CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

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CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

THURSDAY, FEBRUARY 11, 1965

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Indianapolis, Ind.

The subcommittee met at 9:30 a.m., pursuant to call, in the auditorium, City-County Building, Indianapolis, Ind., Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senator Moss.

Staff members present: Frank C. Frantz, Jay B. Constantine, professional staff members, and John Guy Miller, minority staff director.

OPENING STATEMENT OF THE CHAIRMAN

Senator Moss. The hearing will come to order, and we will begin.

It is a pleasure to be here in Indianapolis this morning once again, and I welcome all of you who have come to this hearing. I am sure we will have an interesting day and one in which we can assemble a good deal of information that will be beneficial to the committee.

I understand that Mayor John Barton, who had planned to be here, has been somewhat delayed. He will be here later in the morning, and we will call upon him when he arrives.

This is the Subcommittee on Long-Term Care of the Senate Special Committee on Aging. We are conducting here an official Senate hearing in which all of the testimony that is given will be taken down by our reporter and will be available in the form of a permanent record for the information of the Congress as legislation affecting nursing homes and similar institutions is considered in the future.

This subcommittee was organized a little over a year ago for the purpose of carrying out a comprehensive study of the conditions and problems in the Nation's nursing homes and in the entire spectrum of facilities and services which offer care on a long-term basis to the infirm aged.

Existing Federal programs already are involving us in this field, both because the Federal taxpayer is a purchaser of care through the public assistance programs and because Federal programs are assisting in the construction of new facilities.

It is important, therefore, that our programs be designed to assure the safety and proper care of the patients who are the ultimate beneficiaries of these programs, that they be responsive to the needs of the communities where they are used and in keeping with the most modern developments in the care of long-term patients.

We began this work last year with studies and hearings in Washington. This year we plan to have hearings in cities throughout the country to examine in detail the problems we have identified. We are in Indianapolis today for the first of these hearings, and I am sure we will develop here a useful record on the problems involved in maintaining standards of care and safety in nursing homes.

I should point out that this is a factfinding hearing. We are not here for the purpose of trying to fix blame or censure on any particular event or any State or community or group. We are simply trying to build a factual record on which we can pass a judgment in the Federal field.

We will be in Indianapolis today and in Cleveland Monday morning. We are going then to California and will be in Denver, Colo., the following week. So this is a countrywide factfinding hearing.

We appreciate the many fine witnesses that will be called upon today. They are each specialists in certain fields and can contribute to this fund of knowledge that we wish to build. Our only purpose, as I say, is to make a complete and factual record.

At the beginning I announced the mayor was not here. I am now informed that the mayor is here, and I am very pleased that the Honorable John Barton, mayor of the city of Indianapolis, has come here this morning.

We will ask the mayor if he would come forward, please. If you would like to go to the microphones, Mayor, we would like to hear from you.

STATEMENT OF HON. JOHN BARTON, MAYOR, CITY OF INDIANAPOLIS, IND.

Mr. BARTON. Honorable Senator Moss, distinguished senatorial members of the committee, and to the others gathered here this morning who are interested in long-term care for the aged, as mayor of Indianapolis, I greet all of you in the name of our citizens and assure you we are honored to have such distinguished persons in our city.

However, you are here for an important study on care of the aged and your interest in our older citizens. The question of long-term care for the aged is a significant one for our Nation and our city.

Our senior citizens are entitled to care and in many cases are not receiving this care. It may be because of lack of funds or lack of proper knowledge or proper care. This must be rectified.

In Marion County and Indianapolis we have 48 licensed facilities for the care and housing of the aged. This comprises 2,100 beds. It is not adequate for our needs now and as Indianapolis continues to grow, our needs will increase greatly. I certainly hope a plan for adequate care and some means for financing such a program will emerge from this worthwhile hearing.

I would like to cite a few figures that will show clearly our needs now and in the future. The Marion County Department of Public Welfare is paying for the care of public welfare recipients in 34 nursing homes. In addition, they are paying for the care of public welfare recipients in the Marion County Home.

They are using 395 beds in licensed nursing homes, plus 47 beds in the Marion County Home. The daily cost of a person in a licensed

nursing home ranges from $4 per day to $5.50 per day, depending on the cost of the home and the condition of the nursing home patient. This, of course, is exclusive of the cost of drugs and the physicians' services.

During the calendar year of 1964 the total cost of old-age assistance, including medical expenses, was $2,024,573.99, or an average monthly cost of $168,714.49 paid to an average of 2,814 recipients per month.

We also had a cost factor of $347,806.38 for blind assistance and a total cost of $98,035.61 for disabled aid. These figures are for Marion County alone. And we need more because of our increasing population. Over 9 percent of the residents of Indiana are over the age of 65.

We need more facilities to care for the ones not able to care for themselves. This is our problem in Indianapolis, in quite simple terms.

I do want to once again thank this distinguished committee for coming to our fine city, and I want to assure this honorable group that this city administration stands ready to assist the committee in its work and do whatever is possible to fulfill our obligation to our senior citizens.

Thank you very much.

Senator Moss. Thank you, Mayor Barton. We appreciate your fine statement.

I think you touched on some of the points on which we want to get information today. As you point out, 9 percent of your population is already 65 or over, and that percentage is going to rise still more as we have people with longer lifespans.

The other problem is that the funds we have available do not seem to be adequate. We have to determine how we can utilize those funds better and perhaps how we might allocate more funds.

So we thank you very much, Mr. Mayor, and appreciate your coming here today.

Both Senator Hartke and Senator Bayh had hoped to be with us today, and had prepared statements to be delivered here at this hearing. Unfortunately, because of commitments by which they were bound in Washington, neither of the Senators from Indiana have been able to join us this morning.

They have, however, sent on to this committee copies of their statements, and I have them here before me. They will be introduced into the record at this point, first the statement of Senator Hartke and then the statement of Senator Bayh.

(The statements referred to follow:)

STATEMENT OF THE HONORABLE VANCE HARTKE, A U.S. SENATOR FROM THE STATE OF INDIANA

I want to welcome the members of this committee to Indiana and to thank you for the keen interest you have shown in our State and our people.

Mr. Chairman, nearly half a million Hoosiers are age 65 or over. Many of these now require nursing home care and we can anticipate that the requirements will be greater as the years go by. Across the Nation the number of persons 65 and older rises at a rate of 1,000 per day, and 4 out of 5 of this number have a disability or a chronic disease.

I feel certain that every Indiana family joins me in the hope that each of our senior citizens always will receive adequate medical attention. And when our elders are confined to nursing homes, there is no excuse for us to settle for anything less than appropriate care in a safe setting.

The job of providing safe and adequate nursing home care to those who require it is a task which we must all undertake. The problem is—or will be—a personal one for virtually everyone. If we are to meet the needs properly we must have the help of private and religious organizations, local, State, and National Governments. We must work out the answers together to help people help themselves.

Indiana already has an excellent foundation for nursing home care and we must commend the State agencies responsible, the Indiana Association of Licensed Nursing Homes and the individual institutions for their valuable efforts in this regard. But we cannot close our eyes to substandard homes and substandard care.

Careful scrutiny of the nursing home problem by this committee will make a valuable contribution toward improvement in this field.

STATEMENT OF THE HONORABLE BIRCH BAYH, A U.S. SENATOR FROM THE STATE OF INDIANA

Mr. Chairman, I regret that prior Washington commitments prevent me from personally presenting testimony before your distinguished committee today. I assure you that my inability to be with you in no way suggests a lack of interest on my part. On the contrary, I will continue to support all programs designed to enable our senior citizens to live comfortable and constructive lives.

Indianapolis, and the entire State of Indiana, are honored by the distinguished junior Senator from Utah. His efforts on behalf of the aged are well known and greatly appreciated.

The high quality of witnesses assures that these hearings will make a significant contribution to our knowledge concerning the conditions and problems in our nursing homes. Those scheduled to deliver testimony are eminently qualified to discuss this situation in our State.

Brilliant successes in the sciences have lifted us to new heights of affluence. Our accomplishments in minerals and energy, in electronics and aircraft, in automobiles and agriculture, in medicine and space, have surpassed prior predictions. However, we have been shockingly negligent in our efforts to provide for our elderly citizens. The magnitude of the contemporary problem prohibits the use of noncomprehensive and erratic methods to solve the problems of the aged. Today, in America, over 70 percent of the elderly have an income of less than $3,000 per year. Nine of ten of these people will require hospitalization at least once during their lifetime, after age 65, and their stay will be twice as long as younger people. Average hospital costs have risen from less than $10 to close to $35 per day in a short span of 15 years. This unfortunate situation affects not a small number of Americans, but indeed a great percentage of our population.

In 1930 there were 6,706,000 Americans over the age of 65. It is estimated that by 1970 there will be nearly 20 million senior citizens living in our country. These people will constitute almost 10 percent of our population.

Although many older people do not need hospitalization, they do require some help in maintaining themselves. Thus, there is a necessity for nursing homes and other related long-term care services.

Nursing homes had their inception in the United States during the early 1900's. Many such establishments originated as boarding homes to which people first came in good physical and mental condition. However, as these people became older, their health declined and many became chronically ill or disabled.

For decades many older citizens have been forced to live lives of uncertainty and pain in dilapidated firetraps masquerading under the label of "nursing homes." This is hardly just reward for a full and constructive life.

Fortunately, recent years have seen an increased awareness of this disgraceful situation that has resulted in an increase in local, State, and Federal action. Programs have been devised to meet particular needs. Much good has been accomplished, but our patchwork efforts still leave a great deal to be done.

The creation of the Senate Special Committee on Aging in 1961, certainly marked a turning point in American efforts to help the aged. The appearance of this committee in Indianapolis and the warm responses of community and State leaders to these hearings should increase public awareness and provide a receptive form for constructive action.

Compiling expert testimony must be the first step toward the adoption of construction of local, State, and Federal programs to help the elderly. To this effort, I level my full encouragement and support.

Senator Moss. We appreciate the interest and the help that we get from these fine Senators representing the State of Indiana, and we are pleased that they have given us the benefit of their testimony, which is now part of the record at this hearing.

Our next witness before the committee will be Dr. A. C. Offutt, who is the Commissioner of Health of the State of Indiana. We are pleased to have you, Dr. Offutt, and look forward to having your testimony.

STATEMENT OF DR. A. C. OFFUTT, COMMISSIONER OF HEALTH, STATE OF INDIANA

Dr. OFFUTT. Thank you, Senator Moss.

Mr. Chairman and members of the subcommittee, I am Dr. A. C. Offutt, State Health Commissioner and Secretary of the Indiana Board of Health.

I have submitted to you a statement which I would propose not to read in detail, unless so requested. I would, however, like to comment on some of the items in the statement.

Senator Moss. That would be a very agreeable procedure with us, Dr. Offutt. The statement will be incorporated in the record in full as it is printed, and we will ask you to comment on it or highlight any part of it as you would like to do, sir.

(Statement referred to follows:)

PREPARED STATEMENT BY A. C. OFFUTT, M.D., STATE HEALTH COMMISSIONER, INDIANA

Mr. Chairman and members of the subcommittee, my name is Dr. A. C. Offutt, State Health Commissioner and Secretary of the Indiana State Board of Health. It is a privilege to appear before this committee on behalf of our organization and all those disciplines that comprise the public health profession.

The Indiana State Board of Health was established in 1881 as a part of the executive branch of State government. The statute creating the State board states, "The State Board of Health is the superior health board of the State, to which all other health boards are subordinate." The statute continues, "The State board shall have supervision of the health and life of the citizens of the State and shall possess all powers necessary to fulfill the duties prescribed in the statutes. * * *"

Over the years, the board's program has developed and changed with the times, the growth of the State, and the needs of its people. It has had its failures which have been disconcerting, but we are proud of its success and achievements. For example, Indiana was among the first, if not the first State, to establish by legislative action a program of gerontology and chronic diseases within the official State health agency. This was accomplished approximately 20 years ago.

The health of the aged population in Indiana, of which there are some 460,000, is not a new concern of the State board of health. We have been aware of the problems in this area for many years. It is estimated that 25 percent of all persons over 65 need medical care for some form of chronic illness. Indiana has approximately 115,000 citizens that fall in this category. Certainly, chronic illness is not peculiar to any age group; however, as age increases, so does the incidence and severity of the illness.

Much can be done to improve or change the health status of older people. There are certain services which, when properly organized and made available in communities, will effectively meet the needs of a large number of older people.

The elements of such a program are:

1. Education of the well person to the value of good health and the methods and procedures for maintaining good health;

2. Preretirement programs acquainting individuals approaching retirement age with some of the difficulties that they may encounter and ways by which these may be avoided or steps to be taken in anticipation of such difficulties;

3. Incorporating concepts of effective living for a lifetime in the school curricula, along with the present course of study, which is primarily concerned with preparing an individual for the productive years.

4. More effective accident prevention programs designed to reduce the number of accidents that result in handicaps that lead to dependency;

5. Appropriate and acceptable chronic disease detection programs; and programs of public education directed toward primary and secondary prevention in order that complications and disability may be kept to a minimum;

6. Feeding and dietary services that assure older people the necessary nutrients required for maintaining good health;

7. Coordinated health care programs, properly administered and providing a wide range of services to the individual in his own home or other facility where care can be given to the extent needed by the individual; such a program includes: homemaker services, home nursing services, rehabilitative services, nutrition services, dental care, etc. Under this program the individual receives the type and degree of care that is needed and which encourages the independence of the patient. The situation is eliminated wherein the individual is confined to a hospital or nursing home bed when they do not require care of that intensity.

We come now to services provided in institutions. There are a number of types of institutions that provide care for older people. Hospitals and their roles in health care are fairly well recognized. The specific roles of the general hospital, the chronic disease hospital, and other specialized hospitals are well defined and related to the purposes of these hospitals is the rapidly developing and expanding concept of "progressive patient care."

This concept seems to offer much to the appropriate care of the chronically ill and the older patient. Under this program a patient receives care commensurate with his condition, the extent of his needs, and the capability that he has for helping himself. I am certain that it is immediately apparent to you that "progressive patient care" provides an orderly transition between the hospital and the services available in a coordinated health care program.

Other institutions providing health care, especially for the chronically ill and aged, are nursing homes and homes for the aged. Important strides have been made in upgrading the quality and quantity of care provided by these facilities in Indiana over the past several years.

This improvement has resulted in part from an established licensing program and the standards related thereto. This, coupled with the desire of most of the administrators to upgrade services and facilities, has resulted in a perceptible joint improvement project.

A brief recounting of events related to our efforts to improve the quality of care for the aged seems appropriate at this point. A law enacted by the Indiana General Assembly charging the State board of health with the licensing and inspection of nursing homes became effective on November 3, 1943. The law required that a qualified nurse be in charge of the program and prescribed certain physical standards such as exists, firefighting equipment, etc. It also mandated the keeping of patient records and prescribed standards of patient care. In retrospect, the standards left much to be desired, but, at the same time, compliance would be very expensive. It was immediately apparent that compliance with the law would force the closure of a large number of the existing homes. The effects of such action were obvious.

Because of the difference in the actual cost of care and money available to purchase such care, the decision was reached to shift the responsibility for licensure from the State board of health to the State department of public welfare. Consequently, in 1945 the Indiana General Assembly amended the 1943 law to accomplish the shift in responsibility; however, in 1946, court action invalidated the licensing law. In 1947 the general assembly enacted new legislation which remained in effect until July 1957. At that time legislation was enacted which shifted nursing home licensure back to the State board of health.

In 1963 the Indiana General Assembly mandated creation of the Indiana Health Facilities Council within the administrative structure of the State board of health through which almost all health care facilities are regulated and licensed.

It should be noted that hospitals are licensed and regulated by the State board of health under powers granted by another statute.

Those who have been closely associated with the nursing home program in Indiana will agree that progress has been made in upgrading care in this type of facility since 1947. We believe that this progress has been significant since

the enactment of the Health Facilities Act of 1963. The data which follows are evidence of this progress:

Homes licensed:	
Proprietary	417
Nonproprietary	92
Total	509
Licensed beds:	
Proprietary	10,373
Nonproprietary	6,557
Total	[1] 16,930

[1] Occupancy rates, 81.3 percent occupied.

	Percent
Staffing with registered nurses or licensed practical nurses:	
Licensed homes adequately staffed	53
Licensed homes inadequately staffed	27
Licensed homes employ no registered nurses or licensed practical nurses	20
New health facilities licensed since Jan. 1, 1963:	
Proprietary	11
Nonproprietary	1
Total	12
Plans approved for construction since Jan. 1, 1963:	
New facilities	28
Remodeling of existing facilities	24
Hill-Burton homes:	
Existing	1
Planned	1
FHA insured:	
Completed	5
In planning or construction stage	2

We are aware that our task is far from completed, and we are dedicated to pursue a course of action which will assure the aged citizens of Indiana needed and adequate health care.

We believe that nursing homes and other care-of-the-aging facilities are essential to this effort; but hospitals of various types and well-organized programs of coordinated health care, including home care, are vital parts of a constellation of health care which must be available to all communities of our State.

We believe that the community programs which were encouraged by the Federal chronic illness grants provided considerable impetus toward establishing this constellation. It is with regret that we observe this program apparently being phased out before it has had a chance to prove its value.

I assure you that our efforts related to chronic illness and problems of the aged will be directed toward preventing dependency and promoting and prolonging independent living for all our citizens.

Dr. OFFUTT. For 84 years the Indiana State Board of Health has been a part of the executive branch of the State government of Indiana. The statute which created the State board of health says in effect that:

> The State board shall have supervision of the health and life of the citizens of the State and shall possess all powers necessary to fulfill the duties prescribed in the statutes * * *

Over the years the program of the board of health has developed to keep pace with changing times and the changing population. The emphasis has been on public health.

For example, some 20 years ago Indiana was first, or perhaps one of the first States that recognized the emerging problem of chronic disease and aging. At that time Indiana did set up in the official health agency a program for the consideration of the diseases that are incident to aging and to the problems thereon.

We have a large number, as the mayor has just mentioned to you, of people who are over 65 in Indiana. It is estimated that at least 25 percent of these people have one or more chronic conditions.

This illness, or this condition, let us say, probably requires some type of medical care. Sometimes this is very superficial, sometimes it is a more comprehensive type of care. We probably have 115,000 citizens in this State who would fall into this category, which would be about 25 percent of all the people that we estimate are over age 65.

There is a tremendous number of things that can be done, in our opinion, to help and to establish a properly organized program which could be made available in the communities to the people who need these services.

I would like to cite to you about seven points that I believe are important in providing community services to those individuals that we talk about and who may need them.

I think the first thing that should be recognized is the fact that we need an educational program that begins early. This educational program probably should have two prongs. One of them is to educate the person who is well to the fact that good health is a valuable asset, and that he should be taught the things that he may do which will enable him to maintain this status of good health.

Then I think another thing, and I would say this is also a matter of education, is the establishment of preretirement programs so that when retirement comes it is an evolutionary process rather than a revolutionary process. With this type of program, then, we could indicate the problems that will come on with the approaching age and help the individuals plan to meet those problems.

Then another educational aspect in the care of the aging is the matter of incorporating in the school curriculum itself information on lifetime living, because now our school system is geared to preparing for the productive years of life, and little is said about the period in which the individual's productivity may decline somewhat.

We also think that there should be developed in the community an effective accident-prevention program. Certainly many of our people are forced into states of dependency simply because they have some sort of handicap because of an accident, and they become dependent on someone else.

Also we think that appropriate and effective chronic disease detection programs are important.

I would be remiss if I did not mention dietary programs. There is a lot of misinformation about aged people and their dietary needs. We think this is an important thing if good health is to be maintained.

Finally, and perhaps one of the most important things in the whole field of community aid to the aged, is the establishment of some type of coordinated health care program. Now, I do not care what name is applied to it, but I refer to a program which properly administered will provide a wide range of services in the community that the individual can have available to him as they are needed, and this would go through the whole gamut of home-care services and rehabilitation in the entire field that our folks need.

Of course, I should say a word here about the institutions. There are a number of institutions which are concerned primarily with the care of the aged. I think the role of the general hospital and the

chronic disease hospital is well known to everybody, and I could pass over that hurriedly.

But one of the types of institutions available for the care of the chronically ill and aged are the nursing homes and homes for the aged.

As far as Indiana is concerned, I am happy to report to you that there have been very, very important strides made in upgrading the type of care and the quantity of care provided in these facilities over the recent years.

I think this improvement has resulted, in part, from an established licensing program and the acceptable standards that are related to this program. This, coupled with the desire of the administrators themselves to upgrade services and facilities and to work with us in the licensure program has resulted in a very perceptible joint improvement project.

Now, I hasten to tell you, of course, the field is one in which we have many obvious shortcomings. This is a program of long-range achievement. While much has been done, much yet remains to be done.

There is the matter of actual operational licensure program that came back to the board of health after being passed from the board of health to the department of public welfare, and then 10 years later was returned to the board of health for management.

We have been involved directly in this since 1957. In 1963 the Indiana General Assembly created a 13-member health facilities council. This council, and the law creating it, provided for the licensure not only of the type institutions commonly known as nursing home and the type known as the home for the aged, but provides also for the licensure of institutions commonly called boarding homes. The entire complex of the licensure program for people unable to maintain themselves at their own residence has changed since 1963.

We are quite aware, as I have said, that our task is far from complete. Much remains to be done.

I want to tell you that the council and the State board of health are dedicated to a course of action which will certainly assure that our aged citizens will receive needed and adequate health care.

We believe that nursing homes and other care of the aged facilities are essential to this effort. We think that hospitals of various types, with well-organized programs of coordinated programs of health care, including home care, are also vital parts of the constellation of health care which must be available in all communities in the State of Indiana.

In short, planning and coordination of programs for the elderly at community level is vitally needed.

I also believe that community programs, which were encouraged by the Federal chronic illness grants, provided a considerable impetus in Indiana toward establishing the constellation that I have been talking about.

I do regret, from what I observe, that this program is being phased out, and I think it did not have a chance to prove its real value.

I hope I am not being repetitious, but I think this type of community effort that provides service within the community which can be made available through the training of individuals to provide the necessary and required services is important.

Communities can provide needed services by developing programs that will demonstrate the methods of allowing our aged people to give necessary meaning to their declining years. I think it is unfortunate that on occasion the years after 65 have no meaning for anybody, and I think there are things that can be done about this.

I know that communities can develop centers for aiding our older citizens in order that they may realize their fullest potential. Many of them are retired with a great deal of potential left. All of this can be done while providing the services that are needed to maintain those citizens who actually laid the groundwork for our present status and to maintain them outside institutions in an independent living situation.

Finally, I would like to assure you that our efforts related to chronic illness in the problems of the aging will be directed toward preventing dependency and to promote and prolong independent living for all of our citizens.

Thank you, sir.

Senator Moss. Thank you, Dr. Offutt, for a very fine statement.

I would like to underline your last statement there, that one of the objectives is to give continued incentive for living and independence to elderly people, rather than having just a custodial holding operation in their older years.

Are the nursing homes licensed by the board of health here?

Dr. OFFUTT. Yes, sir; they are.

Senator Moss. The licenses are granted by your board?

Dr. OFFUTT. That is right.

Senator Moss. This is based, I assume, on inspection not only of the facilities but the personnel who will operate the nursing homes?

Dr. OFFUTT. Yes, sir.

Senator Moss. How frequently is the home inspected thereafter?

Dr. OFFUTT. This is a very difficult question. If you will bear with me, I will make a stab at it.

Senator Moss. All right, sir.

Dr. OFFUTT. We have nine inspectors who are regular inspectors. We have an additional two that we call special inspectors, and we have one engineer full time who does work for the nursing home program.

We inspect the homes for licensing and enter a comprehensive report. This covers the care in the home, the personnel, and the facilities with regard to sanitation.

Now, the difficulty in answering your question is this: If we find a home that has problems, we try to work with them. We see our mission as educational rather than punitive. We will try to get the home into compliance.

This is the problem of the number of visits. Sometimes it is as many as four or five a month. Sometimes it goes over a longer period, 5 to 6 months, in which we are sending in people who are above and beyond the number which I have named here.

We put our other part-time people to work in this program who are not identified as being directly in the nursing home licensure program. I speak now of people like the health educators, the nutritionists, the sanitarians, to name only three. They are the people who may make a number of visits.

In addition to the visits we make there are, of course, visits made by the fire marshal, and I am sure you will hear more about this.

Senator Moss. Is there any requirement in the licensing of these nursing homes for the availability of medical services or nursing services?

