastic dedication to the extension of these services. We are glad to have the chance to share in this adventure in concert with our colleagues in the federal, state, community, and local levels across the nation.

# # #

Municipality of Anchorage

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GEORGE M. SULLIVAN, MAYOR

DEPARTMENT OF HEALTH AND ENVIRONMENTAL PROTECTION

October 30, 1979

State Committee on Services
to the Elderly
Pouch V
Juneau, Alaska 99811

Dear Committee Members:

As per my conversation with Jim Kelly in Anchorage October 17, I will outline what I see as the home care needs of Alaskan senior citizens. The Anchorage Home Health Agency is at present the only certified Home Health Agency in the State of Alaska. As a section of the Municipal Health Department, Home Health serves the entire Municipality of Anchorage. The Agency carries a case load of 30-40 patients monthly with approximately 50% of the patients being Medicare recipents and an additional 12-15% Medicaid recipents.

Under federal guidelines for Medicare reimbursement, a Home Health patient must be homebound, require skilled care, and the care must be directed by a licensed physician. In Alaska, Medicaid regulations used these same guidelines for authorizing Home Health care.

In considering the possibility and advisability of combining Homemaker and Home Health Aide Services in Alaska, I would like to first address the existing gaps in services provided at present.

The Homemaker Services in Alaska, as you know, are provided statewide by Easter Seal Society. To my knowledge, Home Health Aide Services are available only in the Municipality of Anchorage through the Home Health Agency. There are distinct differences between the services provided by these two providers, the most noteable being that the Homemakers do not give personal care and Home Health Aides do. Also, while a Home Health Aide might provide some homemaking tasks, these are very limited in scope and through existing Titles 18 and 19 regulations can be only for the person receiving skilled care and cannot add significantly to the time spent in the home.

The gaps that exist, then, in Anchorage are: 1) a person receiving only Homemakers Services receives no assistance with

personal care. 2) Home Health Aide Services may be given only in conjunction with skilled care, meaning that when the need for skilled services ends so must aide services end, even when the need for those personal care services still exists.

The Anchorage Home Health Agency and the Easter Seal Society coordinate services in Anchorage, often seeing the same client or referring clients to each other as our assessments indicate a possible need for service. At present, Anchorage Home Health Agency contracts with the Alaska Nurses Registry for Home Health Aide Services. If Homemakers and Home Health aides were combined into a single service we would be willing to consider contracting with the provider of the combined services for Home Health aides, as we could view this as a potential advantage to our patients. This could mean that persons requiring both services could conceiveably receive them from the same person, thereby decreasing the numbers of people whom the patient would have in their home and providing continuity of care.

Under existing regulations, however, the scope of services given through a Home Health Agency could not be increased, meaning that the actual service of available to the patient with Titles 18 and 19 funding would remain unchanged.

Should Homemakers and Home Health aides become a combined service in Alaska, it would be important that there be adequate supervision of both services, but particularly Home Health Aide Service which is frequently given to frail people who have multiple health problems and need continued medical follow-up even when skilled care is not indicated. During this past week I have attended the Ninth Annual Conference of the National Association of Home Health Agencies. During that conference I heard many issues addressed that related to those matters of importance to your committee. Leonard Schaeffer of Health Care Financing Administration spoke at the conference of the narrow scope of the existing law and its failure to meet the social and demographic changes occuring in the country. There are changes being proposed in that law at the federal level. HR3990, currently in committee, would relax some of the Title 18 requirements for provision of home care, specifically removing prior hospitalization requirements as well as eliminating other limits imposed by the existing law.

Many states provide for greater Home Health coverage under Title 19 then is allowed under Title 18. An example is the provision of services in the home beyond the acute phase of illness, thereby providing some maintenance services in the home. Under current regulations in Alaska home care can be only intermittent skilled care to homebound individuals under the direction of the physician. Example of patients who could be better served at home are terminally ill and chronic lung patients, requiring maintenance care (chronic care) to prevent increased need for more costly services. Home care has been documented as being less costly then institutional care and the revision of existing regulations in Alaska could provide for more comprehensive home

care programs for our senior citizens, thereby more readily keeping them in their homes and out of the more costly institutions.

