Survey of Welfare Clients To Determine Need for Home Health Aides

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REALIZING the impact of the medical care legislation and the potential for improving, coordinating, and bringing about more effective use of health services in the home, the health and social services departments in Contra Costa County, Calif., joined forces to appraise our public assistance medical care program. Formerly, public assistance recipients needing personal care, such as bathing, feeding, dressing, or assistance with rehabilitation programs in the home, received additional funds in their grants to pay attendants for care. It was the recipient's responsibility to find and employ someone to perform the needed services. There were no qualifications for employment or standards set for care given.

Legislation enabling the State to discharge its responsibility under Title XIX of the Social Security Act became effective on March 1, 1966. The same legislation also terminated the programs for public assistance medical care and medical assistance to the aged in California. Consequently, California counties were advised that home health aide services provided under the California Medical Assistance Program were intended to become the source of home health care services for public assistance recipients (*1*, *2*).

The State department of social welfare in its Circular Letter 1812 of July 8, 1966 (*3*), directed that recipients in the attendant care program on July 1, 1966, could not continue to receive payment in their grants for attendant care after home health aide services were available to them. This letter also indicated that the transfer of these recipients to home health aide services should be accomplished by January 1, 1967. The letter further directed county welfare departments to engage in joint planning with county health departments to aid in developing home health agencies where no home health agency existed or where services of such agencies were felt to be inadequate.

Provisions for the training, employment, and supervision of the attendant as a home health aide are described in the California home health agency licensing requirements. Two of the general requirements for home health aide services were that:

1. The attendant rendering personal services must be a qualified home health aide, having completed 120 hours of training or having been certified by examination.

2. Such home health aides must work under the direction and supervision of a registered nurse employed by a home health agency certified by the California State Department of Public Health (*4*).

Home health aide services are defined in the regulations of the California Medical Assistance Program, section 51133 (*5*).

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Home health aide services are those supportive services which are required to provide and maintain normal bodily and emotional comfort and to assist the patient toward independent living in a safe environment. These services are provided through and under the supervision of a registered professional nurse.

A. Home health aide duties include:

1. Helping patients with personal hygiene.
2. Helping in and out of bed and assisting with ambulation.
3. Helping with prescribed exercises which patients and home health aides have been taught by appropriate health personnel.
4. Helping patients with eating and preparing meals.
5. Assisting with oral medications that can be self-administered.
6. Performing those household services which will facilitate the patient's self-care at home and are necessary to prevent or postpone institutionalization.

B. Services may include 24-hour coverages where such is medically indicated.

On November 25, 1966, the State department of social welfare published Circular Letter 1812–D (*6*), which provides for deferring the requirement for home health aide services from January 1, 1967, to December 31, 1967. This additional time for the transition from attendant care to home health aide services will allow home health agencies to qualify for participation in the medical assistance program.

On September 1, 1966, only one small voluntary organization in Contra Costa County had been certified as a home health agency by the State department of public health, and approximately one-third of this agency's 91-patient caseload was covered by Medicare. No training program for home health aides existed in the county.

Preparation to carry out provisions of the medical care legislation at the service level required that the agencies involved attempt to estimate the needs for home health aide services within the county. Ideally, the entire county should have been surveyed to ascertain (*a*) what segment of the population would need attendant care, (*b*) kinds of disabilities engendering the need for attendant care and types of services required, (*c*) time required to render such services, and (*d*) number of persons required to supervise and perform the services.

Contra Costa County in 1966 had a population of 532,000. A total of 32,850 persons were on public assistance rolls. Of these, approximately 821 received supplementary aid to pay for personal or domestic services, or both, rendered by attendants in the home. Since handicapped welfare recipients would need, under the California law, to receive home health aide services by January 1, 1967, this study was undertaken to estimate the number of hours of personal care they required.

Methodology

In September 1966 the social service department of the county provided a list of 821 clients receiving supplementary aid to pay for personal or domestic services, or both, rendered by attendants in the home. The original plan was to determine the need by sampling the caseload and from this sample to estimate the needs for the entire group. The range of the clients' diseases and conditions and the variations in need for personal services caused us to abandon sampling in favor of evaluating the total caseload of those receiving care from attendants.

Evaluation of need was made from the client's social service record. In order to establish a format for case evaluation, a sample of 50 records was reviewed by a public health physician and two public health nurses. Using the criteria for home health aide duties given in the regulations of the medical assistance program, a baseline was established and a checklist was used to evaluate each client's need for personal care and to estimate the number of hours of care needed.