Dr. OFFUTT. Yes, sir; there is. There is no requirement that each nursing home shall have a resident physician. There is a requirement, however, that each individual who is a resident in this health facility shall have a statement from a physician on his entrance concerning his condition.

There are also requirements for the keeping of pertinent medical records concerning the client of the home. There are also requirements for nursing care.

Now, this varies from the class or the type of home that is being licensed, but the requirement is either a licensed practical nurse or a registered nurse.

There are also further requirements for the safety of the individual. Certain of them are with reference to certain personnel. The requirement for personnel actually is a general term in that it states that there shall be adequate personnel, and this we then weigh up against the situation pertaining in the home itself.

Senator Moss. As I understand you, then, a nursing home has either a registered nurse or a licensed practical nurse available.

Dr. OFFUTT. I would like to be able to say yes to you. On page 5 of my statement, I have pointed out that 53 percent of the licensed nursing homes are adequately staffed. That is about in the middle of the page. Twenty-seven percent are inadequately staffed. And in answer to your question, 20 percent employ no registered nurses or licensed practical nurses.

Senator Moss. This is not yet, then, a requirement of the license for a home, that they have either a practical nurse or a registered nurse?

Dr. OFFUTT. Licenses are granted when these people are not employed by the home in some instances.

Senator Moss. And your efforts in that area are educational, not punitive, as you say at this point?

Dr. OFFUTT. I think, sir, we have come quite a long way with this personnel requirement, actually.

Senator Moss. I wonder what your procedure is, Doctor, if you find a home that you determine is definitely substandard. Do you have a regular procedure for closing that home or canceling the license?

Dr. OFFUTT. Yes, sir. We follow due process of law in taking care of this.

Of course, if it is a revocation of licensure, this is one procedure. The general process would be this: that if a home is found which is substandard, we attempt to work with the administrator of the home, in order to bring it up to standard as quickly as possible. Sometimes it is delayed by physical plant requirements, and things of this nature.

If there is no effort on the part of the individual to comply with the regulations, then we ordinarily will begin by having an informal hearing. We invite the individual to come before the health facilities council.

At this time the individual is questioned, and we hope will agree with us that it would be advisable to do the things that are necessary to get a compliance with the regulations in order that a license may be issued.

In some instances, unfortunately, this is impossible, so if they continue to operate without a license, we will hold then an administrative hearing at which we take testimony. The individual is entitled to be represented by counsel.

Our deputy attorney general ordinarily conducts the hearing in behalf of the council, and then the findings are made and an order to close is issued.

Under the Administrative Adjudication Act of Indiana, this individual has a right to object to these hearings, and finally to request a judicial review.

All of these things take some time, and on occasion the judicial review will bring out some additional factors which were not brought out initially.

But under some circumstances, and this happens with rather great frequency, we have these hearings, the individual then closes or begins to take steps and assures the court that they will comply with the regulations.

Senator Moss. Have you had any recent cases where it has gone the full route, and you have finally closed down the home?

Dr. OFFUTT. Yes, sir. We have had some recent cases, and I would have to ask for some help from my staff what they are.

A number of these cases occur simply, as I mentioned, when we talk to them about the situation. Some of them we have asked to come into a hearing, and a very recent one which I remember the individual employed an attorney.

After some consultation between the attorney and the administrator, the attorney called me and said would it be necessary for them to come to a hearing, that she was going to get rid of her patients and close. We will of course follow this.

In another instance we went through the administrative hearing procedure and thence into court. The court found that a license should be issued, but at the same time directed the administrator to come into compliance with the regulations.

This was based on a very humanitarian view that there were a number of patients at this rather isolated area and one just could not put them in the streets.

Senator Moss. I would assume that you do not have a surplus of space available in nursing homes, that perhaps it is more on the other side, that you are short in the number of places available for elderly people. Therefore, I wonder if part of the problem is getting more people into the business, as it were, of running a nursing home, or a long-term care facility.

Dr. OFFUTT. I do not take issue with your statement at all. I would say this, however. I feel that one of the factors is the matter of distribution geographically.

I also think that some of these other programs will have a tendency to encourage building and staffing of adequate nursing homes, and here I use the term "nursing home" loosely.

Senator Moss. Is it your idea that it is desirable that these nursing homes be widely dispersed, more in communities from which the people come, rather than concentrating them more in the major cities?

Dr. OFFUTT. Yes, sir. I think there is something to be gained by keeping the individual who must have help from a health facility in

his community. I know I would be much happier staying near my home, even though I had to leave my house.

Senator Moss. Your concern of course is the enforcement of the health aspects of this. Do you have adequate staff, do you think, for enforcement work?

Dr. OFFUTT. This is a loaded question. No public official ever has adequate staff.

Truthfully, we do not. I can say in all candor that it is difficult to find people who, first, are interested in this field. We must get people who are interested.

We, of course, have difficulty in finding trained people. In many instances we find people with an adequate background and then we superimpose on that the kind of on-the-job training that is required.

So that there is always difficulty with shortages of personnel.

Senator Moss. This accident that happened last December focused a lot of attention on nursing homes. Did it have an appreciable effect on what your department was able to get by way of support?

Dr. OFFUTT. I think I could answer that in the affirmative, yes. The unfortunate situation did have that aspect, of focusing the attention of some of us on some of the problems we have.

Senator Moss. We appreciate your testimony.

I have with me the members of the staff of this subcommittee, and sometimes they have questions that have not occurred to me.

If any of you have a question that you think we should get into the record the answers of Dr. Offutt, I would be glad to have you ask them now.

Mr. Frantz?

Mr. FRANTZ. I had one point on boarding homes, Dr. Offutt. You mentioned that the State licenses both the residential and the nursing home facility.

Local jurisdictions license the boarding home in many States and you have the problem that the boarding home residents become nursing home patients, the boarding homes tend to become nursing homes in fact and the State agency has no access to them.

Does having the licensing of both types at the State level solve this problem, or do you still have difficulty keeping a boarding home from trying to be a nursing home?

Dr. OFFUTT. We still have difficulty. But we had a tremendous difficulty from 1957 to 1963, because in this period the problem that you outlined was fairly common. Now, with the proviso that we can license the boarding home, then we have every reason to find out whether or not this boarding home is in fact a nursing home.

I think that the 1963 Health Facilities Act has been very helpful in this, because, if I may use the word here, it "plugged" the loophole.

Mr. FRANTZ. Do you have to make fairly frequent inspections of boarding homes to be sure they do not have patients requiring nursing care?

Dr. OFFUTT. That is correct.

Mr. FRANTZ. About how frequently are you able to do that?

Dr. OFFUTT. Again I cannot give you a figure. I can simply say not frequently enough. We are not able to make them often enough.

Senator Moss. I think Mr. Constantine has a question.

Mr. CONSTANTINE. Dr. Offutt, does your department regularly evaluate and oversee the quality of medical care provided in nursing

homes? Your testimony indicates that each patient should be cared for by a private physician. Do you know how often they are actually visited by a private physician? Have you made any effort to determine that?

Dr. OFFUTT. I do not know whether we make a recognizable effort or not. I do know that we would do this in the course of examining the records of the patients. Then we would see how often the physician would see the patient. This is a matter between the patient and his physician, actually, as to how often they are seen.

We also know that the administrators, of course, in many instances recognizing, or the nursing staff recognizing the fact that the patient is having some problems will see that the physician calls.

Mr. CONSTANTINE. But the health department itself does not evaluate the quality of the care?

Dr. OFFUTT. Not in that way.

Mr. CONSTANTINE. I understand much work is done at the county level. Do you find that the counties cooperate fully in raising standards and enforcing regulations?

Dr. OFFUTT. They cooperate completely, where they have the staff.

Senator MOSS. Do you have a standard record form that is kept in all of these nursing homes that you can quickly review on the health of patients?

Dr. OFFUTT. That is correct.

Senator MOSS. If that is properly reviewed, you could probably tell from that whether a physician has visited.

Dr. OFFUTT. This of course is a problem. Again, sometimes we have a little difficulty encouraging the use of a standard medical record form, but I again am under the impression at least that this has been adopted fairly widely.

Mr. MILLER. Dr. Offutt, on page 5 of your statement, where you make reference to new homes, and so forth, under plans approved for construction since January 1, 1963, I notice you have two Hill-Burton homes, one existing and one planned, and seven FHA-insured homes, five completed and two in planning or construction stages.

I have a question or two about that, and would like to elicit your comments.

These FHA-insured homes, are they proprietary homes, or do they include both proprietary and nonprofit?

Dr. OFFUTT. I need some help from my staff, now.

Is Mr. Koonce there?

Mr. KOONCE. All proprietary.

Mr. MILLER. Now, the number on the face of it appears significant, seven FHA insured and two Hill-Burton. What number of beds is involved?

Dr. OFFUTT. Again I will ask Mr. Koonce if he can answer the number of beds.

Mr. MILLER. Approximately.

Mr. KOONCE. Hill-Burton is 190 existing and the proposal is 77. The FHA are all under a hundred, running from one large one, 150, one 75, and the others are 50 or about 50.

Mr. MILLER. This would indicate that both bedwise and installationwise the FHA insured represents a larger involvement that the Hill-Burton.

I would like to ask you, Dr. Offutt, if you have any comment as to the reasons for greater use of the FHA insurance in proprietary homes as opposed to the Hill-Burton in nonprofit homes.

Dr. OFFUTT. Mr. Miller, I do not. At the time, I cannot think of any reason that I can give you. I do not know.

Mr. MILLER. Related to that, I wonder if you have any comment as to the possibility of there being any elements in the Hill-Burton administration that might tend to reduce its use, or whether it is merely a matter of not having applicants that are interested in this.

Dr. OFFUTT. Being the Hill-Burton administrator, I would know of nothing in the Hill-Burton program that would preclude an applicant getting along with us.

I suspect you are thinking of standards, and this sort of thing. I am not as familiar with FHA standards as I perhaps should be, but I am of the opinion that there is not that great a differential.

It is quite true that in the Hill-Burton program the nursing home category has not been too widely accepted here.

Mr. MILLER. It is not due to lack of funds available to the State, is it?

Dr. OFFUTT. No, sir.

Senator Moss. Thank you very much, Dr. Offutt. We certainly appreciate your coming here this morning and giving us your testimony. It has been very helpful, and we appreciate also the information given us by Mr. Koonce of your staff.

Dr. OFFUTT. Thank you very much, Senator Moss.

Senator Moss. Our next witness will be Dr. W. Dean Mason, who is the chairman of the Indiana Health Facilities Council.

We are pleased that you have come to be with us, Dr. Mason. You may proceed, sir. I see you have a very brief statement here. We hope you will amplify it a bit.

STATEMENT OF DR. W. DEAN MASON, CHAIRMAN, INDIANA HEALTH FACILITIES COUNCIL

Dr. MASON. This is like an outline. It might be the kickoff. I did send Mr. Constantine a copy of a prepared document which I gave before the Governor's commission at Purdue University, which explains a great deal of the philosophy that I have.

I have been a part of this program since I became disturbed about the old nursing home law, the law of 1957, and then began working with other interested people in the State in the formulation of a law that might be comprehensive enough to cover all health facilities in Indiana, and that might be definitive enough to give us ways and means of implementing regulations which would be specific enough to guarantee the security of our aging people.

This statement that I sent to you is simply a statement that I had included in our director of health facilities services report which I edited some months ago.

The fact is that the IHFC has the responsibility for licensing, regulation, and inspection of health facilities as defined in Senate Enrolled Act 442 which was enacted by the General Assembly of the State of Indiana in 1963.

I am sorry I was not here when Dr. Offutt testified. I just flew in from St. Louis. Some of this may be repetition, and if it is, I apologize.

Senator Moss. You go right ahead. We want this in the record.

Dr. MASON. The purpose of this act is to preserve, protect, and provide for the general welfare of the aging, chronically ill, or infirm citizens of the State. The State board of health is empowered to license and regulate health facilities in the State of Indiana, such licensing and regulations to be accomplished through the Indiana Health Facilities Council.

The Indiana Health Facilities Council consists of 13 members appointed by the Governor. Two members are from the medical profession, each holding an unlimited license to practice medicine in the State of Indiana; one member is a registered nurse; one member is a hospital administrator; three members are persons licensed to operate a proprietary institution providing nursing care, not including hospitals: three members are persons engaged in the operation of philanthropic homes for the aged; and the three remaining appointments represent the professional staff of the department of public welfare, State fire marshal, and the State board of health.

In order to function more effectively, the council has, according to the law, established three divisions. One division is concerned with proprietary institutions providing nursing care, excluding hospitals: one is concerned with philanthropic homes for the aged; and one is concerned with general health facilities, which include the boarding homes of which we were speaking.

The Indiana Health Facilities Council has the power to adopt such health and sanitary rules, regulations, and standards as may be deemed necessary to protect the health, life, and safety of the persons residing within the particular class of health facility designated in the act.

The Indiana Health Facilities Council has the power to classify facilities into care categories, such as "domiciliary," "convalescent," "comprehensive," "chronic illness," "aged," or any combination thereof.

The thing that the Indiana Health Facilities Council is responsible for is the execution of the sovereign will of the people of the great State of Indiana as expressed in law.

It is our responsibility to coordinate continually the interests and the viewpoints of those who provide facilities and services and the welfare of those who use them.

Policies in licensing are shaped and affirmed by those home licensing regulations, by public consciousness of the needs and rights of the clientele, and by the public's consciousness of meeting these needs.

Nursing home standards guides are published by the U.S. Department of Health, Education, and Welfare. They suggest that standards are not just laws or words; they are tools that can be used effectively for the purpose of education, control, evaluation, and planning for the future.

The Indiana Health Facilities Council has been interested and concerned that the regulations which have been established prove to be the most effective means whereby the aging people of our State can be assured that they will have a decent opportunity for life and living in the environmental setting in which they find themselves at a time of special need.

The standards and regulations established by the Indiana Health Facilities Licensing Council and State board of health in cooperation with other agencies are always subject to critical evaluation and critical review.

The Indiana Health Facilities Licensing Council is responsible for the execution, as I said before, of the sovereign will of our people.

There have been many things stated in publications across the Nation in which there have been critical evaluations of licensing programs. I point specifically to McCall's magazine and to other articles.

The editor of Professional Nursing Homes, in an article that many people in this hearing have read, said one of the reasons some State licensing officials are reluctant to close down substandard nursing homes is because they fear the displaced patients would have no place to go.

I assure you, Mr. Senator, and other members of this committee, that this is not true in our case. We are very conscious of the problems which we face in our society, that it is not easy to place people in other environmental settings but we are conscious of the fact that we are delegated the responsibility of assuring not only the people of the State of Indiana but the people who need care that they can have that which is their just due.

This is what we are trying to do. The Indiana Health Facilities Licensing Council is determined to assume its responsibility in accomplishing the task which is delegated to it by the general assembly and the people of this great State.

It is my suggestion that we, as a responsible agency of the people, are going to use the educational approach rather than the big stick of law enforcement.

It has been interesting that there was a considerable amount of reaction to this particular statement. This is where I have been extremely disturbed about the press in Indiana. It has irked me to no end that once we started this program, that I said we had a responsibility for educatiing the people of Indiana about what was being done, the only way we could get some response from the press was to have a fire taking the life of 20 people.

Then we could call a press conference and fill a room, but up to this time, we could not get them to interpret what we are trying to do for the half a million aged people in our State.

Not only do people have to be educated, they have to know what needs to be done, and the operators have to know we mean business. We have to help the general public to know what it is that needs to be done.

It is tragic that so many people say: "Well, here is an old person. So what? If they can be cared for, let it be done." This is a lack of social consciousness, a lack of being sensitive to the needs of people as a part of humanity.

I might get to preaching a bit, here.

We are interested in the problems which the health facility operators must face, and how they can be met. We are conscious of the fact that there is a problem of obtaining adequate professional staff for our health facilities, as Dr. Offutt stated.

Thus the council is dedicated to the fulfillment of its responsibility to preserve, protect, and provide for the general welfare of the aged people in our society.

I was interested in the late President's report that came out, you know this is just out, of the older American from the President's Council on Aging last year, in which it says the work can all be assigned to the Federal Government.

This is neither desirable nor possible. Federal, State, and local governments should join with private and public organizations. From such effort must inevitably come the opportunity for the older American to fully participate in the fruits of his labor.

I commend you, Senator Moss, in the fact that you are coming out to the grassroots, and you are joining us in accomplishing the great responsibility we have, across the face of America, in facing the tremendous needs of the 17 million people in America who are not wanting only a decent place to live, but a sense of purpose for living.

This is what must be done. This is my conviction, and I am very grateful for the opportunity that has been mine in the formative months of the council to be able to sit as chairman and to try to see this thing develop.

If I could elaborate on the press, again, I think they have let us down in Indiana. I say this frankly, and I will be criticized for it.

At the press conference after the fire, I said we were going to have two public hearings for two homes which had been served the papers relative to the hearing. I have heard many of these as the hearing officer. And do you think we had a man from the press for either one of these?

The senate was voting on the right-to-work law, so they were all down there. Just let the old people wait until we have another fire.

That is the problem we face. How in the world we are going to get it done, I do not know, but I am willing to do something about it.

Senator Moss. Thank you, Dr. Mason.

We appreciate having your comments and the information you have given us, and your obvious dedication to this problem that we have of providing not only care for our older people, but, and I like the phrase you use, "a purpose for living."

One of the things I have always thought we might overlook in places is that we do not have nursing homes or old folks' homes just as a place for old people to sit. They have to have a purpose, a desire, an objective in life, and the way you phrased it was very good.

In dealing with your problems here, is it the council or the board of health that actually licenses? How do the council and the board of health tie in?

Dr. MASON. Actually, the Indiana Health Facilities Licensing Council is the council that is appointed by the Governor, and it has the responsibility of actually acting on the issuance of the license. The license is issued by the State board of health through the action of the Health Facilities Licensing Council. It has the power to adopt the rules and regulations.

As I stated, here in this department the council has the power to classify facilities, and it is the one the State board of health has empowered to license and regulate health facilities in the State of Indiana, such licensing and regulations to be accomplished through the Indiana Health Facilities Licensing Council.

I was trying to think of a comparative illustration relative to the Federal Government.

We are the official group that acts on the license. The reports are made to us, we take action, and the license is issued through Dr. Offutt's office.

Senator Moss. You hold the hearings?

Dr. MASON. I wish you might be here on Wednesday of next week. I do not know how many licenses we will act on, probably a couple of hundred.

We have our staff, which is a part of the State board of health. We have implicit confidence in them. They make a report to us. We have a report similar to this type, which tells us the facility, the type of facility, and then the staff recommendation.

They recommend what we should do, defer action, or grant the license. And we have many appeals for variances.

I think we have made tremendous strides. I think we have a long way to go. There is no question in my mind about this. This is true across the country.

Senator Moss. Does the council set the various standards and requirements that must be met?

Dr. MASON. Yes, the council is the one that adopted the standards in the beginning, and they were adopted by the State board of health.

I am sure you gentlemen have copies of the regulations. We did this. This was our preliminary work. This was quite a task, believe me.

Senator Moss. I am sure it was.

Are they realistic, or will they go through a period of evolution?

Dr. MASON. I am not an expert, Senator Moss, in the area of dietetics or sanitation, so these assignments were given to the various responsible agencies as a part of the State board of health and other State agencies. They were asked to give us the recommendations which they had relative to regulations.

Then we asked the philanthropic homes to make suggestions. We asked the Nursing Home Association to make suggestions. From these we crystallized our regulations.

Right now we have a number of amendments that are going to be introduced at our meeting next Wednesday. We have some complaints, and ideas, and these will have to be hashed through, you see.

Senator Moss. I asked Dr. Offutt the loaded question about sufficient staff. Is your problem the same? You feel you do not have enough staff?

Dr. MASON. Of course, you see ours is the same situation as Dr. Offutt's. It is the same staff. We are a professional voluntary group, appointees of the Governor, the 13 of us that are seated.

There are three representative State agencies. The others are either professional workers in the field of adult work or doctors or nurses. That is Mr. Koonce's department.

Of course, the tragic thing, if I can inject this, with the American people is the fact that they recognize the fact that our population is expanding, that with this we have great social needs, and yet they are not willing to give the legislators the right to vote more money, because they are afraid of the taxes.

This is a vicious circle. We must recognize these are social needs. If we have the responsibility, we must assume this.

I was at the State board of health when they discussed their budget, and when it went before the State committee, it was pared off.

Sometimes it is hard for people to see the value of putting another investigator on. Here is another thousand dollars. I do not know. This is something you boys in Washington have to work on. We have to work on it in Indiana, too.

The Governor's commission on aging—we have a tremendous program here under Dr. Davis. We wanted to expand this year. We need fieldmen. We need to direct services. But we did not get the budget. There are other agencies that need it.

It is inevitable in our society. The good Lord has given it to us. I am grateful for living where people are concerned about people. I am glad to pay taxes.

Senator Moss. Concerning what you would like to do in the enforcement of standards, are there other pressures, other than the general one of lack of funds, that you have to contend with?

Dr. MASON. We face the inevitable pressures which you have. I made it very explicit that there are no political maneuverings with this. This is factual. We have had to face some pressure moves, which is quite normal.

You just cannot get around this, you see. We have some pressure moves. It is a normal sort of thing for the high type nursing home to want to pressure us to quickly eliminate the lower standard home, because of competition, you see, in a community.

Now, this is not a realistic thing. If the home is substandard, it ought to be closed, but it should not be closed in order to divert some people over to another home. We have had pressure like that.

I have been told we have not given people enough time in council hearings, but I feel that is my business, and vice versa. We have to make a determination, you see. But we do face pressure, Senator. That is quite normal.

Senator Moss. Now, the staff of the board of health makes the inspection of these homes on health matters. Is it the fire marshal that makes the inspection on physical facilities, safety factors?

Dr. MASON. That is right. The fire marshal, Mr. Anderson's office, is responsible. Mr. Workman gets us a report on the fire safety relative to the standards and regulations.

I want to make an appeal here. I think that Mr. Anderson has had to face a lot of problems. I think he is terrifically understaffed, when you think of all the places he has to go.

I get somewhat irked and disturbed at times when many applications are held up because we do not have their report, and I have told them this. I have appeared before the investigators myself.

I was somewhat disturbed the first time I appeared. They said, "Dr. Mason, what difference does it make? You wouldn't do a damned thing about it after the report is passed."

I said, "That day is past. We want a review from you, and then we will take action."

I have impressed on them it is our prerogative to take action. They bring it to us, and then we decide whether it should be closed or not.

Senator Moss. Have you found that some of the inspections have been superficial?

Dr. MASON. I think I am busy. I am not any busier than I think I am. The report of course we get, and I get it ahead of time, is the report Mr. Koonce screens out for us.

I think we would have to ask Mr. Koonce that. Some of them are sent to me where they need a little more evaluation.

I talk very frankly to Mr. Workman and Mr. Anderson about this. I think this is a two-way road we are traveling, and we have a reciprocal responsibility to each other, and we are certainly not in the business of cutting each other's throats.

We have simply too much to do, and we have to join hands and hearts to get it done.

Senator Moss. I am going to ask my staff associates if they have questions of you, Dr. Mason.

Let me tell you, before we do that, I am greatly heartened by the dedication that you demonstrate, and the enthusiasm you have for moving purposefully into this field that is so important for us. I cannot commend this too highly.

Dr. MASON. Thank you, sir.

Senator Moss. Mr. Constantine, do you have a question?

Mr. CONSTANTINE. I have a few.

You spoke of the dissatisfaction with the fire marshal's report. We have reviewed the report on the Fountaintown home inspection, and the State health department inspection, of December 1, two and a half weeks before the fire.

How do you account for the clean bill of health that the fire department gave as to fire hazards, and the conditions noted in health inspection?

Dr. MASON. You said complete satisfaction with the State fire marshal's report. I would rather not be quoted in the hearing on that point. As far as I am concerned, I said this is a matter of the fire department reporting to our office, and then Mr. Koonce has to evaluate this report.

So far as I am concerned, the bone that I have had to pick with Mr. Anderson and Mr. Workman has simply been the matter of getting the reports to us, so we can take action. Many homes are dependent upon the licensing to get State aid or whatever they get.

I have not said one way or the other. I would not want to be committed at that point.

Now, I do not know whether the one you refer to—I think I have it here some place. I thought I might look it up and see what Mr. Koonce said on this.

I do not know, now. It may be that the council needs to be a little more strict with the fire marshal's office relative to these reports, that we should have it spelled out a little more specifically.