Finally, I would propose the provision of grants to new agencies in Alaska, providing monies to encourage the development of Home Health Agencies in the state and making it possible for those communities considering such a move to afford expert consultation on complex matters such as those regulations governing the provision of care under Titles 18 and 19. The potential for maintaining people in their home is great given adequate funding and adequate supervision of those people giving the care. I have described some of the gaps that I see existing in the current available services. Also I have discussed one or two proposals for improving this service to senior citizens. If there is anything further that I can do to assist in this matter, I would be glad to do so.

Sincerely,

Janice Wills

Janice Wills
Home Health Agency Supervisor

JW/cl

THE EASTER SEAL SOCIETY FOR ALASKA CRIPPLED CHILDREN AND ADULTS

EASTER SEAL INFORMATION AND REFERRAL SERVICE
P O BOX 2432
ANCHORAGE ALASKA 99510
274 1641

58323

STATE SOCIETY OFFICE
P O BOX 2432 99510
726 E STREET 99501
ANCHORAGE ALASKA
277 1324

EASTER SEAL SOCIETY/HOMEMAKER PROJECT: Progress Report, August 1, 1979

The program now has functioning Regional Homemaker Supervisors in all six regions. (List attached).

This first month has been devoted primarily to establishing an accurate list of clients and homemakers and working closely with the Division of Social Services to insure that all clients are receiving the services requested. The Regional Supervisors have already begun to travel to the villages to do this.

Nancy Farrington, Project Director, expressed her pleasure at all the help forthcoming from all of the DSS Regional offices and the DSS Central office.

August 7-9 all Regional Homemaker Supervisors will be in Anchorage for a training session. Subjects to be covered are recruitment, supervision, interagency coordination, and training, for a few.

Easter Seal/Homemakers will now begin directing its efforts towards upgrading services, training, and setting up advisory committees as well as providing service.

Nancy Farrington, RN
Project Director

THE EASTER SEAL SOCIETY FOR ALASKA CRIPPLED CHILDREN AND ADULTS

EASTER SEAL INFORMATION AND REFERRAL SERVICE
P O BOX 2432
ANCHORAGE ALASKA 99510
274-1641

STATE SOCIETY OFFICE
P O BOX 2432 99510
726 E STREET 99501
ANCHORAGE, ALASKA
277 1324

EASTER SEAL SOCIETY/HOMEMAKER PROJECT

PROJECT DIRECTOR
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PO Box 2432
Anchorage, Ak 99510
277-2451

CENTRAL OFFICE
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Anchorage, Ak 99501
277-2451

PROJECT BOOKKEEPER
Shirley Sturgis
PO Box 2432
Anchorage, Ak 99510
277-2451

SECRETARY/RECEPTIONIST
Wyleen Baldwin
PO Box 2432
Anchorage, Ak 99510
277-2451

REGIONAL HOMEMAKER SUPERVISORS

REGION 1 - WESTERN REGION
Mary Crew
PO Box 25
Bethel, Ak 99559
543-2528 3141

REGION 2 - SOUTH CENTRAL REGION
Joann Price, RN
PO Box 2432
Anchorage, Ak 99510
277-2451

REGION 3 - NORTHERN REGION
Nora Young
1020 Barnette
Fairbanks, Ak 99701
452-6208

REGION 4 - NORTHWESTERN REGION
Carolyn Michels
PO Box 299
Nome, Ak 99762
443-2772

REGION 5 - SOUTHEAST REGION
Mary Bayliss
167 South Franklin
Juneau, Ak 99801
586-6265

REGION 6 - SOUTHERN REGION
Arlene Jones
PO Box 3147
Ketchikan, Ak 99901
c/o 255-6611 (DSS)

SB 323 HOMEMAKER-HOME HEALTH AIDE SERVICES

Every community in Alaska should have available a homemaker-home health aide service program. The homemaker-home health aides should be trained and supervised by professional personnel and work as part of a team with doctors, social workers, nurses, nutritionists, therapists, and home economists.

Homemaker-home health aides not only provide personal care of the aging, but they strengthen and extend the service of the nurse who instructs in such care as oil massages and exercise; the dietitian who oversees a special diet; or the social worker who helps with mental, emotional and social disturbances.

If our goal is to train one aide per hundred of the aging, that would mean 200 professionally trained and supervised aides just for the aging. (This is a national norm.)

This service respects the rights of Older Alaskans to remain in their own homes in times of crisis dut to illness, disability, or social problems. Its goal is to help the client to learn to help him/her self as much as possible, to achieve or retain independent functioning and self-sufficiency.

Older persons find it difficult or even traumatic to be removed from their own homes and communities, from their familiar surroundings, their families and friends.