A checklist was designed for rapid summarization of the patient's condition and nursing requirements. In addition to the patient's name, address, sex, birth date, and social security number, the form contained blanks for diagnosis or medical condition, kind of special diet, and whether the patient was bedfast, chairbound, able to use a wheelchair, or ambulatory. Check-off items (from 2 to 9 choices) concerning the patient's condition were listed under the following 16 topics: behavior and alertness, need for restraints, walking, moving, special equipment needed, eating, dressing and grooming, bathing, vision, skin, speech, hearing, whether the patient had contractures, bladder and bowel control, need for special nursing procedures, and bedsores.

For the purposes of this study, personal care was interpreted as actually providing physical

assistance such as bathing, feeding, or dressing the person, or duties necessary to help the patient confined to a bed or wheelchair. Domestic services were interpreted as those concerned primarily with the care of the environment such as housekeeping, home management, or homemaking; none of these are covered by the Federal medical assistance program (7). Protective supervision was accepted as meaning that the patient needed to be under surveillance for his own protection, but unless they were stipulated in his record, he was not considered in need of personal services.

We had intended to evaluate the patient's need for personal care from the medical report in the social service record. However, when the medical report was missing or inadequate for our purposes, the information was abstracted from the social service narrative. Using the medical or social service reports for evaluation, a team of public health nurses reviewed the case records of 772 of the 821 persons named on the list from the social service department.

Case records of 48 persons were not read because the patient had moved from the county, or died, or was temporarily in a nursing home or hospital, and anticipated changes in personal needs could not be made. Apparently 39 persons no longer needed attendant services, and because of insufficient information we were unable to evaluate the needs of another 19 persons. Our observations were tabulated from the 715 records in which the patients' need for attendant care was clearly shown.

To test the reliability of the social service record as an accurate indicator of need for personal care, a subsample of 40 patients was also evaluated by a public health nurse. She visited the patient in his home and, using the same checklist, assessed his need for personal care services. On the basis of these observations the nurse estimated the number of hours necessary to provide the care.

Observations

Of the 715 persons whose records were surveyed, 501, or 70 percent, were over 60 years of age, and 456, or 63.9 percent, apparently required no personal services at that time (table 1). However, 20, or 4.3 percent, of the 456 patients required protective supervision 24 hours daily. (The components of protective supervision were not investigated further during this study because such supervision was not interpreted as a personal service connotating eligibility for home health aide services.)

If the county is to receive Federal or State subsidies, or both, for attendant care, home health aide services will be needed for 259 of the 715 patients whose records were reviewed. Relatives were being reimbursed for providing personal care to 86, or 33 percent, of the 259 patients.

Of those requiring home health aide services 80, or 31 percent, were seriously disabled and needed personal care for 24 hours each day. The patient in this group is unable to bathe, dress, or feed himself, and cannot move about unaided—if at all.

A home health aide was needed 6 to 8 hours

Table 1. Need of public assistance clients for personal services, by age group, Contra Costa County, Calif.

Age group (years)	Requiring personal services		Not requiring personal services		Total	
	Number	Percent	Number	Percent	Number	Percent
Under 31	21	2. 9	16	2. 3	37	5. 2
31–40	18	2. 4	23	3. 2	41	5. 6
41–50	16	2. 2	23	3. 2	39	5. 4
51–60	33	4. 7	64	8. 9	97	13. 6
61–70	35	4. 8	119	16. 6	154	21. 4
71–80	72	10. 1	143	20. 3	215	30. 4
81–90	56	7. 9	64	8. 9	120	16. 8
91–100	8	1. 1	4	. 5	12	1. 6
Total	259	36. 1	456	63. 9	715	100. 0

daily by 68, or 26 percent, of the 259 people requiring personal care. These patients too are often severely disabled, frequently living with a relative who works during the day and provides care to the patient at night and on days off at no expense to the county.

The remaining 111, or 43 percent, appeared to require personal care services for 4 hours or less a day. Patients in this category frequently need help with bathing, grooming, or rehabilitative exercises.

Social welfare records showed 541 diagnoses for the 259 persons needing personal and nursing services. A single diagnosis was noted for 81 persons; the remaining 178 had multiple conditions involving several physiological systems (table 2). In 209 records cardiovascular disease, mostly arteriosclerotic heart disease, was mentioned (table 3). Conditions involving the central nervous system affected 114 patients. Other frequent diagnoses were arthritis 61, diabetes mellitus 39, and eye conditions, including blindness, 24. Special diets had been prescribed for 96 patients.

Discussion

Under Federal and State medical care legislation, all persons requiring personal care administered in the home would need the services of a trained home health aide. Obviously, no one agency, either voluntary or public, could begin to plan to implement the legislation.

Table 2. Public assistance clients with single diagnosis or multiple diagnoses, by age group, Contra Costa County, Calif.

