The meeting was called to order in Room #213 at 4:05 p.m. on Tuesday, February 25, 1975.

Senator Gene Echols was in the chair.

PRESENT: Senator Gene Echols
Senator Warren Monroe
Senator Richard Blakemore
Senator Gary Sheerin
Senator William Raggio
Senator Margie Foote

OTHER PRESENT: Please see Exhibit "A".

ABSENT: Senator Richard Bryan.

S.B. 5: Requires health insurance coverage to include home health care. Fiscal Note: No. (BDR 57-391).

The first witness was Dr. William Edwards. He testified in behalf of one of his nurses and stated that he was very much in favor of the bill. He told of a $45,000 work program supporting home health program and thinks this is an excellent bill.

Senator Blakemore asked if the money received was provided for under the 11 cent levy, and Dr. Edwards said that was correct.

Senator Echols said he had had at least three or four comments made by insurance companies that making this request mandatory on all policies, would make premiums out of sight. The insurance companies had suggested that this request be made optional for policy holders. Dr. Edwards said it was his understanding that the premium raise would be a very small one, or incremental. Senator Blakemore asked where he got that information and Dr. Edwards replied that it came from one of the nurses.

Senator Monroe said that he has discussed this with several insurance people and they gave him four points for changes in the bill, but they were nothing serious.

The next witness was Mrs. Mary White, administrator of the Nevada Home Health Services. She provided a packet to the committee, which is attached. She said the program had just been started in Nye County, and has been in the other ten since July. It has been in nine counties for several years. The program was started with a grant in 1961. There were 20 or 30 other home health agencies that started at the same time, but theirs is the only one still in operation.

Mrs. White went through her packet page by page and explained it to the Committee. She explained the rationale step by step and said her organization was in favor of the bill because it would provide home health care to more people.

Senator Sheerin asked Mrs. White if the Nevada Home Health was a private corporation. Mrs. White said that it was a non-profit organization and tax free. They also have funding from other sources.

Senator Blakemore said he thought it was a fine program and certainly has worked. Senator Monroe agreed.

Mr. John Kimble also testified in favor of the bill. He felt that Mary White comments were very pertinent, and approved of the bill. He also spoke about the expenses of medical care today and said he was sure they would continue to rise.

Senator Blakemore motioned do pass on S.B. 5.
Senator Monroe seconded the motion.
Motion carried unanimously.

The mintues will reflect that all present at the meeting were proponents of the bill, and the secretary will provide the Assembly Commerce Committee with a copy of the minutes.

A.B. 68: Lowers minimum age requirement to be certified shorthand reporter. Fiscal Note: No. (BDR 54-576).

Senator Echols explained that A.B. 68 lowered age requirement to be a shorthand reporter and the idea was presented to the Democratic Delegation in Clark County and was generated by the Community College.

There was some discussion about whether certified shorthand reporter was the same as a court reporter. It was agreed that they were the same.

Senator Monroe moved a do pass on A.B. 68.
Senator Blakemore seconded the motion.
Motion carried unanimously.

Senator Sheerin asked for the committee's approval to introduce BDR 54-991 as a committee bill.

Senator Monroe moved to introduce BDR 54-991 as a committee bill.
Senator Blakemore seconded the motion.
Motion carried unanimously.

There being no further business, the meeting adjourned at 4:30 p.m.

RESPECTFULLY SUBMITTED:

Kristine Zohner
Secretary

APPROVED BY:

Gene Echols, Chairman.

AGENDA FOR COMMITTEE ON COMMERCE AND LABOR



Date February 25 Time P.M. Adj. Room 213

| Bills or Resolutions to be considered | Subject | Counsel requested* |
|---|---|---|
| S.B. 5 | Requires health insurance coverage to include home health care. Fiscal Note: No. (BDR 57-391). | |
| A.B 68 | Lowers minimum age requirement to be certified shorthand reporter. Fiscal Note: No. (BDR 54-576). | |

*Please do not ask for counsel unless necessary.

SENATE Commerce + Labor COMMITTEE

ROOM # 213
DAY Tuesday DATE February 25, 1975

| NAME | ORGANIZATION | ADDRESS | PHONE NUMBER |
|---|---|---|---|
| *NOTE: PLEASE PRINT ALL THE INFORMATION CLEARLY. | | | |
| Mary White RN | Nevada Home Health Services | Elko | 738-522 |
| Marguerite TOURREVIL | Elko County Welfare | ELKO | 738-3737 |
| Kazuko Nojima | Churchill County | - | 423-4433 |
| Millie Bennett, PHN Sect. | State Health Div. | - | 885-4740 |
| JOHN R. KIMBALL / John R. Kimball | SILVER QUEEN INN CITY → MEMBER 16 CTY. ADV. COMM. FOR AGING | | |
| MIKE NASH | STATE HEALTH DIV. | 201 S. FALL ST. | 885-4740 |
| Jim Jackson | Health Div | 201 S Fall St | 885 4740 |
| Wm Edwards | Health Div | 201 S. FALL 736 S. Rogers St L.V. | 885-4740 |
| Carol Aldredge - Developmental Disabilities Council | | | 736-1628 |
| Janice Agnew - Nevada Assn. for Retarded Citizens | | 1800 E. Sahara #102 LV. | 732-135 |