They may be inclined to lose touch with reality.

In 1974-75, there were 242 persons aged 60 to 113 being served in Alaska by trained homemeaker-home health aides. This number did not include service by home helpers who were not professionally trained. The number of persons 60 and over has increased since then.

With the continuing increase in the population of Older Alaskas, it is urgent that the funding for this service and for training be increased.

I recommend the passage of this bill; also, that the service be decentralized in order to adapt it to the special needs of the various regions.

Dove M. Kull, M.S.W., A.C.S.W.
Member of the State Commission on
Services to the Elderly

January 30, 1980

POSITION PAPER

SENATE BILL NO. 323
(Identical to H.B. 616)

"An Act making a special appropriation to the Department of Health and Social Services for homemaker health aide services; and providing for an effective date."

The Department of Health and Social Services supports in concept the addition of home health aide services under the Division of Social Services. In the FY 81 budget the Governor has included an additional $303.5 over the FY 80 funding level of $1150.0 for homemaker services. The Department can support additional services up to that level of funding.

Home health aides provide personal care services such as bathing, assistance with transfer activities, assistance with ambulation, and assistance with passive exercises. These services alone would have an impact on reducing unnecessary institutionalization of disabled and chronically ill Alaskans. The impact would be more substantial if home health aide services were a component of a comprehensive home health care program ranging from skilled nursing to homemaker-home health aide services.

Currently the availability of home health services in Alaska is limited. The Division of Public Health has a limited amount of money available for skilled nursing home health services in Juneau and Fairbanks. Payment for home health care is also available under Medicare (Title XVIII) and Medicaid (Title XIX). The home health care available under these federal programs include home health aide services and are limited to medicaid and medicare eligible individuals. The eligibility requirements of these programs are restrictive and, as a result, many people in need of home health care are not able to receive needed services. They may be ineligible due to age, income or a disability which does not fall within the federal requirements.

If the Department developed either a homemaker-home health aide service or a comprehensive home health care program, this program would include the present homemakers who, after additional training, would be capable of providing health aide services under supervision of medical/nursing professionals. In order to implement a new program, much developmental work would need to be accomplished during Fiscal Year 1981. The contractor would need to set up a safe home health delivery service which includes, on a continuing basis, training and professional supervision. The addition of a home health component would result in a higher unit cost during the development phase and increase ongoing administrative costs.

Clarification is needed regarding interim committee intent with respect to eligibility for home health services. Currently, homemaker service is provided to all Alaskans based on need and service availability, regardless of age or income, under the Division of Social Services' child protection and adult protection programs.

POSITION PAPER/Department of Health & Social Services

Clarification is also needed regarding any interim committee intent with respect to contract limitations, i.e., whether or not regional contracts are mandatory. This information will assist the Department in preparing a request for proposals and in determining the allowable administrative costs for contractors. The Department recommends that this not be a requirement for FY 81.

Although the Bill authorizes a $2500.0 appropriation, the Department's understanding is that the interim committee intent is for an additional $1046.5 over the Governor's FY 81 budget request for homemaker services. The Governor's FY 81 budget request contains $1453.5 for homemaker service in the Division of Social Services.

The Department would like clarification regarding interim committee intent with respect to the use of additional funds. It is anticipated that the unit cost of homemaker services will increase in FY 81.

The Department views the addition of home health care services as a means of further assisting Alaskan citizens to receive the services they need in the least restrictive setting possible, as well as reducing the cost of unnecessary institutionalization.

RECOMMENDED BY: Art Holmberg DATE: 1-28-80
Art Holmberg, Director
Division of Social Services

APPROVED BY: Helen D. Beirne DATE: 1-28-80
Helen D. Beirne, Commissioner
Department of Health and Social Services

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill No. 323
Title special appropriation to DHSS/DSS for homemaker home health aide services
Requested by Senate HESS Date January 25, 1980

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Social Services
BRU, Program, or Subprogram(s) Affected Social Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES	0	0	58.5	64.9	70.7	77.1
200 TRAVEL	0	0	6.6	7.3	8.1	9.0
300 CONTRACTUAL	0	0	3.4	3.7	4.0	4.4
400 COMMODITIES	0	0	.8	.9	1.0	1.1
500 EQUIPMENT	0	0	2.5	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	0	0	0	0	0
	0	0	0	0	0	0
TOTAL	0	0	71.8	76.8	83.8	91.6