Age group (years)	Clients with single diagnosis	Clients with multiple diagnoses	Total clients	Total diagnoses
0–65	55	45	100	180
Under 31	12	9	21	31
31–40	12	6	18	31
41–50	10	6	16	22
51–60	17	16	33	68
61–65	4	8	12	28
66–100	26	133	159	361
66–70	1	22	23	53
71–80	15	57	72	161
81–90	8	48	56	132
91–100	2	6	8	15
Total	81	178	259	541

Table 3. Medical conditions among public assistance recipients, by age group, Contra Costa County, Calif.

Conditions	Age groups		Total
	Under 65	65–100	
Cardiovascular diseases	42	167	209
Arteriosclerotic heart disease and congestive heart failure	10	105	115
Hypertension	12	40	52
Congenital and other cardiac disease	2	0	2
Intracranial hemorrhage	18	22	40
Central nervous system disorders	68	46	114
Senility and chronic brain syndrome	7	35	42
Paraplegia, quadriplegia, or triplegia	17	3	20
Ataxic diseases	11	4	15
Severe unspecified CNS disorders	23	0	23
Convulsive disorders	2	0	2
Aphasia	3	1	4
Psychosis or alcoholism	5	3	8
Diseases of the bones	30	61	91
Arthritis	15	46	61
Amputations	3	6	9
Fractured hip	1	4	5
Fractures (other)	8	2	10
Other diseases of the bones	3	3	6
Diabetes mellitus	9	30	39
Diseases of the eyes and blindness	7	17	24
Neoplasms	4	9	13
Cancer, brain	2	1	3
Cancer, other	2	8	10
All other diseases	20	31	51
Mental retardation	12	1	13
Obesity	2	9	11
Diseases of the digestive system	1	7	8
Diseases of the genitourinar system	0	4	4
Diseases of the respiratory system	1	7	8
Other diseases, not elsewhere classified	4	3	7

Lack of accessible data on the impact of the medical care programs in the private sector of medicine and the immediacy of providing attendant care to an unknown number of persons prompted the county health and welfare departments to survey the attendant-care caseload among the patients with whom they had contact. Data regarding welfare recipients eligible for medical care under Federal and State legislation was readily available in the social service records, and therefore these records were a logical first source of information for public agencies.

The welfare case record, when complete, included a form on which the physician stated his diagnosis and his prescription for the kind of attendant care the patient should have in the home. However, our doubts about the reliability of records as the means to assess the actual needs of patients prompted us to send a public health nurse into their homes for a more complete immediate evaluation in a random sample of 40 patients originally surveyed by this method. Public health nurses concurred with the estimate of need for personal services made from the record review in 35 of the 40 referrals. In four instances the nurse felt that no home health aide was needed. In one instance the public health nurse's field assessment indicated that a full-time home health aide was needed instead of the 12 hours per week which had been suggested from the record survey. We feel that the nurses' observations confirm the rationale of this approach.

In surveying the patients' needs and compiling the data, some inconsistencies in the law and difficulties which can be anticipated in implementing medical care legislation as it applies to home health aides became apparent.

In this study, the criteria of physical assistance to the patient was used in deciding whether the needed services might be personal, thus requiring the assistance of a home health aide, or whether the services needed were predominantly those of a domestic worker. The medical assistance program does not cover service that is predominantly domestic.

The California State Department of Social Welfare has indicated that a reasonable use of the home health aide should be considered if protective supervision of the patient is necessary. In an attempt to clarify the word "reasonable" we found that the California State Department of Social Welfare Bulletin 632 (*8*), states that an aide might be used to assist or supervise the person whose memory is faulty. The broader interpretation of the law promulgated in this bulletin seems more appropriate for the older patient. However, under Medi-Cal regulation 51303(*9*) and Public Law 89–97, section 1862 (*10a*), no services shall be covered which are not reasonable and necessary for the prevention, diagnosis, or treatment of illness or injury, or to improve the function of a malformed body member. Perhaps the prevention-of-injury clause can be judiciously applied to older patients with faulty memories or to those with conditions diagnosed as chronic brain syndrome or senility.

Numerous records in the survey lacked medical notations, but often the social workers' notes indicated that some patients capable of attending to their personal needs nevertheless required supervision. While doing the household tasks, yardwork, or transporting such a patient, the domestic attendant apparently was responsible for protecting or supervising the person, especially if his charge lived alone. Because the primary tasks of these workers apparently were domestic services, we were forced to classify these attendants as domestics. The lack of medical notations should be kept in mind because in our survey we found that in 35 instances where the patient was over 65 years old the physicians had simply written "senility" or "chronic brain syndrome" in answer to a query by the welfare department for the medical diagnosis.