Now, the regulations do have it quite specifically, but we have to recognize the fact that the fire marshal's report was made 6 months prior to the report that was brought to the council.

Now, I think this is a fallacy, how we expedite matters, when we have some 800 or 900 homes in the State of Indiana, and when the fire marshal's office is understaffed.

I suppose it is a bit of a dilemma, but a report 6 months old relative to fire protection, especially in older buildings, just cannot be too dependable.

I must be careful in the use of my words, here. This is the thing that Mr. Koonce would have to answer, Mr. Constantine, of whether the report is—

You see, you gentlemen are involved in a great deal of paperwork, as I am, and many others. I like things to be brief. You know my report here. It needs to have content, it needs to have purpose, and get to the point.

Like somebody asked Lincoln how long his legs were, and he said from his waist to the floor, and that is all he needed.

If we are going to take action on something, it must be down here. I have made this very clear. They know this.

Mr. CONSTANTINE. In general, how do the administrators react to your inspections and reports?

FROM THE FLOOR. The audience cannot hear your question, Mr. Constantine.

Mr. CONSTANTINE. In general, how do the administrators of the facilities react to the recommendations concerning deficiencies found by the inspecting agencies?

Dr. MASON. I appreciate that question. I happen to be an administrator myself.

I say very frankly that our investigators are not all they might be. They are fine people, but they are not experts in all fields related to investigations.

I have tried to impress them, as I have spoken most every time we have had a staff meeting, with the fact that they are not abusing their authority in going into a nursing home or health facility, because many times this administrator is immediately on the defensive.

I know how it is. Many times there are a lot of little, insignificant things that are picked up. In the Scriptures they talk about straining at gnats and swallowing camels. This is done in legislation and in any kind of licensing procedure.

So many times the operator will become defensive, which is a normal thing. She or he is nervous, because she wonders what is going to happen, and then many times, when some of the smaller things are brought in, it is a bit ridiculous. I know this from my hearings. I have been very unbiased, tried to be, and I have tried to be sympathetic with the nursing home operators.

I have recognized that many times these testimonies that have been brought, and some of the exhibits, have been a bit ridiculous in some of these items that are listed down there of deficiencies. It sometimes bothers me, because I think it is asinine, if you will pardon the expression, for an organization that is doing something that is important to deal with——

Well, I do not know. I could get some of the reports out for you, but you do not have time.

I got a call at 12 o'clock one night down at Martinsville from an operator of a home in Evansville. She says, "Dr. Mason, the investigator was here today. He said so-and-so, that isn't right, is it?"

And I had to say, "No; that isn't right. That was an improper statement."

This is just something that happened. I know that the investigators will understand this.

I happen to be an administrator along with some other things I do. I took over an old hotel, a spa hotel. When the investigator comes down to my place, and we have a chipped tile floor out there, he talks about one of the chips that is out of there, and puts this on a report. That is asinine, and I am not about to condone that, you see.

It takes a little time in educating those people, you see, in getting the job done. So, you see, there is a reciprocal responsibility if you are going to be effective. Wehave a two-way road.

This bogs down the machinery and makes it somewhat difficult. It is very factual and true. We might as well face it. I will not become apologetic to Dr. Offutt or anybody else about it. This is the truth, the the truth makes people free, you know.

Mr. FRANTZ. You said a few minutes ago that the fire marshal's office forwards inspection reports to your council, and your council actually takes the action on these. Is that correct?

Dr. MASON. That is right. That is correct.

Mr. FRANTZ. So the permission to operate in terms of having passed fire standards emanates from your council, rather than from the fire marshal's office?

Dr. MASON. That is right, we are the one.

This has not been an easy thing to interpret. I would stand corrected from the attorney general's office if I am incorrect.

We bring the reports together and take the final action. It is not the prerogative of Mr. Anderson's office to tell people they cannot operate.

He might tell them according to his understanding of the regulations that they are substandard, but our council runs the stop lights.

Mr. FRANTZ. Could the fire marshal close a home under the authority of his own office, if they determined it was not safe?

Dr. MASON. This I would have to have some legal help on. I just do not know. I cannot answer the question. I am sorry.

Senator Moss. He can probably close it as a fire hazard, but he could not revoke the license.

Dr. MASON. That is it, I am sure. Thank you, Senator Moss. I appreciate your wisdom.

Senator Moss. Thank you, Dr. Mason. We have enjoyed your testimony. It has been excellent, and again let me commend you for the excellent work you are doing.

Dr. MASON. It has certainly been a pleasure.

Senator Moss. We will now hear from Mr. Ira Anderson, who is the State fire marshal from Indianapolis.

Mr. Anderson, we are very happy to have you, sir.

STATEMENT OF IRA ANDERSON, STATE FIRE MARSHAL, INDIANAPOLIS, IND.

Mr. ANDERSON. Thank you, Senator.

Gentlemen, I think you have a copy of my remarks, but I think it might be in order with all the people who want to know what my remarks are that I read it to the committee, if you do not mind.

Senator Moss. You go right ahead.

Mr. ANDERSON. Thank you.

The Fountaintown Nursing Home was a two-story, converted residence, which was constructed of frame and cement block. The house was some 60 years old. It was also in a fairly good state of preservation.

Ten patients were housed in the four rooms on the second floor, and there were three means of egress from this floor, two fire escapes and a wooden stairway. However, 4 of the 10 people lost their lives. Our

investigation indicated that there was a great reluctance on the part of these people to use the available fire escapes.

The first floor housed 24 patients, and 16 of the 24 perished. This also seems a little strange, in view of the fact that there were five doors leading to the outside, three of which were equipped and marked as exits. In addition, there were three nurses, or attendants, two on duty and one was sleeping in.

This home was heated by two hot air furnaces, fired with fuel oil, with the tanks located on the outside. Since it was an extremely cold night, the staff was trying to maintain an 80 degree temperature in order to make the home comfortable for the people.

In our investigation, we secured evidence sufficient for us to believe the fire started directly above the front furnace and smoke pipe, and spread from the furnace to the brick flue or chimney.

It is our judgment that an overheated furnace and a possible smoke pipe and flue burn-out of soot and carbon could have started the fire in the understructure of the floor, burning through to a hollow wall.

This particular area is what we call a hidden hazard area, for it involved a soft red brick chimney structure, and our experience has shown that this type chimney will deteriorate much faster than the new type, which is hard brick.

However, the other chimney on the south of the building was constructed of the hard-type brick.

It appeared that the fire was burning for some time and had built up tremendous heat before it broke through the wall and became visible. The rapid spread from the initial ignition seems to indicate that tremendous heat had driven considerable gas from the wood and all burnable material in the immediate area, for the fire quickly involved the nearby stairs.

We believe because of the rapid spread of the fire, smoke and gas inhalation that it added considerably to the confusion that must have existed in the home.

Although for some time this department has had a rule that a written emergency evacuation plan shall be developed and frequent drills held in conjunction with the local fire department, apparently the rapidity of the fire created panic.

We further believe that as the fire progressed, the heat or possibly falling objects may have broken a gas line leading from a tank some 200 feet away to the two wall heaters on the walls of the front or glassed-in porch, which then accelerated the fire.

It is further our thought as the fire progressed that the oxygen storage room became involved, which further accelerated the fire.

This home for 18 years had been licensed by the State board of health, and had complied with all fire marshal recommendations over a period of many years. Therefore, it is our belief that inspection or lack of inspection was not the answer in this particular fire.

Everyone is aware that type 4 or 5 construction always poses a serious fire hazard in the event a fire gets started.

Senator Moss. Could I interrupt at this time?

Could you tell me what type 4 or 5 construction is?

Mr. ANDERSON. Yes; I have that as defined by our engineers.

Five is all frame, 4 might have a metal roof or some metal or cement or masonite construction.

However, I would like to add here that we do not have any type 4 nursing home construction in Indiana, according to our findings.

I have it broken down in five types. Would you like this?

Senator Moss. I just wanted a general explanation, because 4 or 5, to those of us who are not familiar with your classification, did not mean much, and I wanted to establish, as you have said now, that type 5 is frame and type 4 is partly frame construction.

Mr. ANDERSON. Four would be a combination frame and metal or cement.

Senator Moss. And five would be all frame?

Mr. ANDERSON. Five would be all frame.

Senator Moss. Thank you, sir.

Mr. ANDERSON. However, at the present time the vast majority of nursing homes in the State of Indiana are of type 4 or 5 construction.

We can promulgate rules, which we have over a period of years, attempting to make these homes as safe as possible. However, no group of rules, no matter how closely followed, can guarantee the safety from fire in frame construction.

At this time, we have a rule promulgated which states that oxygen can be stored in an unheated room, vented to the outside. It has been our feeling that this was a reasonably safe rule. However, we are also aware that if a fire got started, that oxygen could pose a hazard by accelerating the fire. By the same token, it is important that oxygen be available, when needed, in homes of this kind.

At the present time we are in the process of reviewing our nursing home rules and regulations, with the view to rewriting them in order to make them stricter, and placing particular emphasis on types 4 and 5.

We do not feel that this is the complete answer. However, we feel that we must take immediate steps to give more protection to our aged and infirm.

We are, for example, considering the possibility of promulgating a rule for the storage of oxygen to be outside the house proper, in a well-vented metal structure, that is kept locked, and that only the cylinder in use will be permitted in the home.

We are also considering other rules, for example:

(*a*) All nursing homes must be equipped with a fire and smoke detection system.

(*b*) All type 4 and 5 construction having any bed patients on the second floor, in addition to the fire and smoke detector, must also install a sprinkler system.

These are very expensive recommendations and will pose a financial burden on many nursing home operators. In some instances, it may force many out of business. This will further complicate the problem, because at the present time we have no solution to house these people forced out of the homes.

This will naturally force hardships on the low-income group. Where will they go? Who will take care of them? How can they be properly cared for?

After much thought, it is my judgment that we are our brother's keeper, and we must find a way to make funds available for low-cost, fire-safe, adequate, and comfortable housing, and this cost range must be within the financial range of the common masses.

Perhaps the Federal or State Government could study the problem with the view to allotting funds for the construction of homes, or

perhaps consider long-term loans at low rates of interest to private individuals.

Senator Moss. Thank you very much, Mr. Anderson. That is a very fine statement.

Of course, what you say in your last sentence, there; the Federal Government is already doing in part, the Hill-Burton funds are available and FHA financing, but perhaps these aids need to be liberalized further, if cost is the factor, as you seem to feel it is one of the problems we have in providing safer homes in which these people should live.

Now, you, or your department, make the inspections, I understand, and a report thereon turned into the council, on the basis of which a license is issued or renewed for these nursing homes. Is that correct?

Mr. ANDERSON. That is correct, insofar as the fire safety of the building is concerned. We make a report on what we think is the fire safety status of the building. A copy is sent to the operator of the nursing home or institution or whatever it is, a copy to the council, and a copy of course is kept in our files.

Senator Moss. Are these reports very extensive in detail, or are they rather cursory?

Mr. ANDERSON. I have samples of it here. In fact, I have the inspection report that was made on the particular nursing home.

Senator Moss. The Fountaintown Nursing Home?

Mr. ANDERSON. Yes. It is rather complete. However, we study them from time to time, when we think of adding, maybe, some to it. We think it is a fairly complete report which you might see, Senator.

Senator Moss. Is it all on that one page?

Mr. ANDERSON. Yes; it is a one-page inspection report. That was made in 1962. We have one in 1963. We have one every year, and we have one in 1964.

Senator Moss. June of 1964?

Mr. ANDERSON. We had two reports in 1964. The regular annual inspection was made in January of 1964, and then there was a follow-up because of some recommendations in June of 1964, and it was found it complied.

Senator Moss. Did that report show that there was a written emergency evacuation plan for the home?

Mr. ANDERSON. That report does not have that word on the report. Our inspectors are all instructed to ask that this be in evidence.

Senator Moss. Do you know whether any drills were ever held in that home on evacuation?

Mr. ANDERSON. I have not talked to the inspector on that home. I have not asked him that specific question, if he asked them that when he was there. It does not show on the inspection form.

Senator Moss. I notice your statement here says that this home complied with the fire marshal's recommendations over a period of many years. I wondered on what you based that conclusion, that they had complied with your recommendations. I have asked about drills, and you did not know about that.

Mr. ANDERSON. I know we recommend drills in every place from private homes to the biggest institutions, and we instruct our inspectors at every staff meeting that that is done.

Senator Moss. You assume that they complied?

Mr. ANDERSON. Yes; I would assume so.

Senator Moss. When I was asking you about type 4 and 5 homes, and what they were, I think you said there were no type 4 nursing homes in Indiana. Was that what you said?

Mr. ANDERSON. Yes. That is right. According to our findings, we do not have any type 4.

I have them broken down, if you would like to have that.

Senator Moss. Yes, sir; we would.

Mr. ANDERSON. Type 1 is what we consider the most fire resistant—concrete and steel, masonry and steel. That is type 1. We have 70 such nursing homes in the State.

We have what we call type 2, we have only 12, and we have type 3, 166.

Senator Moss. What type of construction would type 3 be?

Mr. ANDERSON. That could be heavy timber, wood, or steel protected by concrete or masonry.

Senator Moss. Type 4 is part frame and part some other?

Mr. ANDERSON. Yes; it has the height of the building. If you read on this report, here, it has something to do with that.

Senator Moss. You have no fours, you say?

Mr. ANDERSON. No fours. Type 5 we have 261. That is frame structure.

Senator Moss. So that is the largest category, it is nearly half.

Mr. ANDERSON. That is a little over half, I believe.

Senator Moss. That is right, just over half.

Mr. MILLER. Senator Moss, on that subject, would Mr. Anderson have information as to the number of beds covered in those respective categories, or could he provide it for the record?

Senator Moss. Yes.

I do not know whether you have it at hand, Mr. Anderson, but if you do not, could you provide for the record a breakdown for us of the number of beds that are involved in each of these types of construction here in Indiana?

Mr. ANDERSON. I do not have that number with me, but I imagine that the Health Facilities Licensing Council does have that, Mr. Koonce or Dr. Mason.

Senator Moss. I am sure it would be available, and if you could send it in to us in the next few days, we will incorporate it in the record, and it will help us make it more meaningful.

Mr. ANDERSON. I will be glad to do so, sir.

Senator Moss. Thank you.

(The information referred to follows:)

Number of nursing homes and nursing home beds, by type of construction—State of Indiana

	Number of homes	Percent of total	Number of beds	Percent of total
Type:				
1	70	13.7	5,421	32.0
2	12	2.4	724	4.3
3	166	32.6	5,474	32.3
4				
5	261	51.3	5,315	31.4
Total	509	100.0	16,934	100.0

Senator Moss. Is there any consideration being given now by the fire department to require nursing homes to go out of the class 5 category and into these more fire resistant kinds?

Mr. ANDERSON. Yes, we would be very pleased to work in any manner possible, short of closing out homes where they had no place else to go.

The type 5 frame structures, and especially the older buildings that have been converted from older residences into nursing homes, create our biggest problems in the fire marshal's office.

Senator Moss. You feel that there is a very serious problem that older people might be left without facilities if a number of these places were closed. Is that right?

Mr. ANDERSON. That, I think, is the problem in Indiana, from my viewpoint.

I would like, very much, to see a way that these old people could have enough income or have better housing from some means or other, and more fire safety.

I like the one-story structure. I would like to add that it is my finding and my belief that a fire escape has little value in a nursing home. These people are feeble and infirm, most of them, and they are very reluctant to use a fire escape, tubular or steps. The only thing I would recommend is a fire escape in the form of a stair well with fire-resistant material and doors.

Senator Moss. Mr. Frantz?

Mr. FRANTZ. I just wanted to make a comment on that last point you made, Mr. Anderson.

In the beginning of your statement you pointed out that apparently means of exit were not used as much as might have been expected, and you say you do not think that evacuation is really the thing to be relied upon.

We had testimony on that point from the National Fire Protection Association, and they agree with you on that point. I thought it might be interesting to see what they had to say about it.

Mr. Stephens testified on this point of evacuation that:

> The aged and infirm must be removed individually and bodily from their haven of refuge in case of fire, and some must be restrained actually from reentering.

And he pointed out further on the basis of their investigations that it must be expected that rescuers will be fought by those they are attempting to evacuate, and in many cases not one but maybe two or more might be necessary to evacuate a single person.

Mr. ANDERSON. Thank you, sir. This has been my finding that they will not use the fire escape unless forced to do so.

Senator Moss. How many inspectors do you have on your staff, Mr. Anderson?

Mr. ANDERSON. Twelve field inspectors and a chief.

Senator Moss. They inspect other homes besides nursing homes?

Mr. ANDERSON. Everything from the smallest trash fire, as well as the largest buildings we have in the State.

Senator Moss. So this number is required to cover the entire State of Indiana?

Mr. ANDERSON. That is correct.

Senator Moss. I think the point is well made that, knowing the size of Indiana, you certainly could use additional staff.

One thing I am concerned about is you showed me the inspection forms that you used, and I understand the one in June of last year indicated there was nothing particularly amiss, this home passed the inspection, and yet the inspection made by the health people indicated, among other things, there were some fire hazards.

I wondered about this discrepancy; whether it is simply the pressure of time that caused your inspectors to go through too rapidly, or to what you attribute this variation.

Mr. ANDERSON. I do not think that the pressure caused a man to make a rapid inspection. The man making the inspection in January, which was the annual inspection, made three recommendations. He went back in June to follow up, and they had all been complied with.

This is why we found they complied, while the State board of health, on their health recommendations, found it had not complied.

However, with our small staff, I would like to add that if in the future, at any time, anybody, the health people or inspectors, or private citizens, relatives or whoever, when they make a complaint to us that something is dangerous, needs looking after, we try to pull an inspector off from other duty and put him on that immediately, or just as quickly as it is possible to arrange it.

Senator MOSS. You and I discussed this point in your testimony where you indicated that the emergency evacuation plan had been developed, and that they had complied with recommendations over many years, yet I read in this report made by the health department, the health facilities, that there was no written emergency evacuation plan available, and frequent drills were not held.

Mr. ANDERSON. That is sometimes the case. I would have to check with the inspector.

This inspector that made that inspection has a record for complete inspections, a man that has 25 years in the fire department in the city of Anderson. For some 6 years he was in the fire prevention crew, and about 3 years after that he was chief of the fire prevention division, and for some years chief of the Anderson Fire Department. I rely on him as a very competent inspector.

Senator MOSS. We are not here for the purpose, of course, of censuring or pointing blame at any particular person. We are just trying to find out if there is some kind of breakdown in communication between the inspection functions of the different departments.

The health people found the housekeeping was not good, and the fire department inspection found that it was good, you see.

Mr. ANDERSON. Our inspection was in January, and the followup in June, then we had no occasion after they had complied with our recommendations later on through the year to know that it was needing inspection again.

Had we had a complaint from any source, we would have tried to get a man on the thing and make immediate inspection.

Senator MOSS. Your point is proper, there. Your last inspection was in June, and the inspection of the health council is December 1, so there is nearly a 6-month spread on the two.

But one of the things that was pointed out in the last inspection of the health facilities is that cans of paint which appeared to be of flammable content and a large jar of grease were found stored in the basement. If the housekeeping was good, as indicated on your inspector's report, it would not be consistent, would it?

Mr. ANDERSON. No, it would not. Had we had that knowledge, or our inspector found that condition, he would have ordered it corrected at once.

Senator Moss. Is there any coordination between these reports? Do the health facilities reports come in to you to look at? Of course, yours do go into the health facilities licensing council. How about the other way around?

Mr. ANDERSON. No, our inspection report goes to the health facilities licensing council. Our chief inspector serves as a member of the health facilities licensing council from the fire marshal's office, and he would be notified, I suppose. I do not think he gets it, to my knowledge, gets a regular report. Of course he is there at the meetings, but he would have the report and the minutes.

Senator Moss. That would be the coordination. The fire marshal has a representative on the council and the board of health also has a representative on the health facilities licensing council. Is that correct?

Mr. ANDERSON. That is correct.

Senator Moss. This matter, then, having appeared on this report, inspection having been made on the 1st of December, it should have come to the attention of your representative on the council, in so far as it pertained to fire hazards?

Mr. ANDERSON. If they had a meeting at that time, our chief inspector would have been there, and I would think he would have caught that in the report.

I did not have a report like that. However, Mr. Workman is here. I think he could answer that.

Mr. WORKMAN. Mr. Anderson, the day that report came before the council was the day I was home because of sickness in the family, and I was not able to attend the council meeting at that time, and I was not notified of it until it hit the papers.

Senator Moss. Would you identify yourself for the record?

Mr. WORKMAN. William Workman, chief inspector.

Senator Moss. We have one more question.

Mr. CONSTANTINE. What you are saying is that there is no meaningful regular routine for forwarding the health department inspection to the fire marshal's office, other than as they come up for licensing?

Mr. ANDERSON. That has been the practice, except that our member is at the meeting and has the minutes.

Mr. CONSTANTINE. He sees this as a member of the council, and not the fire marshal's office?

Mr. ANDERSON. That is right.

Mr. CONSTANTINE. You indicate that the majority of nursing homes are type 5 construction in Indiana, and you describe those as always posing a serious fire hazard. Would that not indicate the possibility of another Fountaintown tragedy is a constant threat?

Mr. ANDERSON. It is, sir; a constant threat, and constant worry to our department.

Senator Moss. We thank you very much, Mr. Anderson. We appreciate your coming and giving this testimony and answering our questions.

We are interested, I am sure, in the same thing, in trying to find out how we can better protect the people who use these facilities.

Mr. ANDERSON. We are very happy indeed to participate in this hearing, and if we could save our nursing homes, it would take a big worry off our minds.

I might add, Senator, if our 12 men were able to make all the inspections they would like to make, annually, they would amount to 40,000. A man would make, I would think, four inspections, and four good reports, each working day. So you can see for yourself.

Thank you very much.

Senator Moss. Thank you very much.

We will pass over Mr. McGraw now, and call for Mr. Thomas G. Karsell, who is with the Indianapolis Star.

Mr. Karsell, we are pleased to have you here.

STATEMENT OF THOMAS G. KARSELL, REPORTER, INDIANAPOLIS STAR

Mr. KARSELL. Thank you, Senator, and gentlemen.

I think I was called because a couple of years ago I wrote a series on nursing homes and care of the aged in the State of Indiana. I had also done a series, an 18-part series, on State mental institutions, which of course are heavily involved in the care of the aged in the State.

I should perhaps warn the Senator that I understand Mr. Constantine was cautioned I was controversial, and I do not want to disappoint anyone.

I came to the conclusion from the mental institution series that I did that there is probably no real, true picture of the total needs of care for the aged in Indiana, because our mental institutions are so overloaded with the seniles that are not getting into nursing homes and other places.

Our commissioner of mental health takes the position that he is only to accept senile in our mental institutions. Of course, it is my belief, and the belief of some others, that this prevents care of some of the more acutely ill persons who may be helped in other fields.

I believe that the most of the seniles in our mental institutions could easily be moved to either nursing home, if there were adequate nursing homes, or other facilities.

It has been the conclusion of my series on nursing homes that this is essentially a community problem, and that each community has to provide some facilities for its own aged population.

I presume this is a direct result of the fact that homes are smaller these days, families do not keep grandmother in the home any more, they tend to pawn her off someplace, and this is a changing social custom.

From a nursing home series, I think I did 10 initially, and subsequently in the past year and a half have looked in on some others—indeed two as recently as yesterday—and found that there is a wide range of the kind of nursing homes available.

The ones that welfare patients can afford by and large are pretty bad. There are some quite handsome nursing homes in the State. These are also darned expensive, so not many people can afford to take advantage of them.

I understand Dr. Offutt's concern about closing down nursing homes because there simply is no place for most of these people to go. Most counties in Indiana no longer operate what used to be considered the

poor homes, nor do they even have anything like the poor homes. There is literally no place for these people to go except nursing homes.

The ones which cater to the welfare people are charging perhaps from $100 to maybe $150, depending on the amount of welfare aid each of these individuals receives, and some of them pretty obviously require a lot of care. For even $150 a month you just plain cannot provide very much care for most of these people.

Many of our nursing homes in the State of Indiana are badly situated. Our Near North Side, which is undergoing a radical change right now, as is the case in most cities, contains a great number of these nursing homes. They are badly located. They are in areas of blight. Many of them are the frame structures that were built at the turn of the century. I should think a good many of them were pretty dangerous institutions.