FUNDING (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
GENERAL FUND	0	0	71.8	76.8	83.8	91.6
FEDERAL FUNDS	0	0	0	0	0	0
OTHER (Specify Fund Source)	0	0	0	0	0	0
	0	0	0	0	0	0
	0	0	0	0	0	0

POSITIONS

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
FULL TIME	0	0	2	2	2	2
PART TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

A. Assumption

1. Both positions budgeted for 12 months.

2. A 9% inflation rate for line items 100, 300 and 400.
A 10.8% inflation rate for line item 200.

IV. DATE January 25, 1980 PREPARED BY Art Holmberg Art Holmberg
AGENCY Division of Social Services
PHONE 465-3170

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Reviewed by Michael Ovelono
Division of Mgt + Budget
DHSS 1/25/80

33-001 (Rev. 12/78)

7

Senate Bill No. 323 FISCAL NOTE Continuation

TITLE: "An Act making a special appropriation to the Department of Health and Social Services and Social Services for homemaker health aide services; and providing for an effective date."

III. ANALYSIS (Continuation)

Coordinator for the homemaker-home health aide service would be responsible for:

- the development and maintenance of program policy
- coordination of homemaker-home health aide service with other services and programs
- establishing and maintaining standard of service
- technical assistance
- preparation of program requirements, contract preparation, contract monitoring and program evaluation
- collection analysis and interpretation of statistical data.

At the present time the responsibility for the management of the homemaker contract is being shared by several staff. The addition of a home health aide component would result in the need for a single central office position to establish standards of service, work with the contractor to develop a uniform referral system, record keeping system and establish monitoring guidelines.

Clerk Typist III

The additional work resulting from the new program component would double the present authorization level thus resulting in twice the paper flow, therefore, a clerk typist is needed.

Program Summary

1. New Positions

Range 18 - 6 mos @ $2,465 =		$14,790
6 mos @ $2,640 =		$15,840
		$30,630
fringe benefits @ 25.5% =		$ 7,810
		$38,440
Clerk Typist III - Range 8		
6 mos @ $1,277 =		$ 7,662
6 mos @ $1,393 =		$ 8,358
		$16,020
fringe benefits @ 25.5% =		$ 4,085
		$20,105
	TOTAL	$58,545

2. Other Expenses

Travel - for fiscal and program monitoring

2 Trips to Bethel	468 x 2 =	$936
Anchorage	255 x 2 =	$510
Fairbanks	301 x 2 =	$602
Nome	443 x 2 =	$886
Ketchikan	140 x 2 =	$252
		$3214
Plus $2,216 for travel to villages for spot reviews		$2216
		$5430
Per Diem 3 days per trip for 2 trips to 5 regions plus 1 day to six villages		$6,630

Senate Bill No. 323 FISCAL NOTE Continuation

TITLE: "An Act making a special appropriation to the Department of Health and Social Services and Social Services for homemaker health aide services; and providing for an effective date."

III. ANALYSIS (Continuation)

Space Leased 200 Sq. Ft. @ $1.42 for 2 positions. 282 x 122 = $3,384

Commodities 400 per yr. per position + 9% inflation.

FY 81 Only

Equipment - 2 desks
2 chairs
1 typewriter
1 bookcase

Introduced: 1/15/80
Referred: Health, Education & Social Services and Finance

Funding Information

General Fund	$2,500,000
Other Funds	-0-
	$2,500,000

BY THE RULES COMMITTEE BY REQUEST OF THE LEGISLATIVE COUNCIL (for the Interim Committee On Services for the Elderly)

IN THE SENATE

SENATE BILL NO. 323

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services for homemaker/home health aide services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. The sum of $2,500,000 is appropriated from the general fund to the Department of Health and Social Services, division of social services, for homemaker health aide services for the fiscal year ending June 30, 1981.

* Sec. 2. This Act takes effect July 1, 1980.

POSITION PAPER

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(Identical to H.B. 616)

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RECOMMENDED BY: Art Holmberg DATE: 1-28-80
Art Holmberg, Director
Division of Social Services

APPROVED BY: Helen D. Beirne DATE: 1-28-80
Helen D. Beirne, Commissioner
Department of Health and Social Services

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IV. DATE January 25, 1980 PREPARED BY Art Holmberg Art Holmberg
AGENCY Division of Social Services
PHONE 465-3170

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Reviewed by Michael Orelino
Division of Mgt & Budget
DHSS 1/25/80

33-001 (Rev. 12/78)

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