- Exhibit "A" -

# S. B. 5

## SENATE BILL NO. 5—SENATOR MONROE

JANUARY 21, 1975

Referred to Committee on Commerce and Labor

SUMMARY—Requires health insurance coverage to include home health care. Fiscal Note: No. (BDR 57-391)

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to health insurance; requiring coverage to include expense of home health care and health supportive services under certain conditions; and providing other matters properly relating thereto.

*The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:*

SECTION 1. NRS 689A.030 is hereby amended to read as follows:

689A.030 No policy of health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

1. The entire money and other considerations therefor shall be expressed therein;

2. The time when the insurance takes effect and terminates shall be expressed therein;

3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, dependent children or any children under a specified age which shall not exceed 19 years except as provided in NRS 689A.045, and any other person dependent upon the policyholder;

4. The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points (the "text" shall include all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions);

5. The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in NRS 689A.050 to 689A.-290, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate

Exhibit "B"

Sen. Blakemore

JOINT ACTION COMMITTEE
3335 BARBARA CIRCLE
RENO, NEVADA 89503
MRS. HOLDERMAN, CHAIRPERSON
BUSINESS
HOME 747-3755

February 25, 1975

Senator Echols and Committee Members:

I am unable to attend the Senate hearing today to give testimony in regards to SB 5 urging insurance companies in Nevada to include coverage for Home Health Services in their insurance policies. If there ever was a need for health services, this organization can truly fill this need.

At the rising cost of hospital confinement, Home Health Agencies make it possible for patients in all age groups to have excellent nursing care in the home at a minimum of the hospital cost.

Nevada Home Health Services out of Elko, now services 8-10 rural counties in the State. Many of these small communities have no hospital or physician services available. Home Health Services and Public Health Nurses are the only suppliers of health care.

This bill should include coverage for R.N.'s, LPN's and aides to enter the patients home to give health care and assistance.

I was a former R.N. Consultant for Medicare for five years. Medicare patients are entitled to a limited number of visits by the Home Health Agencies. These services are only covered if an R.N. services are necessary to supervise the needs of the patient. If the doctor wishes his patient to be bathed, as the patient is too elderly to help themselves, there is no coverage for these services under the Medicare program.

Your committee would be aiding the needs of patients across the state of Nevada who need Home Health services, by voting to urge insurance companies to include this service in their policies.

Sincerely,

Melba Holderman, R.N.
Chairwoman of Governor's
Rural Health Action Committee

Exhibit "C"

STATE OF NEVADA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH
CARSON CITY, NEVADA 89701

100

February 25, 1975

Nevada State Legislature
Legislative Building
Carson City, Nevada 89701

Re: SB 5

Gentlemen:

Nevada State Health Division wishes to express support for the Nevada Home Health Services, Inc. I receive monthly a "Statistical Report of Patients" and a quarterly "Fund Status Report" for monitoring purposes.

This organization is probably unique in the country from the standpoint of organizational make-up and total area served. By providing health care in the home it helps to prevent the hospitalization or institutionalization of many Nevada citizens for health care. They thus help to reduce costs of Health care markedly. Furthermore, the patients are cared for at home in a familiar and more normal environment.

In my opinion, the organization is directed by knowledgeable, dedicated and conscientious personnel. The employees of the Agency perform their tasks professionally. We have had no complaints.

The Agency enjoys fiscal support from local governments, Nevada State Health Division, the Federal government, third party payors and private individuals. Agency review for Medicare Certification shows sound fiscal management and satisfactory organizational policies and procedures.

It is hoped that you can favorably consider this Agency and its grant application.