I probably at this point ought to take issue with Reverend Mason's statement. Most of us in the press feel that we have looked in at nursing homes for quite a long time, beginning a couple of years ago, and we remember the press conference that Reverend Mason called some time ago, after the Fountaintown disaster.

Most of the members of the press certainly were concerned about the press conference was called. It was a very curious thing, about the Fountaintown fire, which I covered, and which I am sure indeed all of the rest of the press covered.

Most of the members of the press certainly were concerned about the things which you mentioned, Senator, the fact that the department of health did find fire hazards in that nursing home, when indeed the State fire marshal's office did not, and my newspaper has been interested in the problem of inspections of these homes for quite a time.

About a year ago I remember I found in a nursing home in Tipton a nursing home operator who told me that although the fire marshal's office inspector had said that they must not have patients on the second floor, unofficially it was all right, and I subsequently published this.

Perhaps this is part of Mr. Anderson's concern about there not being a place for these people to go.

I remember a statement made some time ago, indeed by Reverend Mason, that it was a real concern about what to do with these people, that even though some of the nursing homes were not very satisfactory, they were better than some of the public institutions, for example, a jail, and I remember a very pointed comment one of my colleagues made in which he pointed out that the Fountaintown Nursing Home people would have been better off in jail.

And you really cannot very much excuse, or I do not feel that you can excuse, a less rigid inspection because these are indeed lives that are at stake.

In the case of the Fountaintown disaster, we found that the health facilities council inspector, a registered nurse, indeed had made official notification of the fact that the administrator of the nursing home was hostile, very unfriendly about the inspection, and had informed her that he always threw communications from the department of health in the wastebasket. He did not pay any attention to them. This was the reason she showed up with an inspector on that particular day.

I believe, from the nursing homes that I have looked at, and from checking the inspection reports in the health facilities council, that the

council inspectors are certainly doing a marvelous job. There simply are not enough of them.

And in every nursing home that I have been to, other than the rather plush ones, the nursing home administrators and personnel all kind of regard the council inspectors as the enemy rather than as someone trying to help them raise the standards of their nursing homes.

We have in Indiana, and I am kind of unclear about this, what is called for want of a better term a grandfather clause in our nursing home regulations, and if this is not an official clause in the statute, it is at least by custom. The implication is that if a nursing home was bad before a cutoff date of I believe 1957—I am not certain about this—that it is perfectly all right to be bad in 1965, because the rules have changed in the meantime.

Again, this seems to me to be a patent absurdity. They are 7 years worse now than they were then.

We do not seem to be able to do very much about this. I think the series that I did—and I want to defend my associates with the other newspapers and with the TV stations, all of whom have taken an interest through the years in various aspects of nursing homes, I think all of our concerns have been to raise the standards of nursing homes.

I do not think the fire at Fountaintown surprised anyone. Perhaps where it happened did. I think we all knew it was going to happen. It was inevitable.

We have so many very substandard nursing homes in the State that we are indeed almost bound to have another disaster. I do not see how it could be prevented. The two places I looked at yesterday, the fire inspector noted several discrepancies in fire regulations, the sanitarian found that there was an accumulation of dirt and dust, which are, of course, fire hazards, as well as sanitary hazards. The health facilities inspector found that they were unsanitary, that a great many provisions were not being met, provisions laid out by the law. And this is after repeated inspections.

I certainly understand Dr. Offutt's interest in keeping as many of these places going as possible. In a case such as these two establishments, where they had been repeatedly warned, and apparently indeed there was a statement in one inspector's report very little attempt had been made to improve the conditions, shows that we are going to have to have some punitive action taken in situations of this kind.

Indeed, keeping a couple of blind women on a second story seems less than simply good sense to me, and yet this happened in one of those places yesterday.

Really, this about all I would say. I am appalled at the kind of care we give most of our older citizens.

Senator Moss. Thank you, Mr. Karsell, for your observations, and having done it over a period of time, I am sure that you have contributed a lot to us in your observations of the kind of services we have here in Indiana.

I wonder how would you characterize the degree of competence or professionalism of the average nursing home operator here in Indiana. Is he a professional, or is he someone who kind of drifted into it because he had a house and took some folks in?

Mr. KARSELL. Most of them I have talked with, and I am talking about the poorer quality nursing home, are simply people who have decided—well, indeed many of them began by taking one or two, and

they started adding on to their homes and increasing their patient load.

It has, incidentally, been rather a problem in some of the rural counties of Indiana that the welfare departments of the counties are so concerned with finding a place for the aged that they really do not much care about the standards set up by the health facilities council. As long as they can find a place to put these people, they are happy.

I should hope that there would be a better liaison between welfare agencies and the health facilities council. Most of the people who run the poorer type nursing homes are certainly laymen with no training.

Senator Moss. Of course, I think you indicated at the very beginning of your statement that perhaps the chief factor in this is the low income or low level of support available to the vast majority of our older people.

Mr. KARSELL. Yes, sir; this is obviously at the root of all the problems.

Senator Moss. Therefore one thing that must be solved before we can upgrade this to the degree we want to is some higher degree of support for these people.

Mr. KARSELL. Yes, sir.

Senator Moss. One other question I wanted to ask you. You characterize as pretty poor the majority of the nursing homes. I wonder can you tell me if very many of them do anything more than simply provide a bed and meals. Do they have other things for older people to do, any activities or interests?

Mr. KARSELL. Now, the two I looked at yesterday are better than a great many that I have seen, but they perhaps will serve as an example. Each had one TV set. One was on a front porch-dining room area, which is obviously rarely used. Another was on an inside and widowless room, which is also very obviously rarely used.

I did not see reading lamps in either place. The magazines that were available were older than things I see in my dentist's office. And certainly some of these people are unable to take part in much organized activity.

But outside of the church-sponsored, or eleemosynary institution-sponsored nursing homes, or some of the very plush nursing homes, I have never seen any indication of any recreational program whatsoever.

Most of these people either just stay in bed or sit against the wall. It is a pretty appalling sight.

Senator Moss. I wanted to get your comment on that, because I have felt that this is one of the areas perhaps we are falling down in even more than safety, if that is possible.

Mr. KARSELL. Most of these people are simply waiting to die.

Senator Moss. Do you have any reason to believe that Indiana is either much better or much poorer than neighboring States in the conditions in nursing homes?

Mr. KARSELL. I am familiar with at least part of the situation in Kentucky. I would limit this to Louisville.

Of course, in Indiana, we always say, "Thank God for Kentucky." I think we are probably better off than they are.

Mr. FRANTZ. Just one point. You mentioned your impression that the nursing home operators, or many of them, look upon the health facilities council inspectors as the enemy. From your interviews with

these operators, why do you think these inspectors are regarded as the enemy?

Mr. KARSELL. Most of the health facilities people expect these institutions to be clean, and they are pretty narrow-minded about dirty bed clothing. They expect decent food. If you have ever been in most of these places, you are immediately overwhelmed with the odor of cooked beans. I am not sure they serve anything else in these places.

The health facilities council has done, I think, a really competent job of inspection, where they were able. They simply do not have enough people. They have been, I think, tough in the areas where they should be, and if you are operating a nursing home for a profit, as some of these people are, this is a pretty cynical way to make a profit, but some of these people are in it strictly for that reason.

You know, it hurts to have to provide good food and clean sheets and this sort of thing. I can think of many places where there were no individual towels and washcloths. I have seen many places where the bed sheeting was just abysmally filthy.

The boarding homes really are much worse than the nursing homes, although any of these poorer facilities are all simply terrible. I cannot help feeling that if we can trot everyone through these places, and perhaps make them realize that one day that is the end of the road for them, too, we might quicken everyone's interest.

Mr. FRANTZ. Dr. Mason described their approach as one of helping and education, and so on. This is fine. I was wondering if perhaps this approach does not come across to the operator, or perhaps it does come across, and this is the threat, the operator feels the threat of being educated and he does not wish to be educated.

Mr. KARSELL. I have seen, I think, a great many who have resisted education.

Senator Moss. Mr. Miller?

Mr. MILLER. Yes, Senator Moss.

Mr. Karsell, in response to Senator Moss' inquiry about the professional qualifications, training, and so forth, of the operators of the nursing home, you stated that in the poorer nursing homes these people had minimal or no professional training, and had more or less drifted into it.

This suggested possibly the corollary that in those institutions where they do have adequate professionally trained people operating them, that they would not be described as the poorer type of home.

Mr. KARSELL. No, of course.

Mr. MILLER. Following that a little bit further, with reference to Mr. Frantz' most recent inquiry about the degree to which the administrators accepted the people from the health department and the fire department and their recommendations, do you find that the professionally oriented administrators are more receptive to the health department people?

Mr. KARSELL. Oh, yes, of course. Indeed, for the most part they are very eager to certainly meet the minimum standards, and I know of several of these places that far exceed the minimum standards, and are eager to provide good facilities.

I cannot help thinking that perhaps this is an area where churches could do an immense amount of good. Churches have come to mean a great deal to our senior citizens, and perhaps this is an area where they ought to be more interested. I know they are doing some things.

Senator Moss. Thank you very much, Mr. Karsell. We do appreciate your coming and giving us your observations.

We had scheduled some witnesses for this afternoon. I think we could perhaps deal with one more before we recess for noon.

Is Mr. Albert Kelly, the administrator of the department of public welfare, here, and, if so, we would like to hear from you, Mr. Kelly.

STATEMENT OF ALBERT KELLY, ADMINISTRATOR, INDIANA DEPARTMENT OF PUBLIC WELFARE

Mr. KELLY. Thank you.

Senator Moss. Mr. Kelly, we are very happy to have you, sir.

Mr. KELLY. Thank you.

Senator Moss and members of the staff, you do have my prepared statement, and I would like to read it for the benefit of the others here.

Senator Moss. You may proceed, sir.

Mr. KELLY. It is my understanding that the purpose of this hearing is to learn of nursing home needs in Indiana and the extent to which present efforts are responsive to those needs.

May I state first that nursing home care has become a most important and essential resource for the care of certain of the sick and infirm among our old-age assistance recipient group; important because of the many considerations required to assure its adequacy and its appropriate use, and essentially due to the fact that an increasing proportion of our elderly persons must have long-term care because of advanced age and extended life expectancy.

Regardless of how critical we may have to look at nursing home care in order to identify major points of concern, we do this, I believe, recognizing at the same time the excellent care provided by the large majority of our nursing home operators.

Public welfare departments are sensitive to the caliber of nursing home care, because of our intense interest in the welfare of our aged clients. In some fashion or other we act as liaison in the use of these facilities for an average of about 6,000 persons per month.

Our major role is to do the best we can to assure appropriate use of nursing home care. To do so we have some ground rules we follow. These include:

(1) Nursing home care must be prescribed by a physician and is paid for only in homes which are licensed;

(2) The recipient must remain under the care of a physician while in the home;

(3) The services of the county welfare caseworker must continue;

(4) The selection of a particular licensed home is the choice of the patient, his family, and the physician;

(5) Discharge from care includes a medical discharge as from a hospital;

(6) Rehabilitation and return to self-care or to family care is a goal whenever feasible.

We have a major concern also because of the cost of care and the problems involved in fee setting.

During 1964, we spent a total of approximately $9½ million for health services for the 72 percent of our old-age-assistance recipients who required medical care in some form or another.

Health services in Indiana under our medical assistance plans since 1942 have included physicians' services, hospitalization, drugs, nursing services, dental care, prosthesis, and other health services as prescribed by the physician, including nursing home care.

Close to 40 percent of this $9½ million, about $3,800,000, was spent for nursing home care through vendor payments under our medical care plans. This cost would be even greater if it included the direct payments made from the basic monthly grant by recipients themselves. The cost of nursing home care advances continuously.

Fees are set through the process of negotiation between the local board of public welfare and nursing home operators. A 1961 law provides for an annual review of rates by the local board and the right of appeal to the State department of public welfare by dissatisfied operators.

We have appointed hearing boards in 20 counties since this law became effective, and while decisions have varied, we believe that the process has helped to adjust rates to a more adequate level. A little less than 75 percent of our counties, 67 out of 92, now pay from $5 to $7 per day. The outside figures are from $3.50 to $9.50.

Some increases in fees are to be expected, and are essential for the same reasons the cost of all services and care is increasing. However, it has been reported to us many times that nursing home operators have requested increased rates on the premise that greater income is necessary in order for them to finance stricter licensing requirements.

Because of our concern for improved health and safety measures, we wish to encourage operators to bring about improvements. There is always the concern as to what extent public funds should be used, however, as the basis or guarantee for the operation of a private enterprise operated for profit. Most of our nursing homes in Indiana are so operated.

In reviewing reports of county boards following negotiation meetings and in evaluating the minutes of appeal board hearings, the absence of factual information from nursing home operators as to the actual cost of furnishing care to their patients is very evident.

Bookkeeping methods in many instances are sketchy, while in others questionable items seem to be included in the costs of care, and in general there appears to be no uniformity in the formulation of a financial statement on which to base a request for a given fee.

I sincerely believe that improvement is being continuously made in nursing home safety and health care through the progressive development and enforcement of licensing regulations, and that further progress can and will be made in a number of areas, including those within the scope of financial responsibility.

Nursing home operators are also making greater effort to learn more about the aged and their problems and how to better enrich their programs to meet the social and emotional needs of their patients. This area of care requires considerable strengthening, however, and a more specific plan of staff training seems strongly indicated.

When we are talking about the emotional and social needs of nursing home patients, we are thinking of persons who, because of advanced age and loss of relatives and friends most frequently must depend on strangers to fill these needs

The average age of the total old-age assistance recipient group has long ago passed the 78-year mark and is well up toward 80 years now.

A current breakdown of our nursing home patients' ages would doubtlessly range heavily from 80 years upward.

One of our concerns for these persons is that the program of emotional and social stimulation and physical care will be such that it will conserve and wherever possible rebuild the morale and will for improvement in health. This kind of vitality in nursing home programs will serve as a stimulation toward increased self-care, happiness, and sense of security, and, hopefully, some possible increase in the number of persons who may return to the community.

With almost 1,800 persons out of our 1964 monthly load of 6,000 staying in the home beyond the 1-year period, it makes this last point of tremendous importance to everyone concerned.

We are also convinced that movement from nursing home care could be increased if more acceptable boarding homes were available. The position of boarding homes, as institutions for living, is shown in our studies of our aging population as needing attention and development.

I repeat: We are of the belief that many recipients presently residing in nursing homes are in need of only adequate housing, proper food, laundry, and suitable supervision for daily living, all of which could be obtained in well-established and soundly managed boarding homes.

Generally speaking, county welfare departments experience difficulty in locating suitable boarding homes for their recipients. The health facilities council of the State board of health instituted licensing procedures for boarding homes in January 1963, but few homes have been found that will meet minimum standards of health, sanitation, fire protection, and personnel.

Hopefully, the emphasis placed on standards and licensing will bring about an increase in the quantity, and improvement in the quality, of boarding homes in the near future.

An increase in adequate boarding homes is only a half solution to this problem. Recipients without outside resources cannot pay their way in a decent setting because of the $70 a month ceiling on old-age assistance grants in Indiana.

If no additional income, such as social security, is available, the possibility of moving from a substandard living arrangement to a comfortable, safe, well-managed boarding home is practically hopeless. Grants must be increased before some of the possible problems of overuse of nursing homes can be solved, and before maximum use of decent boarding homes can be assured.

This becomes a joint Federal and State problem when years of experience proves that advances in monthly grants of assistance follow pretty much the Federal plan for financial participation.

The whole question of nursing home services, as made available to the aged through public welfare programs, requires an even broader look across the financial board. Indiana now has three medical care programs in operation: old-age assistance—medical assistance; old-age assistance—medical only; and medical assistance for the aged, commonly known as Kerr-Mills. All of these provide comprehensive medical services, including nursing home care.

Under old-age assistance, medical care costs were paid 15 percent from county funds, 20 percent from State funds, and 65 percent from Federal funds. This is based on the current Federal matching formula for old-age assistance and medical costs under this program.

While the Kerr-Mills plan, which went in operation January 1, 1965, will help us to meet the needs of an additional number of our medically indigent aged persons, it must be remembered that the percentage share of cost for Kerr-Mills to the State and counties in Indiana will be greater than for the other programs.

This is because the Federal formula for Kerr-Mills as applied to Indiana means only 52.06 percent Federal reimbursement for the current fiscal year, and 50.3 percent for the next fiscal year. Some relooking at Federal formulas seems to be indicated.

I have emphasized the position of costs and money in this presentation today. I have done so deliberately. We cannot consider the formulation of long-range plans for any group, be it aged, blind, disabled, or dependent children, without facing up to the ever-prevailing problem of money—and the importance of money to improved care and services.

I have likewise emphasized other important aspects of nursing and boarding home care, especially those factors which will assure, to some greater degree, more appropriate use of group living and care, and the enrichment of nursing home programs especially.

These latter points are of such great importance I feel my comments, although sincere, almost seem trite because of their brevity. For improvement in all of these areas we examine our own public welfare approach to our important role in these matters, as we evaluate the product of the efforts of others.

We welcome your interest in the aged in Indiana, and hope for your continued guidance and backing in the improvement of our programs.

Senator Moss. Thank you very much, Mr. Kelly. That is a very fine statement, and it does point out that one of the principal problems here is financing the care of our elderly people.

I wonder if I might ask you this question: Suppose you were prohibited from sending any of your people to unsafe or unsanitary homes that do not meet the standards, what could you do?

Mr. KELLY. This is a major problem. It is a realistic problem. I think depending on how fast this situation developed in closing substandard homes would depend my answer.

If tomorrow all homes that were even now substandard were closed, we would have the real problem. We have 6,000 people in the nursing homes. Places must be found for them.

It is not an easy solution. I am confident there has been a great improvement in this area, and it is continuing. I think that we are seeing something more of what we would like to see. But we recognize that this must continue to follow.

Senator Moss. Did I understand that licensing of boarding homes has only begun in the last year or two?

Mr. KELLY. Yes, that is correct.

Senator Moss. Has there been appreciable upgrading, do you think, of those homes since the licensing procedure was undertaken?

Mr. KELLY. I think from our experience, and I think the health facilities council can better answer that question, to date there are comparatively few licensed boarding homes. I think the problem of finance is here.

As I mentioned, in the old-age assistance grant, actually we cannot exceed the grant in our State of $70, and where will you find boarding

homes that can provide acceptable and quality boarding home care for $70 a month?

For medical purposes, such as a nursing home, we can exceed that figure. We are not limited.

Senator Moss. This is the real problem, is it not, for the boarding homes; this legal ceiling on the welfare grants.

Mr. KELLY. This is correct.

Senator Moss. In the case of welfare recipients, are these contracts negotiated in each county for the care of these people?

Mr. KELLY. Yes. In relation to nursing homes, it is the requirement of county welfare boards to fix a fee schedule once each year, and at that time this fixed notice is sent to the nursing home of the rate, and hopefully, a negotiated rate would be arrived at, and I think it is in most instances.

If it is not satisfactory to the nursing home operators, they can appeal to the State department, and then our law provides that we find three citizens in the county, disinterested from the standpoint of operation of nursing homes or public welfare, to hear the grievance and both sides submitting their facts, and this committee of three recommends a rate to the State department, and we in turn mandate that rate down to the county department.

Senator Moss. And Indiana has just begun with the Kerr-Mills program?

Mr. KELLY. Yes, January 1.

Senator Moss. There is hardly time to say whether that has made any appreciable impact on the problem.

Mr. KELLY. No. we will not know about it at this point.

Senator Moss. If the hospitalization bill called medicare is passed and becomes a law, what impact do you anticipate that would have?

Mr. KELLY. I think there is no question but that would reduce our costs, because certain of our individuals, as I understand, would be covered for that portion of time of nursing home care from social security funds, and to the extent they are covered under that program, this would reduce our costs.

Senator Moss. Would the result, then, be your being able to channel more funds into the care of the welfare recipients, or are you still saddled with this ceiling?

Mr. KELLY. I want to make it clear, Senator, we are not saddled with a ceiling with reference to medical or nursing home care. We are saddled with a ceiling in our boarding homes. This is because we cannot provide outside of the maximum assistance for anything but medical care.

I do not think it would have a particularly appreciable effect on our costs, because there is certainly a limited number of days of nursing home care provided.

For instance, and as you noted in my presentation, we have 1,800 people who already have been in nursing homes longer than 1 year, and great numbers for periods of months.

Senator Moss. Thank you.

Do you have any questions, Mr. Frantz?

Mr. FRANTZ. I wanted to ask you some of the details, Mr. Kelly, about your payments for medical care.

What do you pay for medical fees? Can you tell us the schedule, and whether you have a limit on the number of visits you will pay for, and so on?

Mr. KELLY. No; Indiana for a long number of years has had what we believe to be one of the finest medical programs under an old-age assistance program that States can have.

Again, the amounts that can be paid for medical care are determined at the local level. They vary from county to county. In the case of medical services, it is a negotiated figure, again. In the case of drugs, there are some discounts in some counties. In hospitals, again the negotiated rate.

There is no limitation as to days of nursing care, stay in homes, or doctors' services. We do not limit the number of days or calls of the physician.

Mr. FRANTZ. Through what procedures do you verify, for purposes of making payments, the physicians' visits, the prescriptions, the administration of medications, the termination of prescriptions at reasonable intervals, and this sort of thing?

Mr. KELLY. The doctors write prescriptions, and they are taken to the local drugstore and compounded. The physician bills the department for his services on a prescribed claim. The druggist bills the department for his services, and for the prescription.

I would say that in most counties a limitation, and this is done in consultation with medical societies, is placed on the number of refills of a prescription. This does not mean that they would not continue to give it, but it must be on authorization of the physician that it is necessary to be repeated.

Mr. FRANTZ. Does your staff check the patient charts to see that this particular medication was ordered and the order signed by the doctor, and that it was in fact administered, before making payments?

Mr. KELLY. No; we do not. The physician writes the prescription, as I say. We do not see the prescription. We do see on the drug claim what the prescription was that was filled, that we are charged "X" amount for a particular product or drug, but we do not see the prescription.

Mr. FRANTZ. And you do not verify that nursing home personnel actually administered the medication?

Mr. KELLY. No. We think this is the physician relationship to the patient and the nursing home.

Senator MOSS. Mr. Miller?

Mr. MILLER. Yes, Senator Moss.

On page 38 in your statement, Mr. Kelly, you say you are convinced that movement from nursing home care could be increased if more acceptable boarding homes were available, and down further in the paragraph, "many recipients presently residing in nursing homes are in need of only adequate housing, proper food, laundry, and suitable supervision for daily living."

I have an inquiry as to what type of supervision for daily living you have reference to.

Mr. KELLY. I will try to answer that for you.

For instance, perhaps even getting him up, helping him dress, so that he can get around. Presently we cannot find this type under the boarding care. And this may be all he needs. So when we cannot

provide it in any other way, the doctor will indicate he needs nursing home care.

Mr. MILLER. What you mean is special personal care, but not medical?

Mr. KELLY. That is right.

Mr. MILLER. If I may go to another question, on page 37 you state—

a little less than 75 percent of your counties now pay from $5 to $7 a day for nursing home services.

I had a question when I saw that as to whether this $5 to $7 is the range between counties, or whether it is a range between homes within a county, or whether it is a range within a particular home with reference to particular patients.

Mr. KELLY. It could be all of that, but generally it is not. The $5 I refer to here is the going rate in the county for all of the homes. In another county it may be $6, $6.50, $7. There are exceptions. Some of the counties do have different rates for different homes.

I should add each county welfare board, in addition to the fixed fee, has the right for a deviation in a particular case. Maybe this case requires greater service, and the nursing home operator is indicating there should be more money.

Mr. MILLER. Your comment on that point was in anticipation of my next question, which, somewhat differently phrased, was related to whether efforts had been made in any of the counties to separate board and general nursing services from what might be described as special services that would have to be prescribed or required by individual patients.

Mr. KELLY. I think one or two of our counties, or more, have been looking into this, but I do not believe that any of them have adopted it. We think it is something we need to look at. It is very hard to establish, however. Some counties are interested in this type of arrangement.

Senator MOSS. I think Mr. Constantine has a question.

Mr. CONSTANTINE. Mr. Kelly, on the first page you refer to the excellent care provided by the large majority of nursing home operators. Now, presumably the welfare department has conducted audits and regular inspections of the conditions in the homes in which welfare clients are placed to provide a basis for making this statement.

Mr. KELLY. No, I do not think we inspect the homes. This is the responsibility of at least two other agencies, not ours. However, if one of our caseworkers would come across some condition in the home that she felt was not corrected through notifying the Indiana Health or State Departments, we, in turn, would advise the council to check on it, but this would be the extent of our inspection.