We found that 100 clients had live-in attendants. According to our criteria 80 required personal services. The need of 20 persons was adjudged primarily domestic, typical of patients requiring supervision or surveillance.

In this survey we learned that relatives are being paid for services to one-third of the patients for whom a home health aide seemed necessary. The family members often have performed personal services as needed for the patients for many years.

Public Law 89–97, section 1862–11, however, states that expenses incurred for items or services are excluded from coverages "where such expenses constitute charges imposed by immediate relatives of such individuals or members of his household" (*10b*). Consequently, implementation of the Medicare program without disrupting services to these patients and their families cannot be accomplished without reconsidering this portion of the law, especially when the relative-caretaker is a qualified home health aide.

Under Medi-Cal the certified home health aide relative may be compensated for physician-prescribed personal care. Unlike Federal Medicare, at the present time, there is no limitation

in Medi-Cal on the number of home health aide visits which may be made to care for the patient.

With the identification of personal care needs derived from this survey we were able to make practical plans to recruit and train home health aides to fulfill the personnel requirements to implement this portion of the Medi-Cal legislation. Wherever possible, the attendant already caring for the patient was recruited for home health aide training. In addition we were able to pinpoint the geographic distribution of public assistance recipients who needed home health aide services. This knowledge has aided us in planning the deployment of trained personnel throughout the county.

We feel that if our medically supportive program for patients receiving public assistance is to be timely and appropriate, (*a*) emphasis should be given to skillful management of the disease processes and rehabilitation should be attempted whenever feasible, (*b*) further frequent assessment of the mental alertness and functional levels of older patients in their own homes will be needed, and (*c*) guidelines for a system of periodically reassessing these patients should be effected.

However, no simple means has been devised which can predict an individual's or family's ability to manage hardship and limitations imposed by physical infirmities.

Summary

To determine the need for personal care services in the home among welfare recipients in Contra Costa County, Calif., social service case records were reviewed for all clients receiving attendant services in September 1966. Validity of this method was subsequently confirmed when public health nurses made home visits to assess the needs of a subsample of the patients surveyed and concurred with 35 of 40 evaluations made from a review of the records. Of a total of 821 clients, attendant care clearly was necessary for 715. Of these, 63.9 percent apparently required primarily domestic services, and 36.1 percent will need home health aide services when the Federal and State medical care legislation is implemented if the county is to be reimbursed for personal care under medical care legislation.

More than two-thirds of the patients had multiple conditions involving several systems. Of 259 patients requiring personal services, 31 percent were seriously disabled and needed care for 24 hours each day, 26 percent needed service an estimated 6 to 8 hours daily, and the remaining 43 percent apparently required help for 4 hours or less a day. A family member was being paid to provide personal care for one-third of the patients.

In many cases the domestic attendant apparently was expected to watch over the patient. Frequent assessment of the mental alertness and functional levels of older people in their homes will be needed to prevent accidents, promote rehabilitation measures, and maintain maximum health potentials in the home as long as possible.

REFERENCES

(*1*) Calif. Administrative Code, title 22, sec. 51217, Home health agencies, and sec. 51219, Home health aide services. Register 66, No. 19, June 25, 1966.

(*2*) Calif. Welfare and Institutions Code, div. 9, pt. 3, ch. 7, Basic health care, and ch. 8, Extended health services. Mar. 1, 1966.

(*3*) Calif. State Department of Social Welfare: Attendant care—home health aide services. Circular Letter 1812 (Old age assistance, aid to the blind, aid to the totally disabled, aid to families with dependent children, California Medical Assistance Program). July 8, 1966.

(*4*) Calif. Administrative Code, title 17, sec. 941, Home health aide services. Register 66, No. 37, Oct. 29, 1966.

(*5*) Calif. Administrative Code, title 22, sec. 51133, Home health aide services. Pts. (a) and (b). Register 66, No. 6, Mar. 5, 1966.

(*6*) Calif. State Department of Social Welfare: Attendant care—home health aide services, extension of transition period. Circular Letter 1812–D, Nov. 25, 1966.

(*7*) U.S. Social Security Administration: Conditions of participation for home health agencies. HIM–2. U.S. Government Printing Office, Washington, D.C., 1966, pp. 13–15, 19–20.

(*8*) Calif. State Department of Social Welfare: Resources for attendant care services. Bull No. 632. Rev. June 8, 1965.

(*9*) Calif. Administrative Code, title 22, sec. 51303, General provision. Register 66, No. 19, June 25, 1966.

(*10*) P.L. 89–97, 89th Cong., H.R. 6675, July 30, 1965, sec. 1862, Exclusions from coverage, (*a*)1; (*b*)11.