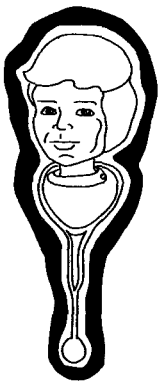
Very truly,

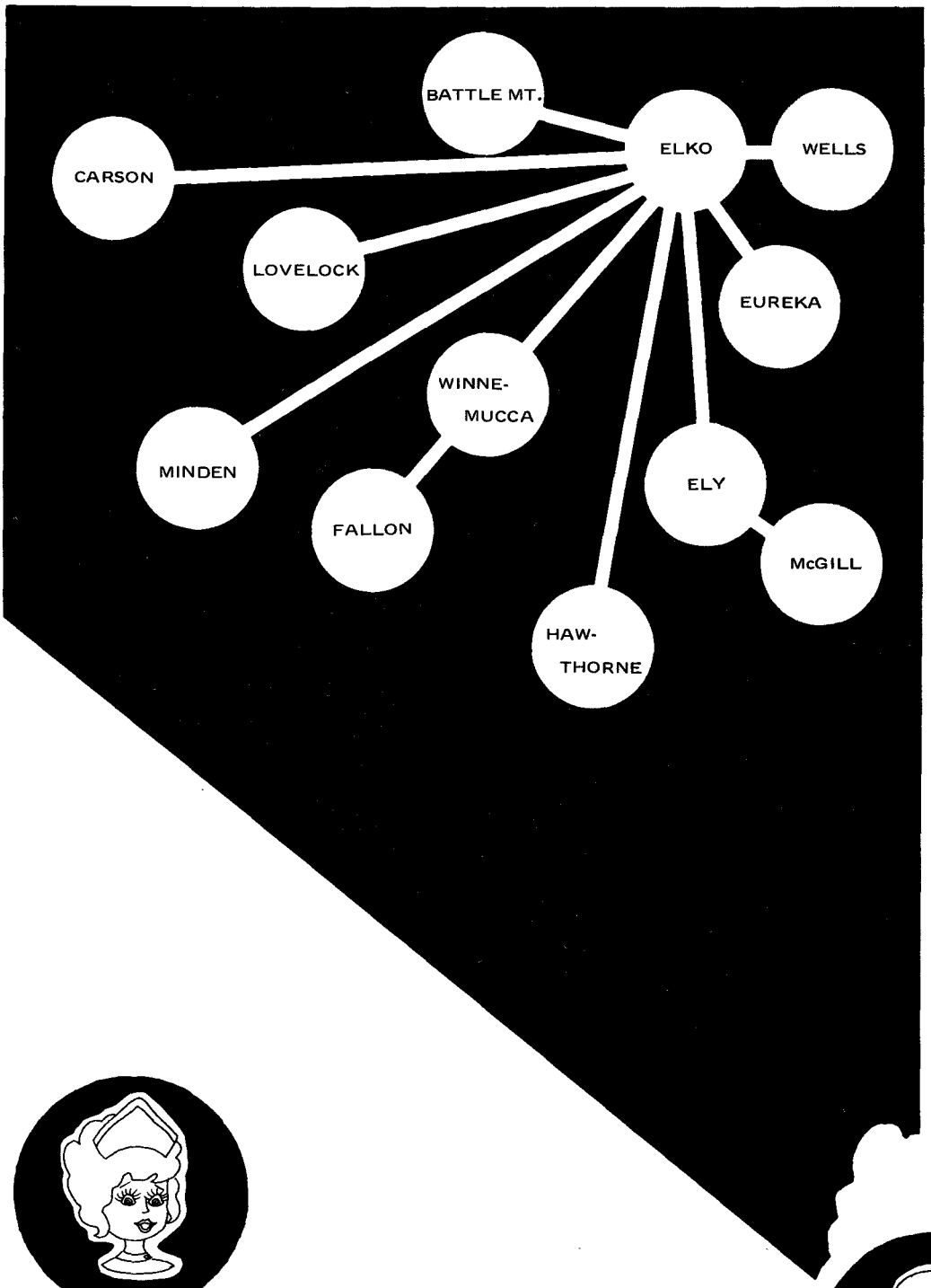
William M. Edwards, M.D., M.P.H.
Chief, Bureau of Community Health Services

WME/rg

# NEVADA HOME HEALTH SERVICE










## LET US HELP YOUR PATIENT !

Over

# NEVADA HOME HEALTH SERVICES, INC.
# PROVIDES

## VISITING NURSE

- Patient assessment
  - physical evaluation
  - response to therapy
  - supervision of medication, diet
- Nursing procedures and techniques
- Teaching, counseling
  - patient
  - family
- Coordination with other agencies for patient services
- Written and oral feedback to physicians
- Supervision, instruction, home health aide, homemaker

## THERAPISTS

- Rehabilitative, restorative exercises
- Application of therapeutic devises
- Gait training
- Application of heat and cold
- Speech Therapy
- Instruction of patient and family
- Nursing and ancillary personnel

## HOME HEALTH AIDE

- Personal care and hygiene
- Maintenance of patient environment
- Meal preparation
- Assistance with prescribed exercises and transfer activities
- Taking prescribed medications
- Emotional support

## HOMEMAKER

- Routine light housekeeping
- Meal preparation
- Teaching household skills to family member
- Child care
- Limited personal care/hygiene

NEVADA HOME HEALTH SERVICE, INC.
HENDERSON BANK BUILDING RM 202
P.O. BOX 1141
ELKO, NEVADA 89801



June 28, 1974

REPORT TO JIM JACKSON
(Bureau of Health Facilities)