Mr. CONSTANTINE. You have no regular audit procedures?

Mr. KELLY. As to quality and so on?

Mr. CONSTANTINE. Correct.

Mr. KELLY. No.

Mr. CONSTANTINE. Then, one other thing; most of this seems to be at the county level. Do you feel that that is the most desirable administrative mechanism?

Mr. KELLY. We could spend several days discussing this aspect of it. There are times when I think it is all wrong, and there are times when I think it is really the thing to do. I think that in some

counties I would have to say that some of our boards are not as cognizant of the going cost of medical care as perhaps they ought to be, and this might pose some difficulties for us.

But still, in all, who knows best about what is happening at the local level than the local authorities who are in the home, in and out of the home every day or week? And from this standpoint I think much can be said for some county operation.

Senator Moss. Thank you very much, Mr. Kelly. We appreciate your testimony. You have been very helpful to us.

We appreciate all of the witnesses who have appeared this morning. It has been a very productive hearing. We are glad that so many of you have come to listen and hear testimony given.

We will be in recess now until 2 o'clock. You are invited to return then, if you would like, to hear the remainder of the testimony that will be given then.

We will be in recess, then, until 2 o'clock.

(Whereupon, at 12:10 p.m., the hearing was recessed, to reconvene at 2 p.m., the same day.)

AFTER RECESS

Senator Moss. The hearing will come to order. We will resume this afternoon.

I have been furnished here with some data on Marion County about the licensing of health facilities. It appears to be a very meaningful and excellent compilation. We are pleased to have this for the subcommittee's information and I appreciate it being brought in for us.

We will begin this afternoon with Dr. Nathan Salon. He is going to be accompanied by Dr. Davis, I understand. Dr. Salon is on the Indiana Commission for Aging and the Aged, and Dr. Davis is the chairman of the commission.

Will you gentlemen come forward, please?

We particularly appreciate the help we have had from Dr. Davis in making the arrangements for this hearing. He has been most cooperative and helpful, and we appreciate it.

Dr. Salon, will you go ahead, sir?

STATEMENT OF DR. NATHAN SALON, INDIANA COMMISSION ON AGING AND AGED; ACCOMPANIED BY DR. GEORGE E. DAVIS, CHAIRMAN, INDIANA COMMISSION ON AGING AND AGED

Dr. SALON. Senator and gentlemen, I want to say at the outset that Mr. Davis has not read this statement. We have not gotten together on it. So I hope he approves everything I say on it.

Senator Moss. He is sitting close, so he can put his elbow in your rib.

Dr. SALON. The Committee on Mental and Physical Health of the Indiana Commission on Aging and Aged met for the first time on March 10, 1956, and at that time defined the purpose of the committee:

> * * * the primary purpose of the committee will be to study physical and mental health problem facing the aging and aged with the intent of delineating those problems into specific recommendations for the Indiana State Commission for Aging and Aged to consider when making recommendations to the Governor of Indiana * * *.

Since that time the committee has consistently worked toward this objective. Among the several areas earmarked at this first meeting for special study was this one:

Raising the standards of administration and patient care in the various kinds of institutions presently engaged in caring for the aged and chronically ill.

We have pursued this objective since that first meeting 9 years ago with tangible progress. In fact, one of the reasons for its immediate adoption was its tangibility. Three months after our first meeting, the health committee recommended transfer of the licensure of nursing homes to the State board of health. The commission approved this recommendation and cosponsored the Licensure Act enacted by the 1957 general assembly.

During 1957 our committee entered into an intensive educational program—for itself and for the public. During this time we visited public and private institutions caring for the aged, including the sick aged, brought in consultants for committee growth, and sponsored a statewide public hearing for general education.

This was held in Fort Wayne in the fall of 1957, with an attendance of over 300 persons—primarily representatives of medicine and allied social sciences concerned with health problems of the aged.

As a committee we were well aware that our concern lay not only with institutionalized aged persons, but also with the larger number not institutionalized; that we must lend our efforts where results could accrue with some degree of recognized measurement, and concurrently work in the less tangible fields of education and prevention.

The Governor's commission on aged and aging, through its subcommittee on mental and physical health, has developed the concept of independent living. It has been recommended that a study be made of the causes leading to the institutionalization of the aged, the physically and mentally handicapped, and the chronically ill, and to explore ways by which such individuals may be enabled to maintain their independent living status for the longest possible period of time.

A bill which was lost last year by one vote is now in the legislative hopper. It will, if passed, implement this recommendation.

A recent survey of county homes of the State was made by the State board of health and the Governor's commission on aging. As anticipated, the report clearly showed the changing role of the county home in our society.

With facts and figures, it pointed out that the county home is a community facility primarily housing the aged, the sick aged, the mentally retarded, and the chronically ill of diverse ages.

It showed that 50 percent of the buildings erected more than 60 years ago are still in operation, but with minor alterations. While physical plants have in most instances failed to change, the residents and their condition have drastically changed. Sixty-two percent of today's residents are over 65 years of age, with multiple mental and physical disabilities.

Many of these homes do not require a medical examination on admission, and do not provide a regular medical examination of their residents, and have no established policy of medical procedure. Most of the county home buildings are antiquated, obsolete, and definitely hazardous. County homes must become medical institutions with standard health and medical procedures.

Our county medical societies have been requested to establish committees to serve as liaisons with the nursing home, so that practical and acceptable health and medical care practices may be instituted.

Only recently has the licensing of nursing homes come under the jurisdiction of the State board of health. Already we are seeing good results in some parts of the State. Still further progress will be made in this area as soon as proper licensing will be accomplished through implementation of the Health Facilities Act which was passed by the last legislature.

Another study was made on rehabilitation. We know that about 20 percent of the individuals in our county homes, and as many as 12 percent in our nursing homes could be made well enough to be discharged into the community for independent living if a program of rehabilitation would be instituted. At the present time, rehabilitation services are practically nonexistent in any of these institutions.

It has been recommended that a continuous program of training in the elementary principles of rehabilitation be provided for the personnel of the county homes and the nursing homes. This will take funds, but it will be worth it in the happiness it will engender, and will aid greatly in relieving hospital bed shortage by releasing present long-term patients from these institutions.

This new concept must also include some other services such as proper foster homes, homemaker services, "meals on wheels," and comprehensive medical care in the home.

We believe the service which will best implement our philosophy of independent living is in the home care program. This is a method of bringing hospital-type care into a patient's home, with the full complement of medical, nursing, and social service.

It is an effective and economical method of treating patients with long-term illnesses. It has positive values for the patient and his family, as well as for the hospital, physician, and community as a whole. The patients with long-term illness pose many problems for the community. For many such patients, home care has been found to be the ideal method.

Medical rehabilitation is a dynamic concept, and an active program. Here the skills of the rehabilitation team, consisting of the physician, the dentist, the physical therapist, occupational therapist, speech therapist, nurses, social workers, psychologist or psychiatrist, and other trained personnel, are integrated as a single force to assist the patient in reaching the maximum of his physical, emotional, social, and vocational potential.

We need to learn more about the psychodynamics of older people. I have no doubt whatsoever that of all the aspects of old age, the discoveries in the field of psychology are more important for the stability and the happiness of old people.

Advanced age is not a bar to recovery from mental illness. The majority of patients 65 and over with mental illness can be restored to the community and need not spend their remaining days in a State institution.

Changes in medical care demand closer cooperation of nursing homes with hospitals. This is feasible and advisable. The general hospital can provide the nursing home with such services as dietetic consultation, physical therapy, engineering, business office procedures,

et cetera. The hospital can bring to the nursing home the most advanced thinking in the field of care.

Laboratory and X-ray can be made readily available. The high cost of general hospital stay and the change in the attitude of both the public and the medical profession can lead to a new type of patient entering the nursing home. It is possible to consider that long-stay surgical, medical, and orthopedic cases might be transferred to a skilled facility.

Skilled nursing homes in cooperation with the many services of the hospital must demonstrate that they have standards that are acceptable and that the service they are trying to give is beyond that of personal care.

Nursing homes can be of help to hospitals in accepting the long-term care patient, thus relieving the hospital bed shortage.

I see a change in some of the nursing homes in the past few years. The older patient is getting more of the care he deserves. Nursing homes have been influenced to alter old approaches and adopt new ones. They are moving from custodial institutions to multicare facilities.

There is more awareness on the part of some administrators as to the role they must play. They are developing more competence in assuming the therapeutic, recreational, and rehabilitative needs of the aged and aging.

Since the survey of the county homes, some have closed, and others have been upgraded. The operators of county homes are beginning to see the value of proper medical administration, and are beginning to think in terms of rehabilitation services.

A good sign is that some operators have even asked for another survey.

The blights of our time have been that we have regarded all old people the same way, and that we tend to treat them all alike—that segregation is the way to solve the problem. There is a decided change in this attitude. Physicians are taking more interest in chronic diseases.

The entire program is complex and formidable—it is too big to do alone—it must be done by all of us, and we must have the cooperation of all physicians, nurses, and social workers, and educators.

The problems of older people are sociomedical—nurses and social workers are indispensable to the medical team. We must insist on progressive care, instead of the static care that most older people have been getting.

Legislators are developing a better understanding of the problem. We must find ways of handling the problem financially. Everywhere I sense a feeling of awareness and concern which is healthy.

This, then, is our history and our hope for the immediate future. I believe that the State of Indiana is in an enviable position to show the way for a better future for the older citizen. Close cooperation of the Governor's Commission on Aging, the Indiana State Medical Association Commission, and the Joint Council on Aging, and all the State health and welfare agencies makes this possible.

We are fully aware of the importance of the grassroots approach to extend community understanding from which intelligently planned and well-directed action programs can emerge.

These are my final comments, and these are my own comments.

I feel that we have all failed to do the job that can be done in this area of our concern. The State board of health has been most cooperative, but has been rather slow and permissive in handling the nursing home problem.

However, I quickly add that their hands have been tied because of lack of funds. If the legislative acts that are passed would at the same time allow sufficient funds to implement these acts, a more comprehensive job would have been done.

No time should be lost in upgrading the nursing homes. Restorative and medical care calls for trained personnel in charge of personnel enlisted in training programs. Those directly involved with patient care can be taught the techniques which will most effectively restore the individual to his highest potential. For many it will mean the difference between being permanently bedridden or ambulatory.

However, the fees allowed by the welfare department have not been realistic—they are entirely too low to allow proper restorative treatment. The State welfare department is cogizant of this fact, but in many cases has been unable to communicate these needs to the county level.

Some of the operators of nursing homes are not sufficiently informed in the skills of operating a nursing home, and the help they use is generally of poor quality. Many do not belong to the Indiana Nursing Home Association. Neither are they accredited, and are making no attempt to improve their status.

Now, I say only some of them. I do not include all of them. However, many operators are now attending seminars that are given from time to time by the American Medical Association, the National Joint Council, and the Indiana University Medical School. Unfortunately, too few are in this category.

Many physicians are not interested in this facet of practice, and therefore are not knowledgeable in the physical and mental aspects of aging. Our medical schools, except for a very few, offer no courses in geriatrics, and the student and resident staffs of hospitals are not exposed to the medical aspects and to the psychodynamics of older people.

The care of the disabled older person has become the primary responsibility of every physician, every nurse, every social worker, and the entire community.

The graitude of the elderly patient for help in regaining lost health and for understanding is heartwarming and satisfying.

Our sincere interest in the welfare of our patients, and our desire to provide the best possible service is most important. We are dealing with human beings, and this fact makes it imperative that we accept the social responsibility which our work entails.

This report is given in a spirit of humility—all too well knowing that there is still much to learn in this field.

Senator Moss. Thank you, Dr. Salon, for that very excellent statement.

We may have a few questions to ask.

I want to ask Dr. Davis if he has any statement he would like to make at this point.

Dr. DAVIS. Dr. Salon has covered the case very well.

I thought it might be interesting to you and to the audience, to know that the Indiana Commission on Aging and the Aged was established by legislative act as a nonpolitical group.

To give you just a brief glance of the areas in which we are interested, the committee on physical and mental health is the committee of which Dr. Salon is chairman. In addition to those committees, let me just enumerate without elaboration the various committees we have set up.

In addition to the committee on health are the following committees: housing, education, community organization, religious organization and institutions, research, use of free time, legislation, committee on senior citizens' centers, employment and maintenance of income, publicity, and an interdepartmental committee which involves other departments of the State in an attempt to keep them informed about the work of the Indian Commission on Aging and to keep us informed of the things they are doing in that area.

I would like to point out one thing which Dr. Salon has not seen fit to emphasize, but I want to emphasize it. It was due to his good services that a joint council to improve the health care of the aged was established in the State of Indiana.

This joint council consists of membership from the State hospital associations, the State medical association, the State dental association, and the State nursing home association, which constitutes a body that compares notes with great profit to everybody involved in this thing.

Our Dr. Salon has just hinted at this, but I think he would agree with me that we are very much interested in the field in which very little currently is being done; namely, the field of rehabilitation.

We need much more demonstration projects for that matter in the field of rehabilitation. I think that our nursing home operators are not averse to dealing in rehabilitation techniques, but the facts are that many of them are not familiar with what the techniques are. We have not had the funds with which to employ the personnel to do the demonstration work.

One other thing I would like to call attention to and emphasize again is our interest in the area of home care and homemakers' services.

We have a few programs in home care in Indiana that are already underway, but they are very few in number. We hope they will grow rapidly, but so far they have been very few.

This point was touched on this morning, and I know it is kind of an indefinable area, but when mention is made of the fact that nursing home occupants, for the most part, just sit waiting until the Grim Reaper arrives, this may be true in some instances. It is not true, I think, in our better homes.

Now, I suspect that it is true in some of our poorer homes, where the individual is not introduced to any program of activities at all. But I present to you the difficulties of organizing and operating an activities program for a group of, say, 15 or 18 people. If you have 60 or 75 people or a hundred people in a nursing home, this becomes a comparatively simple thing, but to organize an activities program for a very small number in a nursing home is a pretty difficult thing, as a matter of fact, plus the fact that the number of people available who have knowledge in this field is quite limited.

Even our philanthropic homes that have been built by our churches for the most part have great difficulty in finding people to head up the development of activities programs for the residents in their homes.

This means we need to train people in this area, that they have not been trained, and are therefore not available.

So there is not much point in criticizing about the situation until we can tell nursing home operators where they can find people who have abilities of this sort. They just are not available right now.

There is one thing I would like to add. This is a very interesting development. About a year or 2 years ago we added to our commission a member of the dental profession. Somewhat because of his interest in the field, there developed within the past year at the time of the last meeting of the State dental society a plan which I want to announce here.

The dentists of this State decided that they would make an examination of the mouths of all people in nursing homes and county homes in the State of Indiana, free of charge. Now, of course, they have not said that they will give them the treatment indicated, nor should they be expected to do that, but at least until we have known what the problem is, we have not known what the magnitude of it is.

Now that this is in progress, I think that we are in a position to deal with the question of how dental work is going to be provided for older people.

Senator Moss, I appreciate very much the work that your committee is doing. As chairman of the Indiana Commission on Aging, I cannot conceive of this morning's testimony and this afternoon's testimony being anything but helpful to the people of the State in giving them a concept of what is really involved.

Thank you, sir.

Senator Moss. Thank you, Dr. Davis. That was an excellent statement that you gave us.

It is a very fine thing you mentioned, about the dental association making these examinations so you then do have information on the magnitude of the problem of dental care needed. This is fine.

Does the commission on aging have staff people attached to it, and if so, how many?

Dr. DAVIS. The commission has a sizable staff. I am the staff, with one exception. We have a fieldman part time. His services are made available to us to do fieldwork by the State board of health. Our total staff consists of this 1 part-time fieldman, a secretary, and me.

Senator Moss. I would take from that that this does handicap somewhat the amount of work that you can do.

Dr. DAVIS. We have pleaded before the ways and means committee for at least two fieldmen in the next biennium. Whether we get them remains to be seen.

Senator Moss. I think the need for additional staff would be self-evident for a problem as large as this.

I was most interested in Dr. Salon's statement. He pointed out that you are making considerable progress in many areas, and I am glad. That is heartening, indeed. But the limitation of staff and funding may be holding you back somewhat.

Dr. DAVIS. I would like to add one thing, if I may.

I want to hold the fire marshal's hands up a little bit, too.

As director of the adult division at Purdue University prior to my present job as executive director of the commission, I worked with the fire marshal through a unit in our division.

I know that the fire marshal has always lacked the number of inspectors that he needed to do a decent job, in spite of the fact there is a dedicated fund out of which money might come for the employment of such people. I hope this money may be spent for additional inspectors.

I do not see how you can expect a decent job to be done in inspecting with the staff he has, limited as it is. I congratulate him on the excellence of the job he is doing, as a matter of fact.

Senator Moss. Thank you.

Are you familiar with S. 811, the bill that has been introduced by Senator McNamara in the Senate, and which I have cosponsored with him, called the Older Americans Act?

Dr. DAVIS. Yes, I am.

Senator Moss. Do you have any comments on that?

Dr. DAVIS. This would establish a new liaison. This establishes a Commissioner of Aging responsible to the Secretary of HEW. Is that right?

Senator Moss. That is correct.

Dr. DAVIS. This, I am sure, is needed. Problems relating to aging are not primarily welfare problems. They are educational problems and should be distinctly known as educational problems.

In my humble opinion, as gracious as the Commissioner of Welfare has been, I do not think we will get the emphasis that we need until we have a separate Commissioner responsible to the Secretary.

Senator Moss. Thank you, Dr. Davis.

Dr. Salon, you mentioned need to develop sort of outpatient or out-of-institution services. That would have the added value of freeing much more of our space for people who must be within the nursing home or care home. Is that right?

Dr. SALON. That is right, plus the advantage to the patient himself, the psychological advantage of being with his family and living within his own home. We feel they get better faster in their home.

Senator Moss. In other words, the very best place for an older person to be is in his home, as long as he can be cared for there.

Dr. SALON. Yes.

Senator Moss. You commented also on the fact that very few of our medical schools specialize in or even have courses in geriatrics. Is it your experience as a medical doctor that doctors pay relatively little attention to these people who are in the nursing homes?

Dr. SALON. Yes. I think doctors in the past have been geared to the care of acute diseases. They are much more dramatic, of shorter duration, and you see results. Frankly, the little increment of function that a person can develop so that he can become independent is a tremendous thing, and it is worthwhile striving for.

Senator Moss. One of the other fields, then, we need to concentrate in is interesting the medical profession more in upgrading the quality of care for these older people.

Dr. DAVIS. May I add one thing further that Dr. Salon did not make mention of? It was his committee that was responsible for it.

There was mention made this morning of a variety of people sent from our mental institutions to nursing homes. This being true, his committee worked with the mental health division and an institute or seminar, call it what you want, dealing with the handling of such patients, mild mental cases in nursing homes, was established on an annual basis.

We have had the second one of them this year, and I hope that nothing will interfere with its continuance. This is an attempt to get to nursing home operators some concepts which they would not otherwise have about handling people of this sort.

Senator Moss. That is very fine.

Mr. Constantine?

Mr. CONSTANTINE. Dr. Salon, you speak of the desirability and indeed the necessity of providing a comprehensive range of services, including rehabilitative and convalescent services and various therapies, et cetera.

Do you think that those services in general can be effectively provided in converted frame dwellings, or do you feel it would be far more desirable and effective to provide those in facilities which were constructed as nursing homes?

Dr. SALON. That depends on the administrator of the nursing home, and the staff that he wants to develop. I think a nursing home can have anything the staff wants. I believe that if this new legislation will go through on independent living, the State board of health is going to have a medical team composed of a physiotherapist, a nurse, and dietitian that will go to these nursing homes and county homes to try to teach them the elements of rehabilitation and dietetics and general nursing care.

Frankly, it is not so difficult. The average stroke patient can make a tremendous progress by very little advice. You do not have to have a full-time physiotherapist. The nurse can be shown how to position a patient with a stroke and how to get some exercise in his arms or legs, and then teach him how to do it himself.

I think it can be done in the average nursing home, if they are willing to do it.

Senator Moss. Thank you very much, gentlemen. Your testimony has been most worthwhile. It has been excellent. We appreciate indeed your coming to be with us, and we appreciate the help you have given this committee in arranging these hearings.

Our next witness is the Honorable Jesse Dickinson, who is a member of the Indiana Commission on Aging and Aged.

Mr. Dickinson.

I understand your title is officially "senator." You were formerly a senator?

STATEMENT OF HON. JESSE L. DICKINSON, MEMBER, INDIANA COMMISSION ON AGING AND AGED

Senator DICKINSON. Yes, "formerly" I think is a better term.

Senator Moss. Once a senator, always a senator.

Senator DICKINSON. I am pleased about that.

I am not certain as to what value I can be to this hearing. I have heard some of the testimony. We certainly have a pretty good idea now as to what needs to be done, certainly in our State.

Perhaps, too, I have sort of a mixed role because as a member of the commission on aging and as a result of the research and studies and so forth that we conduct, we certainly know what should be done, and as a legislator over a number of years, I was involved in trying to get the needs translated into statutes, and presently my employment is conducting a housing facility for elderly people who are in the low-income brackets.

The communication that I had said that we should try to confine this to 10 minutes, but I am going to do better. I am not going to say much, and I will try to confine it to five, because being a person who operated at one time in the fringe area of politics, it is very easy for me to go over allotted times.

So long as I am only going to take 5 minutes, I hasten to inform everyone I was never really a politician. They were all on the other side of the fence. On my side we were statesmen.

Senator Moss. Welcome to the club.

Senator DICKINSON. I thought that this was pertaining principally to nursing homes, and therefore the few remarks that I do have are more or less confined to that.

The importance of the role of the nursing home in the continuum of facilities necessary for older people is well established. Therefore, I think it unnecessary to enter into a discussion on same.

The nursing home needs in Indiana, as I see it, in my opinion, are extensive. In fact, my inclination is to say that the situation is acute.

The acuteness emanates from the efforts to give proper response to the apparent needs. These efforts are reflected, of course, in the statutes.

When I say "acute," I am thinking in terms of the level of maintenance and administration, the kind of care that I think is essential, if we are going to give adequate attention and consideration to the people in this phase of their life cycle who find it necessary to have the services of a nursing home.

Although we do have a number of institutions that I think are up to standard, I think that most of them probably are not up to an acceptable standard. From the time that the nursing home concept came into existence, when many people thought that it was a business that would conduce a fast buck, to the date of the health facilities council's most recent determination as to standards, Indiana has been striving to have a meaningful and adequate program in this area, and as a Hoosier legislator over a period of approximately 20 years, I was involved in these legislative efforts.

In 1957 I sponsored House bill 224, which became chapter 136 of the act of 1957, wherein a new structure in the establishment, maintenance, and administration of nursing homes was attempted. Of course, since that time the efforts have continued.

I cannot say that we have met with the kind of success that I had hoped we would reach over a period of years. Nevertheless, there is progress.

I further think that the degree of success is limited principally because of the rates that can be charged for the largest group of patients.

Now, of course, if a person has adequate income, or if they have financial resources, there is no serious problem, because there are some very good nursing homes. But the bulk of the people who need these

services are folk who are in lower income brackets. They are people who are the recipients of the department of public welfare program. This is where most of the people come from.

I can recall that during one interim period when we were doing studies on the nursing home situation, in an effort to try to present legislation or legislative proposals that would alleviate our problems, we found at that time that in the State of Indiana there were some counties that would allow no more than $3 per day per patient. You can see that you cannot have very much service with this kind of an allowance.

In my particular county at that time we were paying $5.

Really, the people who ran the nursing homes could not maintain the kind of establishments that were essential. Most homes are private commercial enterprises, and therefore, it is a little difficult sometimes to bore in to get the kind of control that is actually needed.

For those who are members of the largest ethnic or racial minority in our society, this poses an additional problem. There are many, many nursing homes that will not accept a person of my group, regardless of the circumstance or the condition that the person may be in.

I can recall one event that I do not have documented, but was a case in a county near my county, concerning a person in my group. It was determined that he had to go to a nursing home. It was thought at the time that his needs did not justify or make it necessary for him to be confined to a regular hospital.

This person was shunted between several nursing homes. A call was placed to the last one, and acceptance was made on the telephone, but they did not tell the racial extraction of the applicant. The person did not get into that nursing home. And he actually died before he was taken anywhere.

I am just relating this incident to show you that on top of all of the problems that everybody has, there is this added dimension for a portion of our population.