COUNTIES - 10

TOTAL OPERATING BUDGET - $190,000.00

COUNTIES MONIES - $41,175.00

TOTAL INDIVIDUALS SERVED - 347

AVERAGE MONTHLY CASE LOAD - 118

TOTAL NURSING VISITS 4,883

TOTAL HHA HOURS 12,764

TOTAL HOMEMAKER HOURS 4,621

PHYSICAL THERAPY VISITS

Contract 281
State

AIDE TRAINING COURSES - 2

AIDES GRADUATED - 14

INSERVICE TRAINING HOURS - 52
Attendance - average - 26 month

WORKSHOPS - 10 Average 3

UTILIZATION REVIEW - 4 Committees
39 Meetings
115 Patients reviewed - 10% case load

Exhibit "D"

## RATIONALE

1. Home health services would be available to a wider age group range

   16. 6 % under 65 years of age

   Average patient load 134/mo

   66.6% Medicare
   5.3% SAMI
   14.3% Self paid
   4.5% Other Ins.
   9.3% County

2. Would extend health coverage in communities by making an additional level of care optional

3. More physicians would refer more patients

   a. Keep patients in hospital to recuperate because no alternative available. Hospitalization or no pay.
      This keeps hospital insurance premiums up

   b. Monitoring of patient post hospitalization reduces admissions

   c. Patients recuperate better at home in own surroundings. Are more relaxed; better motivated; disorientation reduced by the audio/visual stimuli of their own environment.

4. Would make people less dependent on social services.

   9.3% of patient load county funded

   Unexpected medical costs put strain on budget

   Home health services less costly arrangement

5. Would supplement Medicare coverage

   Visits are sometimes used up quickly; patient still requires care

   i.e. dressing changes, multiple services

6. Would be less costly to insurance companies to cover full spectrum of home health services.

   a. Most only pay for nurses, therapists
      Nurses doing aide work

      Some insurance companies may feel aide level not sufficiently competent BUT in Nevada aide certification required by state regulations/standards for licensure of agency.

   b. Reduces inappropriate care; provides alternative care which helps contain costs.

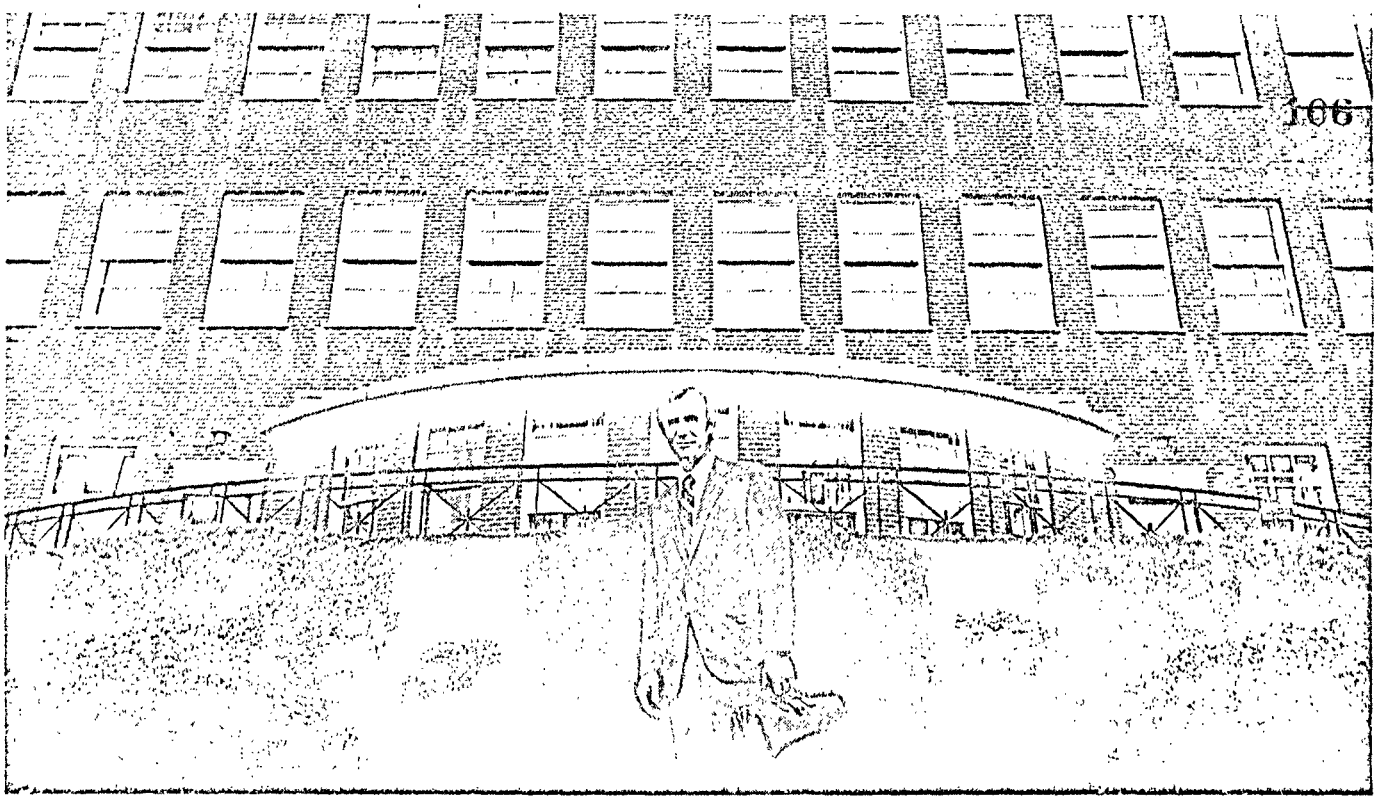
7. Would make acute beds available for those requiring skilled or technical care.