These are some of the things that I feel that we have to get at. Certainly, perhaps, there should be stronger governmental authority. You know, I am a very firm believer in the proposition that if there is something that has to be done, it is up to the individual if the individual can do it, and if it is too big a job for the individual, and it has to be done, then it is up to the private group. When it gets beyond that, then, of course, this is the time when there has to be governmental action.

With reference to the nursing home situation, as well as some other phases pertaining to gerontological activity, I think we have just about reached the stage where there is going to have to be more vigorous governmental action and governmental control.

You know, I can recall the time when I first entered the legislature, in 1943. Our mental hospitals were just, perhaps, a little bit above the level of snake pits. There was a lot of focus on the problem, and gradually we began to pull out of the situation. Although we have not reached our goals, certainly there has been a vast improvement, because the public, the people, are accepting this responsibility. They no longer feel that State hospitals are some place where you simply put people away because they are mentally ill.

The same thing pertains in the area of prisons. There was a time when this was just some place to make a guy pay his debt to society. There was no effort at rehabilitation. We failed to realize that most of the people are returned from prisons. Very few die there. Now this concept has changed, and we are finding that there is more consideration toward rehabilitation.

I think that in the matter of nursing homes, we have just about reached the stage of recognizing that the standards in a nursing home should be no less than those in a regular hospital.

I do not mean that you have to have surgical equipment and this sort of thing, but I am talking about the type of care. Certainly we should have nurses' care and so forth around the clock.

A while ago Dr. Salon was talking about home service. This is certainly a very good area, but I am concerned about the people who cannot be cared for in these structures that were at one time, one-family homes.

Again, I say that we are going to have to do something about creating a higher degree of awareness among the people as to what has to be done.

Now, the health facilities council, just as did the nursing home council before them, have worked, and they are working diligently to set up standards, but you see this does not have as much value as we would like for it to have, or the value does not meet the need, because it does not do any good to say that you are going to have to have a nurse or two around the clock, you are going to have to have this and that, if the person who is operating the place cannot get enough money to keep up those kinds of standards.

You see, this is the crux of the problem, as I see it. We are very well aware of what has to be done, but we have not gotten to the place where we are willing to get the adequate finances.

If you would go down to the Senate from this meeting today and present a bill insisting on certain funds being allowed for improving nursing homes, nobody would look at it, because they do not realize the importance of same.

I think this is one of our biggest jobs. However, the council still has to set up standards and is doing a good job.

I will give you one incident. After the 1957 act was passed I got a letter from an elderly lady who was disgruntled. There were two of them. One had some money, more than she needed, but her health was quite poor. The other lady had a house, and she had strength.

In other words, these two women wanted to live together. You see, one could finance their needs and the other had the strength and the house. They could not have this arrangement under the 1957 act.

When you are a legislator, you try to determine all of the things, you try to foresee everything that may happen, but you just cannot foresee everything. The law goes through, and you hope it does what you intended it to do.

I do not know whether that happens on the national level, Senator, but it certainly does in the State level.

In the letter she told me how this law was going to keep them from doing what they wanted to do, and therefore it was going to be necessary for her to become a DPW case, whereas if this law had not been in existence, they could have avoided that.

She closed by saying: "Mr. Dickinson, my evaluation of your ability as a legislator is that it approaches the epitome of asininity." This was supposed to make me angry.

I answered and said: "Madam, you may be surprised at how often I agree with your evaluation," and we became very good friends.

I told her: "Now, perhaps there is something we can do about this, because although we set up the new standards, we did not allow enough money for the health department to hire enough inspectors to get around to the several hundred nursing homes during the interim." I knew they just could not possibly make it, again, I say, because we did not appropriate the money to hire the necessary staff.

I said: "We will try to arrange to get your case to the bottom of the list. We will be having another session of the legislature, and as I do not have to worry about reelection, I'll be there, and my first bill will be to try to do something to get a solution to your problem."

And I think the record will show that I did just that.

I have not made much of a contribution, but if I can just get across the proposition that, in order to get real progress, I am afraid in Indiana we are going to have to resort to more governmental authority.

I am agreed certainly that there are many of the nursing homes where the people are doing the very best that they can, but they just simply cannot do the job that I think has to be done.

I also think that I have probably talked enough, Senator, because I am just about at the stage where I am beginning to take off.

Senator Moss. Thank you, Senator Dickinson. You did indeed make a contribution.

You indicated you thought you had not contributed much. I think you have contributed greatly to this record. You gave us some points of reference that are certainly of importance.

I think really what you said is, that we need additional education of our whole population to the problem so that they would be willing to meet this financial burden which, you said, was kind of a fulcrum on which the problem stands. And in order to advance that, you have to have a little more Government pressure all the time by way of standards and requirements on nursing homes so that we can move into this area where our elderly people do have proper care.

I agree with you on that point. I am glad to have it in the record, because that is what this committee ought to consider, along with many other things.

I was interested in your relation of the incident where a member of the Negro race, a minority race, had difficulty in getting into a nursing home. Is that changing now, or is that still the situation?

Senator DICKINSON. I think it is changing as much as these kinds of things do change. We have something that has taken 300 years to get into the culture; certainly the changes are not as rapid as I think they should be.

I can recall after this 1957 act went into effect there was a nursing home in a town near the central city of my county, which is South Bend. It was in very bad shape. I drove up there just to take a look at it. I was going to recommend that they move in on this place at once.

But I found this was the only nursing home in St. Joseph County that would accept Negroes that had any beds available, so then I

was in a position of trying to get needed action suspended, withheld, or delayed on this place, because there was no other place at that particular time where Negroes could be served.

Yes, I think this prevails. Of course, when it is strictly private, you see, perhaps in the mind of the persons who are running them, there is justification. This is why I say there has to be more governmental control, because the Government is, should be, and has to be color blind.

Yes, it does prevail.

Senator Moss. Thank you very much. I appreciate it.

Are there questions from the staff?

Apparently not.

Thank you very much. We appreciate your testimony. It was good of you to come.

Mr. Harry Latham is the general counsel of the Indiana Association of Licensed Nursing Homes.

We are very glad to have you, Mr. Latham. We look forward to hearing from you.

We have had witnesses mostly, I guess entirely, of those who were not directly responsible to the management of the home. Now we are beginning to hear a little of the other side, perhaps.

STATEMENT OF HARRY LATHAM, GENERAL COUNSEL, INDIANA ASSOCIATION OF LICENSED NURSING HOMES

Mr. LATHAM. Thank you, Senator.

It is rather interesting that I should follow Senator Dickinson. I have a little secret that he does not know about, as a matter of fact, Dr. Salon does not know about it.

It seems that one of our members, Mrs. Marjorie Pearcy, was a member of the commission on aging subcommittee back in the year 1957. At that time I was aware of our difficulties with licensure, and perhaps Dr. Salon does not remember, but Mrs. Pearcy talked to him at one of their meetings and suggested that the board of health be the licensing body for nursing homes.

Dr. Salon immediately accepted this, and the committee on aging adopted it as a policy.

I happened to be employed at that time in the legislative bureau. They sent word in they wanted a bill. I walked down and gave it to Senator Dickinson, and he was rather surprised because he had just gotten word there was going to be such a bill. So the nursing homes actually helped with that legislation.

I have prepared a written statement. I will read from it, principally for the benefit of nursing home association members who are here, so they will know that I am working in my job, in spite of the fact that I am presently involved with this legislation.

Senator Moss. Go right ahead, sir.

Mr. LATHAM. I am Harry T. Latham, Jr., attorney for the Indiana Association of Licensed Nursing Homes. The office of that association is in my law office at 900 Fletcher Trust Building, Indianapolis, Ind.

I have been attorney for the association for better than 16 years. During that time I assisted in the formation of the American Nursing

Home Association, and served as general counsel for that organization for several years during the 1950's.

As you may or may not know, the American Nursing Home Association is a federation of State associations, and later in this statement I will comment briefly on the activities of that organization and the member State organizations.

According to advance publicity, the main purpose for your visit here is to investigate the catastrophe at Fountaintown, Ind., where 20 elderly persons died in a tragic fire on December 18, 1964.

Presumably, it is your desire to investigate the cause of the fire as the same might relate to our laws, rules, and regulations, and the enforcement thereof.

The association's comments with regard to the fire are perhaps best summed up in an article which appeared in our monthly news letter, which is set out as follows:

TRAGEDY—IT FINALLY HAPPENED

During the entire 20 years or more of the existence of IALNH, the specter of possible catastrophe has hung over us like the sword of Damocles. We have lived constantly in fear of that which finally happened at Fountaintown. Our heartfelt sympathy and condolences go out to Mr. McGraw and relatives and friends of the unfortunate victims.

Surprisingly, the public reaction did not take on the hue and cry for a "scapegoat" that we expected. In this regard, we set out verbatim the following editorial from an Indianapolis radio and TV station, WFBM:

"NURSING HOME CARE AND SAFETY

"Twenty elderly persons died in a tragic nursing home fire in Fountaintown last Friday. So it's only natural for all of us today to be asking ourselves what can be done to prevent such a thing from ever happening again.

"But it isn't simply a matter of passing a new law or strictly enforcing an old one.

"The nursing home at Fountaintown that burned was a frame building. But if you close up all frame nursing homes, where are you going to put the people in them. In Marion County, for instance, 22 of the 47 licensed nursing homes are frame structures. And more than 80 percent of the nursing home beds are occupied.

"If you prohibit patients from being kept on upper floors of frame buildings, or if you require sprinkler systems, or if you require other safety precautions, you add to the nursing homes' costs. Some of these costs will be passed on to the patients. And many people just can't afford to pay any more.

"The State welfare department estimates that close to half the nursing home beds in the State are being used by welfare recipients. County welfare departments pay an average of $5 to $6 a day per person for nursing home care. And a modern, fireproof, fully staffed and equipped nursing home charges twice that amount. So you can see the problem.

"Raising the welfare allowance would help. Passing the Federal medicare program would help. And Indiana's new Kerr-Mills program, going into effect January 1, will help a little. But there are drawbacks to all these proposals.

"We believe the State health facilities council must continue to press for stricter regulations of nursing homes—and homes for the aged, also. But real progress in this area can come in no less time than it takes to find ways to care for all who need care—at a price they can afford to pay."

Since their organization, both IALNH and ANHA have worked on the problem of improving nursing home facilities. It was through these associations' efforts that the FHA law was amended so as to permit the building of nursing homes under that program.

At the present, at Indiana University, there is a research program going on, a part of which is directed toward developing a model or prototype nursing home which could be built at a reasonable cost so that the nursing home industry in this State will have a pattern to follow in building new facilities. So you can

see that something has been and is continuing to be done regarding this problem. It is unfortunate that our efforts in this field were perhaps "too little and too late," insofar as Fountaintown is concerned. However, perhaps we will be in a position to avoid any future reoccurrences.

"The moving finger writes and having writ moves on * * *."

Let us be about our businesses and do that which we can do to avoid reoccurrences of such a terrible tragedy. Perhaps, with the help of the Almighty, our efforts will be rewarded.

In the above article, we quoted an editorial carried by one of our local radio and TV stations. We feel that this is probably about as succinct an analysis of the situation as can be given.

With regard to our laws and regulations here in Indiana, it is our considered opinion that they are about as progressive laws and regulations as you will find in any State in the Union.

The health facilities licensing council, which is the primary licensing agency, is made up of representatives from the nursing home industry, the homes for the aged industry, as well as the medical and nursing professions, and the hospital industry. In addition, the membership of that council includes the State commissioner of health, the assistant director of the State department of public welfare, and the State fire marshal.

This council meets regularly, and through its staff works diligently and understandingly in enforcement of the law and regulations. There are others who have or will appear here who will give you greater detail in this regard.

According to the press, there is some conflict as to whether or not the McGraw home was complying with regulations. The fire marshal advises that as of the time of his inspection the home did so comply. An inspector for another department advised that at the time of his or her inspection it was found that there was noncompliance in certain areas. They could both be right. However, your attention is called to the further fact that as a result of a grand jury investigation, no indictments were forthcoming.

There have been those who have thought, perhaps, that the fire safety regulations were not strict enough. It must be remembered, however, that the fire marshal as well as all officials connected with the licensing of nursing homes were confronted with the problem of having some place to care for these nursing home patients at the costs the counties were willing, and others were able, to pay.

You will be interested in knowing, however, that a special committee on fire safety regulations started meeting in September, and stricter fire safety laws have been proposed which, among other things, require the installation of sprinkler systems or smoke detection devices, or both, in type 4 and type 5 constructed homes. These homes are, for the most part, the converted dwellings.

The basic problem here is the matter of money. According to the State welfare department, the average pay for old age assistance recipients, who comprise approximately 50 percent of the patients in nursing homes, is from $5 to $6 per day.

Taking into consideration the many other regulations the nursing homes must meet, such as sufficient employees to provide 2½ hours patient care per day for each patient in the home, strict dietary requirements, strictly enforced health and sanitary requirements, special areas in the home for lounging and recreation for the patients, diversional and occupational therapy, et cetera, you can certainly see the

problem confronted by a nursing home administrator with regard to building a new fireproof or fire resistive structure.

The $5 to $6 per day rate affords nothing for capital improvement. In fact, as you can surmise, that rate does not even pay the current cost of care. In effect, private patients must pay a higher rate to help cover the cost of the welfare patient.

With further regard to welfare rates, we have a difficult situation here in Indiana, since each of our 92 counties sets its own rate, the counties' portion of which must be provided through property tax.

The solution to the welfare rate problem, as you can see, is not easy. Yet, the providing of safe nursing home facilities is directly dependent, to a large extent, on that solution.

It was indicated, also, in the publicity advising of your visit here, that you might be interested in other aspects of care for the aged, and it is in this regard that I would like to address myself briefly.

As I stated at the beginning, I assisted in the formation of the American Nursing Home Association. It was in my capacity as attorney of the Indiana association that that came about.

In 1949, 11 States held a constitutional convention in Toledo, Ohio, to form the American Nursing Home Association. The basic requirement for membership in the American Nursing Home Association was that the States, in order to belong, must have licensing laws for nursing homes.

It was largely through this requirement and the efforts of nursing home groups within States that we now have membership in the American Nursing Home Association of 48 of the 50 States. Our early efforts were directed to a large extent toward helping to get States to pass licensing laws.

Of course, the associations have been and are engaged in many other activities directed toward improving the nursing home as a health facility. These efforts are primarily directed in the educational area, for the nursing homes are as well if not better acquainted with their professional shortcomings as anyone else.

Here in Indiana, starting in 1953, we began presenting annual institutes on nursing home care under the direction of Indiana University Medical Center, here in Indianapolis. This was the background for establishing in 1964, a 1-year course under the auspices of Indiana University as an inservice training for nursing home administrators and their personnel.

This course covers both the business and patient care fields. It was fully subscribed for the entire year, and will be given annually hereafter. In addition, there has been instituted at the university a 4-year course for public health administrators, with the possibility of majoring in nursing home administration.

All of the above has been through the cooperative efforts of the university, the Department of Health of the State of Indiana, and the Indiana Association of Licensed Nursing Homes.

In addition to the above, the association is engaged in activities in other fields in care of the aged, health, and medicine, and is participating in numerous liaison and joint committees in this regard.

A more exhaustive and complete story regarding the State and National activities is contained in a statement presented to this committee on May 5, 1964, by William E. Beaumont, Jr., the then president

of the American Nursing Home Association. I heartily recommend that this committee review that statement, for there is very valuable information therein.

The nursing home, as you know, is the newest and youngest of the health facilities in the health care field. It came about because of a great need, and has continued because it is fulfilling that need. The acceptance of the nursing home by the more sophisticated professionals in the field has been slow and grudging.

The nursing homes understand the reasons for this, and through their State and National associations, are working diligently to overcome their shortcomings. However, what they may lack at this time in formal professional issue, they certainly more than make up in practical experience. They have much to offer in this area.

Mr. Sargent Shriver commented regarding his new duties under the President's war on poverty program to the effect that if you want to know about problems of the poor people, you certainly should expect to consult with poor people, and it was his plan to do so.

May I suggest that if you want to know about nursing homes and the care of the aged, you should consult extensively with nursing home administrators. There are many highly competent people in the field that can give you much assistance.

That completes my paper. I will be very happy to answer any questions that you might have.

Senator Moss. Thank you very much, Mr. Latham, for a very fine statement.

Representing as you have for many years the nursing homes, we are glad to have you come and give us your comments.

You pointed to the Fountaintown tragedy, and that is not really the reason we are here, although we are interested in all the surrounding facts and what we can learn from them, but we are on a much broader factfinding mission than that, and I think you have helped us a great deal in what you have said.

I think your comment at the end of your statement is most ture, and one that we should follow, in consulting with the nursing home administrators themselves to learn all we can about the problem.

How many of the nursing homes in Indiana belong to your association, approximately?

Mr. LATHAM. Approximately a third.

Senator Moss. Has this been constant now for some time, or are there more joining all the time?

Mr. LATHAM. It is a relatively constant figure, varying maybe to 10 to 15 homes from that figure of a third above occasionally, very seldom below that.

Senator Moss. The association obviously can do a great deal in standardizing and teaching and assisting. I wondered if you have any proposal or any suggestion as to how the others might be encouraged to come into the association.

Mr. LATHAM. I have been trying for some 16 years to get the others in, so I think any suggestion that I have at this point would be of little value, because obviously I have not particularly succeeded.

I think probably our basic difficulty is just as the nursing homes, difficulty in building a new structure or getting capital funds to do so. We can only do so much, as our membership and our income from the dues of the membership can do.

We need, of course, and are well aware of the fact, that we need considerable public relations work. We do the best we can under the circumstances, but at the present time we are unable at any rate to employ a full-time public relations consultant.

We believe this is essential, in view of the fact that various departments of State government and various departments of National Government have hired public relations consultants because they see the importance of public relations consultants in this connection.

The association takes positions on many problems of national importance. We have prepared statements with regard to the proposed medicare proposal now. It is Senate Resolution 1. It is before the committee at this time, I presume. I am sure they have attempted to get it in, and I am sure it is in there.

But how to get more people in, I think very frankly, and this is a personal observation, the nursing home, at least of the past, is changing considerably at this time. A nursing home administrator was a relatively unsophisticated person, not necessarily aware of the value of an association membership. They pay $25 for something, and they wanted to see what they got in return for it.

And quite often, if you are aware of an association activity and what the association can do, much of what you get back is indirect, it is to build the image or whatever it may be, but again that is a matter that I think is slowly changing.

There are many different personalities that enter into it, many things like that. It is changing, we think. Slowly we are picking up our membership. The association has always stood, and as I said, its basis for functioning was to get State licensure.

Here in Indiana I happen to be aware of the fact that—I was not attorney for them at the time—they went at that time, in 1943 or 1945, I forget which, to the Government, as a matter of fact, and asked, that was before we had a license, and asked that we be licensed, because there were those sincere, honest people being tarred with the small brush, with, well, the same snakepits, that were in existence at that time.

There has been a constant effort to improve themeselves, and to improve the profession as such. Over the years I have met, from all over the United States, some of these people. Believe me, it is a particular kind of a person that runs a nursing home, a person who has a heart as big as all outdoors. They can stand the difficulties and the senility of these patients, fortunately, or unfortunately, or whatever it may be.

I could never be a nursing home administrator, I have been in their homes, many times, and I come out so depressed at age as I see it. But these people can take it, they do take it, they treat these people just like little babies, and it takes a special kind of person to do that.

They may not be formally educated in many instances, although they are rectifying that to the best of their ability, but they have the heart it takes to do it.

Senator Moss. I assume your members are proprietary homes, in the main.

Mr. LATHAM. In the main, yes, but we have both.

Senator Moss. Is the margin very precarious on operating these homes? We have talked a great deal today about the fact that so many people who are residents of these homes have little with which

to pay for their care, and consequently it reflects back on the income of the home, naturally.

Mr. LATHAM. Well, it is a very small margin, for the most part, unless you limit yourself and refuse to take welfare patients, but most of them are in small communities, and feel obligated to take welfare patients for what cost they can pay.

Many times they will have a person who has been in there as a private paying patient, and eventually that person's funds run out. Well, a difficulty arises, then, in getting transferred to welfare in which it is a 3-month proposition. And the nursing home will take care of the person and never get paid for it.

At one time in one county in the State the pay was $27.50. That has changed, I hope and presume. In most of the appeals for changes, there have been increases. You get the public interest.

Usually people who sit on those appeal boards in those counties have the first acquaintanceship with it. There have been some 20 appeals taken, and in only 2 instances have they been denied—that is, to my knowledge.

On the other hand, the fact that there was an appeal has caused many county boards to increase their rates somewhat. It is still low. These regulations are strictly enforced, and understandingly, by the visitors from the board of health. They try to work with these people, most of them do.

In addition, the health department has a number of seminars on how to train a nurse's aid. That is another problem. One of the big problems in nursing homes is getting competent help. For many of the help they have to get people in and train them. It is not unusual alone in nursing homes. In hospitals they are having difficulty in getting L.P.N.'s and R.N.'s and aids.

Most people get training in nursing homes, and then go to work in hospitals. That has happened in many cases. These nursing home people actually take these people and train them to deal with these elderly people.

Senator Moss. Do you have any figures of the average after-tax income of the proprietary homes here in Indiana?

Mr. LATHAM. I do not have any such figures. We do not have any in the association. There has been no research along this line. As a matter of fact, we at one time attempted to get a grant from the Federal Government to find this out, and there is presently a program going on as a result of efforts of the American Nursing Home Association to have an investigation to determine this. At the present time I cannot give you any such figure.

Senator Moss. Thank you very much, Mr. Latham.

Does the staff have questions?

Mr. Frantz has a question.

Mr. FRANTZ. Just a couple of details, Mr. Latham.

You stated that your association represents, or has a membership of about a third of the homes. What proportion of the total beds does this one-third of the homes represent?

Mr. LATHAM. First I will tell you that at the present time I do not know what the figure is now, but as of last year there was about a 20-percent turnover in nursing home licensure every year. It would be my guess that I would say that we would have just a little less than half the beds.

Mr. FRANTZ. Which would indicate that you tend to have the largest homes in membership.

Mr. LATHAM. Yes.

Mr. FRANTZ. One other point which you mentioned in your statement, the special committee on fire safety regulations.

This is a committee of your association?

Mr. LATHAM. No, this is an ad hoc committee of the board of health. I happen to serve on it, along with the fire marshal, three members of the Nursing Home & Health Facilities Council. Dr. Resiser, Mrs. Pearcy, Dr. Edwards, and the deputy attorney general assigned to the health department, and myself. There are five of us.

Mr. FRANTZ. Has your association yet taken a stand on the proposed sprinkler and smoke detection regulations?

Mr. LATHAM. I think our association position is perhaps the same as the American Nursing Home Association, in that regard. We do take the position that we approve the use, particularly where there are bed patients involved, of these protective devices on the second floor, and, as a matter of fact, throughout the entire structure under certain circumstances.

It has also been suggested that, and it is being investigated at this time, there are those who maintain that you can build a single floor new construction and sprinkler it, or put in smoke devices, either one, and have just as safe a facility as a type 1 construction, so-called type 1, which is the fire resistive 4 or 2 hour, or whatever it may be, since that principally is built for the purpose of protecting the building, not the people who are in it.

So there is the question of the use of these sprinklers. There is a school of thought that the use of sprinklers and fire detection devices better protect the individual in the home than just the mere fact that you build a type 1 fire-resistant protection, because it is not fire resistant rugs or drapes that you are putting in.

More lives are lost, really, as I understand, from seeing these fire protective devices shown, from heat and smoke inhalation, from the gases, than from burning itself.

Mr. FRANTZ. If I may interpret your remarks, you endorse the use of these devices, but you are not endorsing a regulation requiring them.

Mr. LATHAM. Yes. It is a proposed regulation. It still has to go through the promulgation channels of any regulation so that it has the effect of law.

Senator Moss. Mr. Miller?

Mr. MILLER. You indicated that approximately one-third of the nursing homes are members of your association, and, as a result of Mr. Frantz' interrogation, that this involved approximately 50 percent of the beds?

Mr. LATHAM. I would say less than 50.

Mr. MILLER. In making reference to the statement made by Dr. Offutt earlier this morning, I note that there are about 5-to-1 proprietary versus nonproprietary homes in the State, and that proprietary homes account for 60 to 65 percent of the total beds licensed in the State.

I was curious as to the percentage of nonproprietary homes having membership in your association.

Mr. LATHAM. I think it is a little less than 5-to-1. I would say more than 5-to-1. I was say it was less than 10 percent.

Mr. MILLER. Is there any particular reason?

Mr. LATHAM. One particular reason is that they have their own association, the Homes for the Aged, and many of them belong to that association, particularly the charter and church affiliated homes.

Mr. MILLER. These institutions, however, are a broader service institution than a nursing home, per se. They are homes for the aged with nursing home facilities available and within them?

Mr. LATHAM. Generally speaking, sir, that is correct.

Senator Moss. Thank you very much, Mr. Latham. We do appreciate your coming and testifying before this committee.

Mr. LATHAM. Thank you.

Senator Moss. Dr. Edwards, the vice chairman of the Indiana Health Facilities Council.

Dr. Edwards, we will be very happy to hear from you, sir.

STATEMENT OF DR. EDWARD T. EDWARDS, VICE CHAIRMAN, INDIANA HEALTH FACILITIES COUNCIL

Dr. EDWARDS. Senator Moss, ladies and gentlemen we are very happy to be here and to give you what little help we might have to offer for your consideration.

I would like to read the remarks that have been prepared. I feel sometimes like Jesse Dickinson. What I wrote yesterday I have improved on today, and feel like talking longer, you know.

Senator Moss. Go right ahead, sir.

Dr. EDWARDS. Several of these speakers are pretty hard to follow.

From a history standpoint, the Nursing Home Committee of Knox County Medical Society submitted a report of a survey on June 19, 1962, with recommendation that the society establish a Chronic Medical Service, which was approved. During the following 12 months, the society members took turns inspecting patient care in the nursing homes in the county.

In other words, we criticized ourselves, and thought maybe we could do something about it.

When the Chronic Medical Service started, or in the first 12 months, each physician took a nursing home and went through and checked every chart and patient and made comments as to what he thought should be done, and they were rather frank. We were all friends, and felt free to speak frankly.

This actually provided a free consultation for the patient. It provided constructive critism for the attending physicians, and the important thing it gave those physicians who normally do not go into nursing homes a pretty good idea of what the situation was.

On this base we were able to continue our studies. Several suggestions were made for improving care. The inspection was interrupted in 1963, because we lost a large percentage of the physicians actually providing initial nursing home care, and it made us assume a task force approach, rather than the initial rotating service.

Those of us that were particularly interested then started working more with local operators trying to improve the various aspects of nursing home care that we felt needed improvement.

That is what we have been doing since the termination of our first year following our report to the Knox County Medical Society. We

feel much has been accomplished as a result of the interest shown by the operators and the community.

It was an entirely voluntary program by the medical society with only those who were interested joining the Chronic Medical Service. However, practically every active member participated.

Since the patients were usually under the professional care of generalists and internists, many of the specialists for the first time realized the wealth of clinical material available.

While the rotating physician's "looking over the shoulder" of the attending physician's management of individual cases in order to make constructive suggestions was useful at times, the consensus of opinion was that we might utilize the specialists better if we would conduct special surveys in each field of the nursing home population.

The Indiana State Dental Association has just completed a dental survey locally. There are plans for glaucoma, diabetic, tuberculosis screening programs for this year.

From the experience of the past 2½ years, several factors have been recognized as important in providing the desired level of physician care of these patients:

1. There must be a change in the local attitudes, image, if you like, concerning nursing home care, if patients, their families, doctors, registered nurses and other auxiliary personnel were to fully utilize such facilities, and we could develop the nursing home to its greatest potential.

I would like to say now that Dr. Mason this morning was a little critical of the press. I actually feel a little differently about that. I feel here is the place the local press can really do some good.

I realize they sell newspapers on the basis of what people want to hear, and the more horror, the easier it is to sell, but it would really help the operators and the patients and everybody else if the press would play up some of the things that are actually being accomplished, and not talk all of the time about our bad points. We are all pretty familiar with them, and we need public support and encouragement of the public that something can be done and is being done.

2. The level of patient care must be of a quality comparable to that of the local hospital to obtain patient and physician confidence.

3. Safe, functional, attractive physical facilities of at least 50 beds are needed.

We feel that to provide these service you have to have a large enough number of patients to be a sound financial operation, and to be able to provide the things we think are just over the horizon if not actually here today in providing the level of care that we need.

The doctors at home really appreciate the activities of the council in providing licensing requirements and minimums. We appreciate the fact, too, that the various inspectors really have a rough job.

The State fire marshal's office has been in the limelight here in Indiana for several years, and I do not recall that their budget has increased as fast as their publicity.

Inspectors have problems, too. It is like my seeing a patient. Today I visit the patient. He looks good. There is nothing that requires immediate care. Tomorrow, the clinical situation can change and this happens with any inspector, too.

Thousands of us who were in the Army remember the GI inspection days, and we looked pretty sharp on those days, when a few hours later things were pretty different.

4. Registered nurses with recent general hospital experience in directing aids and orderlies, familiar with local physicians, and physically and emotionally capable of rendering chronic disease care are most effective.

You just cannot take every nurse and put her into a nursing home situation, just like you cannot put her in surgery and have her do a good job. We have to have people physically and emotionally adept at providing this type of care, because it is quite different from the other aspects of nursing that we are familiar with in the general hospital.

We expect them to carry on in a small town much as would an intern. The nurse has to be able to evaluate the patient's condition and realize when is the time to call the doctor. She also has to be able to lead and direct people.

So we feel that the nurse is a critical person here, and it takes a special kind of nurse. And I realize, because I have been hearing this for several months in the council, that these nurses are not too plentiful.

Recruiting efforts for nurses must be realistic as far as the local demand situation and supply is concerned. In other words, you cannot say what you want to pay the nurse and then say, "I can't get them." You have to meet the going rates. You have to provide facilities. You have to give them a professional environment.

You must, in other words, compete with the general hospital, if you want the kind of nurses that you need. The same thing is true of the other people that are working, the aids and the orderlies.

In Indiana there is a growing movement, which I think is going to help us in this situation of supplying nurses, the 2-year program that Purdue has developed. There are several schools that are increasing the production of nurses, and I think that this provides considerable optimism for the future.

5. Proven business methods, including accounting, budgeting, purchasing, planning, and personnel policies are a requisite for operating such facilities. It is anticipated that as graduates of hospital administration become more plentiful, they will be absorbed in this field.

This does not mean that nursing homes should in every instance be affiliated with general hospital. In fact, this might well limit the growth of this segment of medical care by passing on to nursing homes the general hospital's high cost of operation and its lack of sufficient capital funds for its own modernization and expansion. Nursing homes have been stepchildren too long now.

It is anticipated as more hospital type trained individuals are available that they will gravitate to this area of care.

As you know, the Hill-Burton mechanism is trying to help with financing nursing home construction. There has been much said today about increasing the Government interest in the nursing home field, and I hate to have our local situation with our hospital transferred over to nursing homes.

I do not think it would be an improvement, because we have what we have been told by the State fire marshal's office during several licensure inspections that it was a fire trap, and yet we have had conflict between

the board of governors and the county commissioners, and we are not building the needed new facilities.

Local politicians are not providing adequate general hospital facilities in our county. We do not want similar conditions to affect nursing homes.

6. Chronic or convalescent stage care in nursing homes can and should take its place in the concept of progressive patient care. In many instances it is more feasible for private capital, in part or in whole, to provide these facilities, permitting public funds to be expended on the acute general hospital.

7. Since 50 percent of nursing home patients at present are supported by public funds, and the percentage can be expected to increase with aging trends, and the changed public philosophy, adequate care can only be provided by adequate financing based on comparable financial statements resulting from uniform accounting methods.

In other words, I sympathize with Albert Kelly's people in the welfare department when they are trying to be just in their hearings, and yet they cannot compare apples and oranges. Different homes bring in statements, and you cannot tell which one is right, or even close to what it should be, because of inadequate accounting methods.

8. Voluntary health insurance financing of these patients is dependent upon the above plus a clear professional delineation of diagnosis, including the estimation of reasonable length of stay per condition, taking into consideration the occurrence of definable intercurrent acute illnesses affecting the chronic illness, for example, arthritis, amputees, arteriosclerosis, diabetes, emphysema, and so forth.

9. Training programs for nursing home personnel are needed. In addition to the licensed practical nurse programs in Indiana, special intensive local educational efforts should be made to acquaint the entire staff with rehabilitation, psychiatric, and emotional problems of aging, and a continuing refresher course in medical techniques as applied to chronic illness treatment.

There are a lot of problems in just being lonely that can give symptoms. I think we are all familiar in this day and age with psychosomatic illnesses, and that is different from the senile-psychotic patient. We should have programs to help us train the people who take care of these patients to do a better job by understanding the patients.

These classes might be conducted by teams from the regional State mental hospitals, local general hospital, State board of health, local medical specialists, and others.

10. The attending physician should make at least monthly rounds on each patient under his care, and should be available for interim care or followup visits and designate alternates during his absence, so that the nursing home knows whom they can depend on for professional guidance.

11. A medical staff organization is necessary. The exact manner in which it is developed should be adapted to the prevailing medical community situation. It might be sponsored by the local medical society, the local hospital staff, or the nursing home.

In a community with only one general hospital and several nursing homes, either the county society or hospital staff makes a coordinated program relatively simple with the county medical society being fa-

vored, since the various hospital committees under the Joint Commission on Accreditation pretty well fills the agenda.

In a community with several general hospitals, the medical society is the one nucleus for all physicians, where they may benefit from an exchange of ideas and information. Closely integrated hospitals with their respective nursing homes might create unequal utilization of the existing facilities.

12. The question of "closed" medical staff, one house physician, versus "open" staff or private physician for each patient depends upon the patient and medical community preference and established practice.

While a workable system is theoretically possible under the "closed staff," in our area patients are accustomed to making their own choice of physician and consultants. They feel less "institutionalized" if a familiar doctor in whom they have confidence is providing their medical care.

This refers to the remarks I made about the loneliness, the lack of family, perhaps, and frequently the patient's only contact with his former life is the doctor that he has known for years.

We feel that this method of a continuing physician is better able to carry out the concept of progressive patient care, avoiding the assembly line production of "cases." Patients are people who like to feel that the doctor has a personal interest in them, not the administrator.

13. Medical records are necessary to refresh the memory of the attending physician or to provide a quick review of the pertinent medical facts for the consultant or substituting physician. Many times the patient's recall is not complete or accurate, and the floor nurse may not be familiar with these details. She, too, can give better care to the patient if she is informed of the patient's history and planned therapeutic program.

14. If the patient is transferred from an acute general hospital, a copy of his clinical summary may suffice for the admitting history and physcal examination. If he is a direct admission from home, the Knox County Medical Society furnished form is used to record the clinical information by his doctor.

The county society has prepared a simple form which we are encouraging the doctor to fill out so we have a history with pertinent data. We did not like the old form furnished by the State board of health, so we developed our own.

15. Progress notes should be written by the physician at each visit to the patient. In hospital rounds progress notes are written every 3 days. Because we visit nursing homes less frequently, each visit should have a written note. If the patient is transported to a consultant's office or the hospital outpatient department, the NH chart should accompany him, so that the information is available, progress notes can be written, and orders signed. Laboratory reports should be attached to the chart, also.

16. If a patient is temporarily returned to the hospital for inpatient treatment, a copy of the hospital clinical summary should be placed in his NH record.

17. Nursing and medication records should be as similar in format, as possible, to the local hospital records, to avoid confusion for the nursing and medical staffs.

18. The attending physician and nurses should be alert to excessive continuation of medication and to necessary laboratory control of therapy. Blood sugars, prothrombin times, and blood counts are among common laboratory procedures indicated, as well as recheck X-rays.

Such professional cooperation can be provided through local laboratories or through the local specialists' office facilities for laboratory testing.

19. Consent forms signed by the patient or responsible relative should be part of the chart, permitting transmittal of records and examination and treatment by alternate physicians.

20. It should be recognized that the principal source of physician care in nursing homes falls on those general practitioners and internists who are providing initial and continuing care for the community.

Specialization has removed a large percentage of physicians from this sector of professional care, except for consultation services. Physicians assuming prime responsibility for NH patients are also those providing office, hospital, and home care.

While this provides the desirable continuity for good clinical management, it frequently results in a physical impossibility to be in each area of medical service at the same time. The actual result is that the NH visit is made during so-called days off or at night.

21. Adequate remuneration of physician visits is a practical consideration, if desired professional care is to be available for these patients, because this is becoming a large segment of the practice, and we feel that we have to be realistic.

22. Rehabilitation services in nursing homes are needed and fruitful, but the shortage of trained personnel prohibits offering these services, even in many general hospitals.

Frankly, I think, as a practicing physician first to try to get the PT's and OT's and others that are required for rehabilitation in the hospital, and then try to supervise and train some of the people working in nursing homes so that they can do relatively simple activities in this field, and continue a program that was initiated.

23. The future of nursing home care is one of growth. Preventative medicine, early diagnostic efforts, chronic disease research, better utilization of general hospitals, increased dependence of paramedical personnel, greater use of social service and volunteers, and expanded treatment procedures are all facets for further study. Knowledgeable people working together can do much to improve the outlook for the chronically ill.

Once again, the press can help us in interesting people to come in and donate time, as they do in hospitals. Dr. Salon spoke of home care services. This is feasible in some of the larger communities, but in the smaller ones, we feel that home care services may not be as efficient due to shortage of personnel.

The nursing home has developed as a replacement for the traditional home care program, because of the demographic changes. With working wives, there is nobody at home to take care of grandmother or Aunt Nellie, so the people they used to hire to come in, the so-called practical nurse, is now working in a nursing home, and it is very difficult for us to set up programs for the type of patient who really requires a great deal of care.

We feel that perhaps the boarding home concept has a place for the graduate of a nursing home, as they become rehabilitated. As

they become more independent, it is realistic to consider more boarding home concepts.

And in that regard we would like to support Mr. Kelly's remarks for more money for the boarding home aspect of chronic disease care, because we feel there are patients in nursing homes in this in-between level. They are not completely independent, yet they do not require comprehensive nursing care, and better financing for boarding home care would be a big help.

When we talk about financing, much has been said today about the root of the problem being financing. What we need is more dollars. Maybe this is oversimplifying, like this statement that money will not buy love, but it certainly helps support the results.

The money is a secondary aspect. It will come if we can provide information and get local community support for this segment of medical care, if we can enable through the local press the local citizens and tax authorities to understand that you have to provide sufficient funds if you want to deliver the type of care you are promising before election.

The personal approach is very necessary, and in spite of the things the Federal Government can do for us, and we appreciate this, they cannot do it all. They can give us seed money, they can give us encouragement, they can help keep us aware of good standards, but basically, we have to do this at home. It is a community problem that money alone will not solve.

Now, there have been other comments about this. Someone talked about King-Anderson. We have heard a lot about that recently, and of course we have some ideas on that.

This phase of the program, as I see it, and I am talking now as a practitioner at home, is primarily designed for posthospital extended care for 60 days. In our survey we found that 60 percent of our patients in nursing homes had come not from a hospital which would make them eligible for King-Anderson, but had come either directly from home or had been transferred from another nursing home.

So we wonder if this is really going to help as much as promised.

Furthermore, we anticipate that there is going to be a battle of paperwork, because if a patient now is on OAA or MAA and develops an illess and must enter the hospital, administrative personnel will have forms to complete to be eligible for the King-Anderson provisions.

After the hospital stay and after completing the nursing home stay for this 60-day posthospital extension, we have another administrative switching of records back to that OAA or AMA.

If this is not going to give Albert Kelly's people headaches, I do not know what will. I know it is going to give some of the doctors the blues. We do not like filling out forms.

I think that is one thing we learned in the Army. I think the biggest problem in this program that the legislators should remember is an analogy with the Army. You know SNAFU was a real problem there, and we anticipate it might be a problem here with some of this approach to handling the problems of nursing home care.

The majority of the people, according to Gallup, cannot quite understand this. I think the physicians' resistance to the King-Anderson type legislation is on a practical level. Will K–A be as good a pro-

gram to work with as what we now have under the welfare program of the expended MAA which takes in more people?

Actually, we found in our survey at home that when you have a patient in the nursing home, they stayed there. Out of 122 patients, 86 percent of them are over 70 years of age, and that females outlive the males about 2 to 1, that 21 percent had been there less than 6 months, but an additional 33 percent had been there for up to a year, between 6 months and a year, and that 23 percent more had been there 1 to 4 years, and 10 percent more had been there from 4 to 8 years.

So we think perhaps that the program we now have can be helped by improving the boarding home aspects and improving the OAA or MAA perhaps from the standpoint of eligibility, and expanding from an income level standpoint.

It is going to take more money and it is going to take more interest by all of us, not just the administrator and not just the U.S. Senator.

Thank you very much for this opportunity.

Senator Moss. Thank you, Dr. Edwards, for a very comprehensive statement.

You commented very pointedly on your prepared text. I am going to ask that the whole text go in, because you did skip some small parts, and it also has two very fine attachments that I want to be made a part of the record. So that will go in.

(Attachments referred to follow:)

REPORT OF KNOX COUNTY MEDICAL SOCIETY NURSING HOME COMMITTEE, ADOPTED BY KNOX COUNTY MEDICAL SOCIETY, JUNE 19, 1962

Knox County Medical Society shall establish a subdivision, "chronic medical service," to improve the patient care in nursing home and/or convalescent institutions.

(1) To provide a medical staff organization for institutions not presently covered by the Joint Commission on Accreditation of Hospitals.

(2) To provide a rotating system of patient consultation and supervision by members of the chronic medical service.

Active membership of C.M.S.: Shall be members of the KCMS who make application to CMS and who agree to abide by the concepts and practices instituted.

Associate memberships: Shall be those licensed practictioners of medicine who, although they are not members of KCMS, attend patients in the particular institutions, and who make application and agree to abide by the concepts and practices instituted.

Organization of Chronic Medical Services: Appointments will be for 1 year subject to recommendations of the Board of Censors of KCMS and approval by the KCMS membership. There shall be a chairman and a secretary of CMS elected by its membership annually.

Budget will be approved by KCMS with any financial support being the responsibility of KCMS.

Consultation and supervision procedure: Physicians will rotate in making monthly bedside rounds on all patients (number per doctor to be determined on feasible basis) and notifying the attending physician by personal communication of any comments and/or advice which is pertinent. The rotating physician will not make any entries on the patient's chart unless requested to do so by the patient's attending physician. The rotating physician is not assuming diagnostic and treatment responsibility for other than his own patients except in an emergency until the patient's own physician can assume professional care of the problem. This rotating service will be free to the patient and a KCMS community service.

Chronic medical service recommendations:

(1) Attending physicians should visit each ambulatory patient at least every 2 weeks. Intercurrent medical problems will be attended with frequency and in manner necessary to the best judgment of the doctor.

(2) Registered nurse should be in daily attendance in each institution caring for bedfast patients.

(3) Medical records must be legible and in sufficient detail to provide the rotating physician with a working knowledge of the patient's medical problem. Copies of clinical summaries of the hospital stay should be attached to the chart if the patient was transferred from an acute general hospital. Progress notes should be written in each patient's chart when the attending physician makes a visit.

(4) During an absence, the attending physician should provide patient coverage. Personnel of the institution unable to locate the doctor may:

(*a*) notify his professional associate,

(*b*) call the "Doctor's Call Service" to obtain his alternate,

(*c*) refer to patient's chart for written list of alternates, or

(*d*) call any available member of the chronic medical service.

(5) Patients should have an admission or recent laboratory study performed and recorded, including cbc, urinalysis, and such other data as is pertinent to the admitting diagnosis. Following lab studies should be performed consistent with scientific medical practice having due concern for the economic efficiency in clinical management.

(6) Intramuscular, subcutaneous injections, catheterizations, and similar procedures should be performed with disposable equipment which are available to avoid cross infection and to eliminate the need for expensive sterilizing services.

(7) If indwelling catheters are used, the patient should be given urinary antiseptics with rare exceptions. When catheters are changed, they should be removed in the early morning and the patient checked for residual which is then recorded at the time of reanchoring the catheter. Urologist will make monthly rotating rounds on all patients having catheter drainage.

(8) Rotating physicians will review all of the charts of patients deceased during the preceding interval with pertinent comments given at the monthly meeting of the chronic medical service.

(9) The CMS will have monthly meetings in conjunction with the KCMS meetings, at which time the care of these patients will be discussed. Records will be kept by the CMS secretary, who will be responsible for an addendum to the KCMS minutes and dissemination of information to CMS members, as well as maintaining the roster of rotating physicians.

(10) Rotating physicians inspections will be during the first 2 weeks of each month.

(11) Consent forms for inspections by rotating physicians will be signed by patients or responsible relatives and placed in patient's chart. Consent forms for release of information from VA hospitals, etc., will also be signed.

M. C. McDowell, M.D., *Chairman.*
E. T. Edwards, M.D., *Secretary.*

Nursing Home Survey, Knox County, Ind., June 1962. Approved by Knox County Medical Society, June 19, 1962

This survey was conducted by a committee of the Knox County Medical Society to obtain a broad view of nursing home patients and the professional care which they receive.

The attached tables reveal that 122 patients were located in three nursing homes in Vincennes and one in Bicknell, Ind.; 86 percent were over 70 years of age. There were nearly two females for each male patient (63 to 37 percent). Twenty-one percent of the patients had been there less than 6 months, and an additional 33 percent of the patients had been present less than 1 year, but 23 percent were in the 1- to 4-year category and 10 percent ranged 4 to 8 years. It is interesting to note that Bicknell, having the State's highest average age for a community, had two-thirds of its patients over 80 years of age. Indiana Welfare Department (OAA) and township trustees financed 59 percent of the patients, with the remaining being paid by savings, family, and combinations of social security and self pay.

Most of the patients were admitted from their homes (45 percent), with transfer from a general hospital being a close second (40 percent), and the remainder being transferred from other nursing homes.

Diagnosis, as recorded by the attending physician at the time of admission, revealed the patients frequently had multiple, chronic illnesses. Circulatory

conditions were most common, with 27 percent of patients having cardiac disability, 14 percent strokes, and arteriosclerosis in 17 percent. Fractures, usually of a hip, accounted for 14 percent of patients, with some of these occurring after admission. Diabetes mellitus afflicted 8 percent and arthritis was significant in 17 percent. Urological conditions were found in 18 percent of the patients. Only two patients had carcinoma. Parkinsonism was the diagnosis for 3 percent, but 17 percent were described as senile, mentally disturbed.

General practitioners were responsible for the care of 78 percent of the patients, with internists having 16 percent and general surgeons attending 6 percent. The Knox County Medical Society has 25 percent GP's, 7 percent internists, and 17 percent general surgeons. Urologists were the most frequent consultants.

The patients which were bedfast composed 35 percent of the total, with 65 percent being ambulatory. Some of these were using walkers or wheelchairs. Those considered bedfast had to be lifted to chairs. Twenty percent were considered as capable of self-care, with the exception of bathing, and another 35 percent could partially perform their acts of daily living, e.g., eating.

There was extensive use of oral medications with 76 percent receiving over three doses per day. One to three doses per day were given to 12 percent, but 11 percent did not receive any oral medicine. In-dwelling catheters had been used in 21 percent of the patients at some time during their nursing home stay. Subcutaneous and/or intramuscular injections had been given to 30 percent of the patients at some time while there. These included insulin, antibiotics (usually procaine penicillin), liver and B_{12}, diuretics, and psychotherapeutic agents for disturbed patients. Clyses were used in one home for 25 percent of patients as well as levine tube feedings. Oxygen by mask or nasal tube was used on rare occasions.

Some nursing homes had space for isolating or grouping patients who were confused, noisy, and disturbing to other patients. About 14 percent of the patients had at one time or another been disturbing.

Laboratory studies were usually confined to urinalysis and blood sugars ordered for 7 of the 10 diabetics. While many patients received hematinics, it was rare to have followup hematocrits or hemoglobin determinations. Admitting diagnoses included "anemia" for 6.5 percent of the patients. Urological consultations in Vincennes frequently were done at the specialist's office where laboratory studies were performed. Bicknell patients had lab tests performed by attending physicians.

Regular physician visits were made by only one or two GP's in Vincennes. Usual means of patient-physician communication was by nursing home personnel telephoning the doctor who either phoned a prescription, gave instructions to the personnel, or made a visit. This places considerable responsibility upon employees or the operator whose experience is not much greater than that of a member of the patient's family. Sometimes the attending physician was slow to respond with a visit to the patient. While phone prescriptions may save the patient or paying agency the price of a visit, the physician assumes too great a responsibility and misunderstandings may result in less than adequate care for the patient.