   Reduces over-utilization

8. HHS supported by federal government and other agencies interested in curtailing health care costs.

   DHEW... tightening utilization review guidelines; advertizing on TV for home health services

   Health Services Act re-introduced after pocket veto by President last session of Congress. Allows for expansion of home health services and institution of new agencies.



# You may need a doctor. You don't need the whole hospital.

You may not even need an overnight stay.

The point is, modern medicine has advanced. There are operations that don't even require hospitalization.

The result is, the bed you might have needlessly occupied is there for someone who needs it.

Everybody benefits. And everybody's helping to control the rising cost of health care.

For our part, we help by covering such developments as same-day surgery, medical tests done before you go into the hospital and home care programs.

And this unique, personal service that more than 80 million Americans receive right now can continue to serve the nation well under national health insurance.

The Blue Cross and Blue Shield Plans. One national resource you can depend on.

Blue Cross®
Blue Shield®

## American Cancer Society's Resolution Favors Growth of Home Care Programs

The board of directors of the American Cancer Society passed the following resolution at its meeting in October, 1974: "... the American Cancer Society recognizes that home care is desirable for a large number of cancer patients and favors the growth and development of comprehensive home care programs at the local level." This landmark statement came as an outgrowth of a work-study group appointed by the American Cancer Society and will be followed up with guidelines which will be prepared to go to the local divisions of the Society.

## D.C. Medical Society Supports Expanded Home Care Services

The Medical Society of the District of Columbia has urged the government of the Nation's capital city to "be sensitive to the public's concern for their medical care."

One of their specific recommendations was to "develop and adequately reimburse extended care and home care services for the chronically ill." For lack of sufficient alternative services, too many people are in hospitals "at extremely high costs far beyond need," the doctors said.

## Report To Health Insurance Advisory Council Adopted

On the same day that the Senate passed a new home health agency assistance authorization, the HEW Health Insurance Benefits Advisory Council adopted a report from its Committee on Home Care which strongly recommended increased utilization of home care.

The Committee's report noted:

"Properly utilized, in-home health services can provide a preferred means of restoring and maintaining the health of individuals and families, as well as reduce or prevent hospitalization or long-term institutional care.

"Despite the demonstrated value of home health services, priority continues to be given by third party payers and current legislation to the present institutionally-oriented system of health care. Reversing this priority would make it possible for home health care to emerge as a major national health resource and to take its rightful place in any comprehensive health insurance program that may be enacted..."

## Quotes From Congress On Home Health Care

**Senator Frank Church of Idaho,** chairman of the Special Committee on Aging, and the original sponsor of the home health care provisions incorporated into the Health Services & Health Revenue Sharing Act, says:

"... care in the home is a much needed but underutilized form of health care. This is particularly true for the elderly. Many of these older people could remain in their own homes rather than be institutionalized if provided with therapeutic and supportive home health services ... Many rural areas have no home health agencies or agencies that can provide only very limited services. There is almost no way for new agencies to be established, or for existing agencies to expand their services ... There are also measures pending or recently enacted which can be expected to increase the demand for home health services by all age groups."

**Senator Jacob Javits of New York** — home health care is "a less expensive and/or more effective alternative to continuing hospital and nursing home care."

**Senator Edmund Muskie of Maine** — "... hearings demonstrated the need not only for the direct aid to home health services now contained in S.3289 but also liberalization of the standards for reimbursement of home health services under Medicare."

**Senator Robert Taft of Ohio** — "I support this legislation to revise and extend several important health services programs, including ... start-up grants to home health agencies and grants for training personnel to provide home health services."

**Senator Alan Cranston of California** — "... among various systems of health care services, one of the most promising yet least recognized is the system of home health care. Availability of home health care services in the community can offer an alternative to the more expensive nursing home care or hospitalization when the patient's family is unable to provide all the support necessary to meet fully the patient's needs."

## Ford on Home Care

"It is only through mutual efforts of both governmental agencies and private organizations such as yours that we can look forward to the time when health services will be readily available to all and that home care will become an integral part of our health care system."

President Gerald R. Ford in a telegram to the NAHHA annual meeting, Oct. 1, 1974.

# Benefits Cited For Home Stroke Patients

A comparison of stroke patients who received home care with a matched group without home care revealed that the home care group had:

* shorter hospital stays
* greatly reduced overall costs
* fewer readmissions for recurring strokes
* fewer deaths

The study was made at St. Luke's Hospital Medical Center in New York City and reported in *Stroke*, Vol. 5, January-February 1974, by Nancy H. Bryant, R.N., B.S., M.P.H., Louise Candland, R.N., M.A. and Regina Loewenstein, A.M.

The purpose of the study was to compare care and cost outcomes for stroke patients with and without home care in 1971, using 25 home care stroke patients who were matched by age and sex with 25 comparable stroke patients receiving no home care.

The differences in care and cost outcomes between these two groups has considerable implications for patients, hospitals, physicians and third party payers, conclude the authors. For instance, after a nine months' follow-up stroke patients who receive home care had shorter hospital stays, with an average of ten days less.

A dramatic decrease in overall costs was noted, with an average expense of $3,450 for home care patients versus $8,300 for the comparison group. There were fewer readmissions for recurring strokes and fewer deaths (two versus nine).

At the end of the nine months, home care patients were located as follows: 20 at home, two on home care, one in a nursing home, and two were dead. The comparison group showed: eight at home, one at an extended-care facility, seven in nursing homes and nine dead.

The study was made of stroke patients admitted to the home care department of St. Luke's in 1971. Records were readily available from that department as were hospital records of these same patients and of the comparison patients.

The authors believe their study is unique. Other evaluations have focused on one aspect (such as numbers of days saved from the hospital stay), but none of the studies has tried to compare patient costs over an extended period of time, as well as outcome of service, for patients with a similar diagnosis.

National Association
of Home Health Agencies
659 Cherokee Street
Denver, Colorado 80204

as seen in December 4, 1972
business insurance



# Upjohn cuts group health costs by covering post-hospital home care

KALAMAZOO, MI.—The Upjohn Co. has cut the overall cost of its group health insurance by adding home health care following hospitalization to its contract with Travelers Insurance Co.

The coverage, effective since March 1, 1971, pays 90% of reasonable charges by a qualified provider of home health care and related therapeutic services, up to a maximum of $400 in a period of 12 consecutive months.

Not realistic

Paul M. Millholland, Upjohn's manager of benefits administration, said that the decision to use the new home health care was precipitated by several considerations. It was, first of all, an attempt to reduce the cost of the hospital portion of the group medical plans.

The benefits administration manager also told *Business Insurance* that Upjohn owns a Kalamazoo-based subsidiary which provides the kind of at-home health care services covered in the new plan. Called Homemakers, the subsidiary has offices throughout the country, and can probably expect a surge in business since the 7,000 Upjohn employes had the home health care coverage included in their group health insurance.

**THE HOME** health care plan was also designed with the notion that many employes would prefer recuperating from their illness in the relaxed atmosphere of their homes, rather than in the hospital. Mr. Millholland said that in structuring the new plan, Upjohn tried to find something that would appeal to the employe's desire to remain at home, but which would not be too costly for him to do so. The current plan, in which the employe contributes 10% of at-home costs, has proven attractive to both the company and the employes.

Details of the coverage were worked out by the Travelers Insurance Co. through Marsh & McLennan, following a switch by Upjohn from its previous group health carrier, the John Hancock Mutual Life Insurance Co.

The Upjohn man said that since the plan was initiated, the savings from shortened hospital stays have more than offset the costs of the coverage. Travelers estimated the savings over in-hospital care to be almost $3,200, or approximately $152 per claim. These figures were based on estimated hospital costs of $75 to $80 per day and the number of hospital days saved after deducting the cost of home care.

**MR. MILLHOLLAND** says he feels that hospital costs would run closer to $100 per day, consequently resulting in an estimated saving of almost $5,700, or about $270 per case.

Completely administered by Travelers, the home health care plan is a payroll-deductible contributory plan for the Upjohn employes. However, it is not costing them anything additional to the price they were already paying for the group health insurance.

Noting that the plan would cover the employe, plus any dependents, Mr. Millholland said the maximum monthly contribution an employe could make was one dollar.

**HOME HEALTH** care and related therapeutic services as defined in the plan, include the services of a registered nurse or licensed practical nurse; a nurses' aide or home health aide; a household aide whose duties are primarily those of caring for the patient and incidentally providing other services to members of the family who reside with the patient; and a family aide whose primary duty is to care for children or family members other than the patient.

A qualified provider of home health care, as outlined in the contract Upjohn has with Travelers, must: Be an agency whose primary purpose is providing a home health care delivery system bringing supportive services to the home; have a full-time administrator and maintain written records of services provided to the patient. In addition, its staff must include at least one registered nurse or have nursing care by a registered nurse available to it; its employes must be bonded and it must provide malpractice and malplacement insurance.

At the time of the patient's release from the hospital, under Upjohn's new home health care plan, the doctor in attendance simply certifies on the claim form or on a prescription pad that in lieu of additional hospital confinement, a certain number of days of home health care is required. ■

BUREAU OF COMMUNITY HEALTH SERVICES
information
Public Health Service · Health Services Administration



number 1 September 1973

# Health Delivery Trends... AMBULATORY CARE

"The practice of medicine today costs too much. There is too much lost motion. And it takes too many men. It is most uneconomical and is a distinct luxury."

This is what delegates to the second American Health Congress heard at the August 1973 meeting of the Congress in Chicago.

But the words were quoted from a book, "Medicine at the Crossroads", written in 1939, when the "high" cost of hospitalization had reached $4 a day.

Secretary of Health, Education, and Welfare Casper W. Weinberger, keynoter at a plenary session of the Congress, updated the 1939 figures: In 1963, he said the average daily charge for a hospital room was $45; in 1972 it was $103; and it is now, in some places, $145.

D. Eugene Sibery, executive vice president, Blue Cross Association, who discussed ambulatory care as an alternative to hospitalization, told Congress delegates the challenge today is to see to it "that we give the patient the good care he needs, and the kind of care he needs, while he's still on his feet, instead of putting him into a hospital bed where he gets more care than he actually needs."

"The goal now is to leave the acute-care bed for those who need the full spectrum of skilled nursing and technical care. For patients who need less, lesser services must be available." Mr. Sibery said that the Blue Cross system must share the guilt for "concentrating our prepayment programs on hospital care....To put it one way, we were insuring people for sickness. We believe it is time to begin insuring them against sickness...at least insuring them for any and all kinds of health care services, rather than only for occupying a hospital bed."

# home health highlights

NAHHA

report on congressional & administrative actions

Vol. 2, No. 1 | NAHHA Legislative Committee | January 24, 1975


## In This Issue . . .



## President's Veto Message On Health Services Act

President Ford's veto of H.R.14214, the "Health Revenue Sharing and Health Services Act," came as a great disappointment to many professionals in the home health sector. The bill contained language authorizing Federal funds for a one-year demonstration program for expanding and improving home health agencies and for the training of agency personnel. By allowing the bill to die under the "pocket veto" provisions of the Constitution, the President denied Congress the opportunity to attempt a veto override in the closing days of the last Congress.

The bill has been reintroduced in the new Congress, and it is expected that committee action will proceed promptly.

Following is the text of the President's message of disapproval:

I have withheld my approval from H.R. 14214, the "Health Revenue Sharing and Health Services Act of 1974."

H.R. 14214 conflicts with my strong commitment to the American taxpayers to hold Federal spending to essential purposes. The bill authorizes appropriations of more than $1 billion over my recommendations and I cannot, in good conscience, approve it. These appropriation authorizations are almost double the funding levels I have recommended for fiscal year 1975 and almost triple the levels I believe would be appropriate for 1976.

As part of my effort to see that the burden upon our taxpayers does not increase, I requested the Congress last month to exercise restraint in expanding existing Federal responsibilities, and to resist adding new Federal programs to our already overloaded and limited Federal resources. These recommendations reflect my concern with both the need to limit the Federal role to those activities which can make the most necessary and significant contributions.

In H.R. 14214, the Congress not only excessively increased authorizations for existing programs but also created several new ones that would result in an unjustified expenditure of Federal taxpayers' funds. Although the purposes of many of the programs authorized in this bill are certainly worthy, I just cannot approve this legislation because of its effect upon the economy through increased unwarranted Federal spending.

Finally, it should be pointed out that the Federal Government will spend almost $20 billion in 1975 through Medicare and Medicaid for the financing of health services for priority recipients—aged and low-income persons. These services are provided on the basis of national eligibility standards in Medicare and State eligibility standards in Medicaid and therefore are available to individuals in a more equitable and less restrictive manner than many of the programs authorized in H.R. 14214.

## HEW Secretary Weinberger Says Home Health Services Underfinanced By Government

Speaking before the Legislative Council of the American Association of Retired Persons and the National Retired Teachers Association, HEW Secretary Caspar W. Weinberger defended his Department's role in upgrading nursing home care and safety, and spoke out forcefully on the need for adequate home health services as an alternative to institutionalization.

"One question that needs to be answered is this: Who should be in nursing homes?" The few studies that look into this question all indicate that far too many older Americans end up in institutions mainly because they are old, alone and have no family to care for them. There are estimates that perhaps 30 percent or more of the patients in nursing homes do not really belong there on clinical grounds," Weinberger told the Council.

continued page 3

*HOME HEALTH HIGHLIGHTS is published bi-weekly by the Legislative Committee of the National Association of Home Health Agencies (NAHHA).* 

Weinberger, continued

"And it is becoming increasingly obvious that government reimbursement programs are encouraging this warehousing of older Americans. **Government reimburses more for institutional care than it does for care in the patient's own home. Because home health services have been under-financed by government, programs like Medicare, Medicaid and public medical assistance provide home health service benefits for only a narrow segment of the older population. That is the way the laws are written."**

The Secretary said that, among many older people, the problem is primarily one of social and economic dependency, not a need for health care in an institution. He added, "These social and economic needs could often be met much better and less expensively with home care programs that would allow older people to remain in their own homes—where they would rather be anyhow."

Referring to plans for expansion of nursing home beds in many areas, Mr. Weinberger said that, in all likelihood, additional beds would not be needed if adequate home care programs existed.

**"But today, home services do not exist on anywhere near the scale needed. Nor do we have the reimbursement mechanisms to meet the total need. Yet both economics and common humanity argue that we should have these home-care services."**

Other portions of Secretary Weinberger's comments:

"From the recent past to the present, our concerns have been necessarily limited to getting nursing homes up to standard. That work must continue. But for the future, our concerns must also encompass the broader range of treatment options for long-term care of the aging—home health services, nursing homes, outpatient clinics and hospitals.

"Once these options become available, we will also need something else that we do not yet have—a community-based screening system to make sure that people who are old and chronically ill get into—and out of—the right facility or service according to their need.

"Today, many older people go into nursing homes and are swallowed up there. They never get out, regardless of whether it ever becomes feasible to discharge them.

"We need community screening programs to see to it that people don't go into nursing homes when they don't belong there; and conversely that they are discharged from institutions whenever their condition warrants discharge.

"We have made beginnings toward this. For example, we are working on a Patient Assessment Program that state nursing home inspectors can use to determine whether patients are in the right kind of long-term care facility, or whether they should be discharged to another kind of service altogether. HEW's Atlanta Region is the first to begin this program.

"All of this will move us closer to the day when long-term care of the elderly will be based on the needs of the individual, not on what kind of care government will reimburse providers for."

## 93rd Congress: Health Legislation Scorecard

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Of the seven major health bills approved by the last Congress, President Ford vetoed two after Congress had adjourned (including the Health Services Act with special provisions for home health agency grants). The scorecard on 1973-74 health legislation is as follows:

1. Health Maintenance Organizations: **PL 93-222.**
2. Health Planning & Development Act: **PL 93-641**
3. Health Revenue Sharing & Health Services Act: **vetoed by the President (see message this issue).**
4. Nurse Training Act: **vetoed by the President.**
5. Research on Aging Act: **PL 93-296.**
6. Nutrition Programs For the Elderly: **PL 93-351.**
7. Social Services Amendments of '74: **PL 93-647.**

## Quote Of The Week

In another document published by the Senate Special Committee on Aging in its series on nursing home and long-term care policies, improved home health services rank Number 1 on the list of recommendations. The following quote is a good one to use in your own communications with Members of Congress regarding the need for greater recognition of home health care:

**"1. A national policy must be established with regard to treatment of the infirm elderly. This policy should consider the total needs of the individual, including medical, dental, residential, social and psychological services. The policy should look first to treating the individual in his own home with appropriate housing, congregate living facilities, and home health services. Some consideration should also be given to senior citizens hospitals and day care centers and proposals to subsidize the family to help them care for the elderly in their own homes."**

## Coming Soon: A Special Edition of "HIGHLIGHTS"

Some of the most dramatic changes in this Century are taking place in the Congress of the United States. There are not only many new faces, but traditions are being overturned, rules are being changed, committee jurisdictions have been shuffled, and—most significantly— there is a new "mood."

These changes will affect the way the Congress responds to public sentiment, and will also have a bearing on the methods and techniques of public advocacy.

As soon as all committee and subcommittee assignments are made, there will be a special edition of Highlights outlining the important changes taking place, and hopefully giving readers some useful advice on how to make their voices heard most effectively in a year when health legislation ranks near the top in legislative priority.

# A. B. 68

ASSEMBLY BILL NO. 68—ASSEMBLYMEN ASHWORTH, BANNER, MANN, DREYER, BENKOVICH, SENA, PRICE, DINI, HARMON, CRADDOCK, BROOKMAN, SCHOFIELD, HEANEY, WEISE, YOUNG, BREMNER, MELLO, COULTER, JEFFREY, POLISH, ROBINSON, JACOBSEN, BENNETT AND CHANEY

JANUARY 27, 1975

Referred to Committee on Commerce

SUMMARY—Lowers minimum age requirement to be certified shorthand reporter. Fiscal Note: No. (BDR 54-576)

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to shorthand reporting; lowering the minimum age required for registration as a certified shorthand reporter.

*The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:*

SECTION 1. NRS 656.180 is hereby amended to read as follows:

656.180 An applicant for a certificate of registration as a certified shorthand reporter is entitled to such certificate if he:

1. Is a citizen of the United States;
2. Is at least [21] *18* years of age;
3. Is of good moral character;
4. Has a high school education or its equivalent;
5. Is a bona fide resident of this state;
6. Satisfactorily passes an examination administered by the board; and
7. Pays the requisite fees.

(30)

Exhibit "E"