Intercurrent acute illnesses or exacerbations of chronic disease are not uncommon in these patients. Expensive hospitalizations were frequently avoided by use of medication by other than the oral route.

Rehabilitation procedures, e.g., ambulation training or practice, were not common due to lack of facilities and experienced personnel.

Physician records were scant with few patients transferred from a general hospital having a copy of their hospital summary sheet. Admitting diagnoses and occasional progress notes indicated the patient's course. With the exception of those physicians having associates in the office, professional coverage during an attending doctor's absence was largely left to the "doctor's call service" and the industry of the operator of the home.

Diets were supplied by the State board of health whose inspectors were more concerned with physical facilities. Licensed practical nurses were used when available. RN's were not in attendance at the time of this survey. During the past year, the largest nursing home briefly employed an RN with unhappy results. The registered nurse apparently does not feel at ease in a nursing home situation and is inclined to stress "the hospital way." Obviously, different means must be developed for nursing homes to achieve maximum quality care without increasing costs to hospital levels.

Physicians should consider a medical staff organization for nursing homes which would be feasible in raising the standards of patient care. This group should make pertinent recommendations to physicians, nursing home operators, and others concerned with the care of chronic disease.

ADMITTING HISTORY and PHYSICAL NURSING HOME

Last Name	First Name	Attending Physician	Alternate Physician	Consultants

Adm. Date_____ Age_____ Sex_____ S. M. W. D. Race_____ Occupation_____

Present Illness—Onset - History - Complaint

Past History - Operations - Hospitalizations, Etc.

Physical Examination

Lab. Data:
C.B.C.
Urine
Bun
Others

Date Last Chest X-Ray
Result:

Diagnosis:

Planned Therapy:

Nursing Requirements:
a. Douicilary
b. Intensive
c. Chronic
d. Rehabilitation

Form Approved and Supplied by the Knox County Medical Society

Senator Moss. I was interested in your pointing out the great need we have for registered nurses or licensed practical nurses, in these nursing homes. This morning I believe Dr. Offutt said about 20 percent of our nursing homes had no nurses of either type.

What is your recommendation on that?

Dr. EDWARDS. We have been arguing in the nursing home council that greater effort has to be made to obtain the nurses to work in a nursing home.

We have found locally that when we improved the facility, that we could get our nurses easier. We did not change the supply of nurses,

but we changed the willingness of nurses to work in this facility. That was a big help.

We think, too, we need to change the physicians' attitude and the community—the public's attitude. In other words, that is the reason for the remarks about image. A nurse likes to work in a place she can be proud of, and she does not like to have someone saying, "I am working out in a snake pit." They think she is an inferior nurse.

The community attitudes have to change, the doctors' attitudes. The facilities have to be good. There has to be a recognized high level of care, if you are going to get the kind of people you need.

In many instances in our own situation it was not really a shortage of nurses, it was a shortage of willing nurses. I think this is true in large part.

Also it is a matter of budgets. I am speaking now of budgets for the operator. You almost think of them as stipends, some little pittance handed out to take care of these people. They cannot compete for qualified personnel without sufficient funds for nursing home care.

So we endorse their pleas for sensible amounts of operating capital, if they will follow through and employ the people they say they are going to get.

We feel this new nurse training program is going to make more nurses available over the State, and that the alternative is that if you cannot supply the level of nursing care in a particular existing nursing home, then perhaps the thing to do is to stop trying to give comprehensive nursing care in that particular place and switch over to the boarding home type operation. There is a large group of people that fall into that category.

And then you get back to the support payment. That $70 a month would not supply the facility and even the relatively small employee force needed to operate the boarding homes.

I think many of the operators faced with a shortage of trained personnel in their area would do better to concentrate on the boarding home approach, and many of these people are of the welfare category, providing that the agencies do come through with more realistic payments.

And I think maybe that could be your committee's biggest contribution.

Senator Moss. I appreciate your recommendation that nursing homes ought to have about 50 beds or more to reach the optimum of service. Might there be some effort made at consolidation, then, of a number of smaller sized ones?

Dr. Edwards. Actually, this is somewhat a natural result of the efforts to raise standards through licensure. Some are faced with the decision, "Do I put more money into this, or do I get out and go to work for another operator?" This is a real thing.

We have to remember that nursing homes grew kind of like Topsy. Frequently they are operated by middle aged or elderly women, and they got into this because it was easier to bring the people to their home, and they gradually added on. Then they had gotten into such a big business operation it is difficult for them to meet modern standards of care.

And as far as the "profits," so-called, most of these operators are getting mainly personal satisfaction plus bed and board, but they are not getting enough profit to provide for their own old age.

In other words, this is not a real lucrative industry, and the bulk of our people in Indiana doing this kind of work are doing it more out of the goodness of their heart than sensible business administration.

Frequently the operator is barely getting a living, but a great deal of personal satisfaction. I would say the majority of the operators that I have had experience with are unusually fine people, and are not, as has been expressed here today, of the opposite type.

Senator Moss. I concur, I think, with that, Dr. Edwards.

We appreciate your testimony.

Are there any questions from the staff?

Apparently not.

Thank you, Doctor. We appreciate it very much.

Dr. EDWARDS. Thank you.

Senator Moss. Our next witness is Mr. Raymond Berndt, who is the director of UAW in region No. 3.

Mr. LEONARD. Mr. Berndt, Mr. Chairman, has been confined to bed under his doctor's care.

Senator Moss. Will you give us your name?

STATEMENT OF RAYMOND BERNDT, DIRECTOR, UNITED AUTO WORKERS, REGION NO. 3, AND JAMES LARUE LEONARD, REPRESENTING OLDER AND RETIRED WORKERS, DEPARTMENT, UAW

Mr. LEONARD. James Larue Leonard.

I am an employee of the Older and Retired Workers Department of the UAW, AFL–CIO. I am not a professional in this field of activity.

My union, back in 1955, recognized that something needed to be done for people when they became too old to work and too young to die, and I think that if you have read the papers of recent months, you will see where we became very much interested in nursing home care through our present retirement educational program that has been in effect for approximately 7 years.

You will find in our contracts that we have recently negotiated they were referring to nursing homes and convalescent homes.

We have prepared this statement, and I would like to read it, because if Mr. Berndt was here, the man who has probably within our organization of labor done as much or more to interest people in their moral responsibilities to the aged than any man that I am personally acquainted with. Mr. Berndt is the UAW director of Indiana and Kentucky.

We were glad to hear Kentucky mentioned this morning. We are not very far ahead of them. I can tell you that, because I have resided there and know of their problems. We have nothing to brag about when we say we are ahead of them. It is a very thin line.

We sincerely appreciate the opportunity to appear before your committee to discuss ways and means of improving a situation too long neglected, and which cries for attention of all people of good will.

We are concerned in this matter primarily as citizens of Indiana. We are concerned specifically with the welfare of our members who are citizens of Indiana.

We have negotiated and are presently negotiating contracts which provide extended nursing care in qualified nursing homes for our members needing such care, beginning September 1, 1966.

We fully realize that there are not adequate homes for this type of nursing home care. The unfortunate fact is that the type of care specified in the contracts is not available, or is available in such limited amount as to nullify these provisions in our contracts because of the inability of existing nursing homes to meet these qualifications.

We hope that the provisions of our contracts will pave the way to the elevation of the quality of nursing care for all eligible citizens.

What we in the UAW and the other parties to our contracts, such as General Motors, Ford, Chrysler, et cetera, consider a qualified or "approved facility" is defined as follows:

> * * * a ward, wing or other specially designated convalescent chronic disease or long-stay care unit operated by or under the supervision of an accredited participating general hospital. The definition also includes a participating hospital, nursing home, or convalescent facility which is affiliated with a participating general hospital * * *.

The staffing and services of an "approved facility" are also defined: They must provide 24-hour nursing care. This care must be given by a registered nurse or under registered nurse supervision, and regular medical attention must be provided on a continuing basis.

Under our contracts, those members eligible for nursing home care would be in condition of health requiring continuing and expert care and facilities.

We think enforceable standards should be established by the Federal Health, Welfare, and Education Department, and that the State welfare and health departments be adequately financed to insure compliance with these standards within the State.

We think that adequate finance should be provided to maintain realistic licensing inspection. A sufficient staff of inspectors for continuing safety inspection by the State fire marshal's department should be provided for in the appropriated funds.

The State fire marshal's office has 12 inspectors. Last year there were 11,000, or more, inspections made by these 12 men. In January of 1964 the law required strict inspections be made of nursing homes by the fire marshal before licenses are issued. The fire marshal's office had requests for 40,000 inspections during the year.

Many of the nursing homes were inspected. Many were found wanting in fire protection. Many of these inspections require repeat visits.

We feel that no license should be extended, nor granted, until the requirements of the State fire marshal's office have been met. We also believe regular inspections must be made to keep structures presently existing in proper condition to prevent tragedies through fire of one kind or another.

In Indiana, nursing homes still exist that have not yet complied with the laws, primarily due to the fact that there has been inadequate personnel to make the necessary investigations. As fast as they are found and reported, action is taken to make them comply with the law.

Over 50 percent of these structures are renovated old buildings. Some are so dilapidated and have been so "doctored up" that many people will not let their aged relatives become patients of such homes.

We are constantly being asked questions by people from all walks of life as to how to get into a nursing home, and what kind of services are given. In the greater number of instances we must reply that there is no nursing home, in our knowledge, within their particular area, that can give the kind of service for a bedfast patient that is required, such as a registered nurse in charge, with constant medical attention available.

We believe that this is a must in a licensed nursing home that cares for bedfast patients. We believe that the proprietors of these nursing homes are attempting to do the best possible job with the existing, but inadequate, facilities and personnel.

And we have 23 units, Mr. Chairman, of United Automobile Workers established in the State of Indiana, and practically all the principal cities have aged people, and these particular units are not just for the membership of the UAW alone. The people are retired schoolteachers, professional people, church people, and it is open to the public, because we have taken seriously to this fact that there needs to be education in this field.

I have had Dr. Davis before our groups. We have had such expert personnel as dietitians from the State health board. We have had the Red Cross and the nurses to come out and tell us and show us how to take care of bed patients.

So we recognized sometime ago the need of education in this field, and we have taken this ways and means, because we, too, sometimes find it difficult, lacking the funds to have moneys to advertise and televise and radio propangandize what we are doing in a community, and we have to do it by word of mouth.

Once in a while the press will give us a big story, but we think that this type of education is the only way we know how to help you and this committee and the peoples of this Nation to recognize this problem that confronts the aged people.

If the objective of standardizing the qualifications of, and facilities for, nursing home care is realized, then regulation of fees within reasonable limits should also be established.

I know in upper echelons of nursing homes where people can buy it, nursing care is not too much of a problem. They have the money to buy. But there is a moral responsibility upon we who work in this field and know that we have a responsibility to those who do not have the funds to pay.

We think that this is probably the chief reason of the inactivities in the community level, that the interest has not been aroused because it costs money, and we have to look to agencies of Government for this money.

Where these services are available, we find the cost prohibitive and, consequently, the person who needs this type of care is being denied proper care.

We suggest that appropriate means of financial assistance, such as long-term loans, could be made available, for instance.

We know we are a private enterprise in this State, and free enterprise and all of that sort of thing. When we talk about these things, we always get a group of people that object.

We threw another agency of Government in here, because we feel that people are in private enterprise. We feel through the Small Business Administration that these funds could be provided for here,

and would be for these worthy and aften dedicated people to improve their services and equipment.

It may be possible, under those circumstances, to reach the high standard of operation that we desire, and we are sure all other citizens of our State also desire.

We would like to remind the committee that there are over 500,000 people past the age of 65 in Indiana. Many of these people are living beyond their means of support and are reaching an age where they must have types of care which we think can best be answered by the nursing home program.

There might be a different type of nursing home. The boarding home idea is very dear to my heart. I do not know how we can take people who are ambulatory patients with facilities of mind and that sort of thing, but need watching to see they do not fall, and things of this nature, into a nursing home where patients are out of their heads part of the time, and no soundproof walls, and things like this. I think different types of nursing homes could be developed, and constructed here.

These people's finances have dwindled away because of rising costs of living that was not planned by themselves during their work life. The span of life has so expanded that many of them live longer than they expected to, and we can only see in the future that the demands for different types of nursing homes to care for not only the ill and bedfast patients, but to the ambulatory patients who must have someone to watch and care for him at that age of life when he does not have the full facilities of an active mind.

So there may be different types of nursing homes required to take care of the different types of patients. These should be well planned and located in an area that is congenial to the needs of the individuals finding themselves in need of nursing home care.

I do not think that nursing homes should be established in areas where there is a constant problem, noise, transportation, things of this nature. I think that there could be meetings in the area, and maybe some small town that is almost a ghost town that has all the necessary facilities for a nursing home, and has people that could be easily trained as practical nurses.

There would be a source of maintaining that town in its proper activities of services to mankind.

We respectfully suggest that rapid action is necessary to meet the demands and needs of our swelling population of citizens who have reached that age too old to work—too young to die. We pray that the efforts of this committee, directed in behalf of the elderly throughout this Nation and who are very much in need through circumstances ofttimes beyond their control, be fruitful.

Senator Moss. Thank you, Mr. Leonard, for a very fine statement.

We regret that Mr. Berndt was not well enough to be with us, but you certainly have done yourself and your organization proud with your presentation today.

I think the UAW is to be congratulated for the initiative and leadership that is being taken in this field of care for elderly people.

Mr. LEONARD. I might add that Mr. Charles Odell was drafted out of the services of Federal Government. We think he is one of the greatest experts in the field of aging, and he is my immediate supervisor or director, so we do have the kind of people that are sincere

in trying to develop this thing, not on a selfish basis, but for the needs of every community.

It is a moral responsibility, and we want to do our part in it.

Senator Moss. We congratulate you on that. We look with favor on the efforts that are being made by your organization.

One question.

Mr. CONSTANTINE. Mr. Leonard, your union, UAW, now operates a hospital in Detroit, other unions operate hospital facilities, and religious organizations operate hospitals. Is the UAW, or is labor in general, considering going into the nursing home field in terms of operating nursing homes?

Mr. LEONARD. I do not think that our union wants to be in competition with any other segment of our society in this particular field of endeavor, but we want to help these people to establish this type of home, if we are competitive, because the great needs and the moral responsibilities we feel so heavily upon us to do so, I imagine the executive board would take some action. I do not know what.

Senator Moss. Thank you, sir. We appreciate it very much.

That completes the list of witnesses we have to testify before this committee today. I know that there are in the audience a number of nursing home operators, and other who are intrested in this field, and may have something to contribute.

I would invite you to write us a letter or a memorandum. You can send it to me, to the U.S. Senate, and we will include it in the record, if it is factual and presents some facts or point of view that the committee ought to have before it.

We do not want to preclude anyone, nor overlook any information that might be available to us. For that reason, this record will be open for 2 weeks. So any time within the 2 week, if you would like to forward to us a statement, if in the testimony today you have heard things that do not accord with your point of view, feel perfectly free to set down your point of view, because we do not want to prejudge on one side or the other or get a slanted view before the committee.

I think we have had a fine hearing today. I am very grateful to all of those who have appeared, and grateful to you who have stayed here. We have had a good audience today to listen to this, which is indicative of the interest in this field.

I think it has been underlined again and again today that the problem we have is important and acute, but that we are making progress on it. That is our goal, to know all we can about it, so we can better meet a social problem that we have in this State and throughout the United States.

Thank you all very much.

This hearing is now adjourned.

(Whereupon, at 4:20 p.m., the hearing was adjourned.)

(The following statements were received after the hearing and placed in the record according to the chairman's instructions:)

STATEMENT BY THE INDIANA DEPARTMENT OF MENTAL HEALTH, INDIANAPOLIS, IND., S. T. GINSBERG, M.D., COMMISSIONER; J. R. GAMBILL, M.D., DEPUTY COMMISSIONER

PSYCHIATRIC PROBLEMS OF THE AGED

I appreciate the privilege of meeting with you today and participating in this Senate hearing on the long-term care of the aged.

We, in this decade, are becoming more concerned with the aging and the aged. This was not always so. During the period of the Roman Empire the average life span was 23 years. In 1900, the average age rose to 40. There was no problem about the aged.

Today, people live longer. Life expectancy of white female infants is now 74 and at 65 the life expectancy is 81. One-third of all people 65 and over have a parent living. The medical profession has made great strides in prolonging life. But this has created new problems. Now we have the problem of the aged. We have new medical problems as well as social, economic, nursing, dental, dietetic, recreation, and housing.

The aged deserve our attention. We are concerned with their multiple problems. But aging is not an illness. There is no disease due to age. We should rather consider the aged as having tremendous potential, strength, and assets. These assets can be mobilized. The community could furnish a wide range of facilities and services designed and programed to provide a satisfactory home and community life consistent with the individual's physical, mental, and emotional capacities leading to independent living.

The aged may and do develop wide varieties and degrees of illness. I will concentrate on mental illness and its effects upon the aged.

The number of persons over 65 in the general population is growing rapidly. There are over 17 million in the Nation, with an increase of approximately 400,000 a year. In Indiana, the estimate is 475,000, or over 9 percent of our population, are over the age of 65, and the number is increasing by 10,000 each year.

A review of first admissions to public mental hospitals in the United States indicates that 31,000, or 25 percent of first admissions, were over 65 years of age. In Indiana during 1964 there were 630 persons over 65 admitted to our State mental hospitals. This constituted 13 percent of all admissions. The great majority were diagnosed cerebral arteriosclerosis and senile brain disease. Other psychotic disorders, especially depressive reactions, were diagnosed.

Many misconceptions about mental illness persist. One that deserves correction is that when a person over the age of 65 develops a mental illness, he is doomed. Psychosis in the elderly is treatable and curable in a surprising number of cases.

In Indiana last year, 27 percent of all admissions of the aged were discharged in 6 months, and over 32 percent were discharged from the hospital within 1 year.

However, many aged patients are admitted with multiple conditions and in serious condition. Seventeen percent of these 630 patients die within 3 months and 23 percent within 1 year.

The treatment program in the mental hospital is comprehensive. All forms of therapy are utilized. Special nursing care is an essential. Each patient deserves a full program of treatment and rehabilitation. This requires adequate staffing.

Some patients are able to return home. Others have no home nor family. These patients who no longer require treatment in a mental hospital may be able to live comfortably with another family, a nursing home, county home, or other suitable setting. The family care program has been developed to find the suitable setting for the particular patient. Funds are available to reimburse the family or home for the care of the patient. We are able to pay the local rates for such care, within the limits of the average cost of State mental hospitals. We must have more staff to evaluate patients and do the social work to place the patient properly.

In 1961 the old age assistance program was developed to help place more elderly patients into a more suitable facility. Additional funds thus became available and more patients were able to leave the mental hospital. Over 131 patients have been released from hospitals with the help of old age assistance funds. This program also stimulated the families of 141 other patients to find community placements for them.

At the present time, of the 464 patients on family care, 59 are over the age of 65. We can anticipate 2,000 patients leaving the hospital and remaining in this local community under the family care program and old age assistance.

Extending these programs effectively depends upon a cooperative effort on the part of the hospital staff, the department of mental health, the department of public welfare, local welfare agencies, a volunteer program of the Indiana Association for Mental Health, and a wide galaxy of community facilities, agencies, and services.

Many seek to admit aged patients to mental hospitals when the aged become irritable or act childish. However, hospitalization is only one facet of the

mental health program. The aged should receive mental hospital services only when they are mentally ill and there are psychiatric indications.

Aging presents many social, economic, and cultural factors. The mentally ill aged should receive services in the community from the same agencies and clinics serving other groups. Mental health services, inpatient and outpatient, should be organized to allow free movement of patients between services, depending upon treatment needs.

Let me emphasize an interesting and significant development in the trend in the treatment of the mentally ill. Only a few years ago, more than 20 percent of all admissions to our mental hospitals were patients over the age of 65. This is now down to 13 percent. There were approximately 4,000 aged patients in residence in the State hospitals and schools for the mentally retarded. In spite of their increased numbers, fewer aged patients are now being admitted, and with increasing releases only approximately 3,500 aged patients are in the State institutions.

The community has assumed more responsibility for aftercare and for treatment of the mentally ill.

Old-age assistance and social security has enabled the elderly to live in the community whereas formerly families would have placed them in a mental hospital. Mental hospitals have begun to screen patients prior to admission and have found more suitable places in the community. State mental hospitals have also found community placements for those hospitalized patients who have improved. General hospitals and family physicians are caring for the medical needs of the elderly instead of shunting them to State hospitals. Medical journals are letting the profession know that disease in the aged can be treated or even prevented.

Among the programs and facilities needed for a comprehensive community program are:

The family physician
The psychiatrist
Psychiatric clinic and center
General hospital
Nursing home
County home
Foster home
Homemaker service
Day-care centers
Public health service
Public heath nurse
Recreation program
Clubs for the aged

Thus, we see there must be a coordination of community facilities and services to meet the varied needs of the aged population. We must develop a program of prevention focused on sound mental health concepts to help alleviate the problems of adjustment of the aged. People should be encouraged to prepare for retirement and old age early in life by positive mental health.

Thus, much can be accomplished to prepare all citizens to meet aging with enthusiasm and gratification, to accept their limitations, to continue independent living, to provide motivation for the constructive use of their time and assets, and to make more pleasant our increased years of age.

STATEMENT BY MRS. MABEL J. RAY, ADMINISTRATOR, SUNNY ACRES REST HOME, BEDFORD, IND.

The following are our views on what we feel to be three major problems in the area of long-term care for the elderly:

Welfare: Welfare funds now available for the care of the elderly are alarmingly low. Our county has only recently increased the amount to $150 per patient per month. When the letter from our local welfare department authorizing this increase was received we were shocked to learn that the increase was to include shaves and haircuts for the recipients.

Since a large percentage of these patients are incontinent and others require special diets or specialized care in some form—well, you can readily see the problem with which we are faced. What kind of care can we possibly give these people for this amount of money and still maintain our operations on a sound basis?

We feel that this problem is nationwide and strongly urge that some positive action be taken by the Federal Government—possibly through the State governments—to supplement local welfare allotments for elderly convalescent patients. We are now assuming that medical care for the aged in some

form will soon be a reality and will take care of many of our private patients, at least in part.

However, not only are the current rates too low but a continuous flow of new rules and regulations set down by State boards of health, require remodeling in most cases, new construction in many cases, and increases in licensed staff members. These new regulations, although sorely needed, have necessitated prohibitive increases in operating costs. Inability to afford the proper and necessary care for their patients is destroying much of the incentive of many qualified people in this field.

We strongly urge that Senator Smathers' Special Committee on the Aging, along with Senator Moss' Subcommittee on Long-term Care (and any other current instrument of the Federal Government established for the purpose of investigating care for the elderly) give serious consideration to this problem. Staff training: The necessary current increase in convalescent home facilities has made more urgent the demand for qualified people to staff these homes. Quite suddenly, we realize that not nearly enough qualified people are available—from cooks to nurses' aides to LPN's, RN's, orderlies, administrative personnel. In fact, they are practically nonexistent.

We feel very strongly that a definite training program should be considered urgent, either through Job Corps training or some other feasible means. Funds to promote such a program should be sufficient and immediately available because of the time element involved. These people are needed now. This type of training cannot be learned from books; it is highly specialized and must be learned on the job under experienced and qualified supervision.

And last, but not least, in our thoughts is the need to inform the general public regarding convalescent homes. We are constantly amazed at the complete lack of knowledge we encounter in our dealings with the public. We feel that educating people accurately on this subject can best be accomplished by some centralized means since it would necessarily involve surveys, statistics, comparisons, etc. We realize that a lot of this information is now available through many different sources—but who will take the time and trouble to find out where, and, in fact, to be able to understand it when they do find it? In most cases, the method of recording this information is much too complicated for the average person to comprehend. It must be presented in a concise, simplified, and attractive form. This will take ingenuity and money but can and should be accomplished at an early date.

The above information is for your consideration. We hope you find it useful.

BEACH-CLIFF LODGE NURSING HOME,
Michigan City, Ind., February 12, 1965.

Hon. SENATOR MOSS,
U.S. Senate, Washington, D.C.

DEAR SENATOR: It was indeed a pleasure to meet you at the hearing yesterday in Indianapolis, Ind., and as you so honestly advised, I am going to bring out in this letter a few pertinent facts about the good nursing homes and the many dedicated operators who for many years have cared for our aged people in the various parts of our State.

First, I most emphatically want to take exception to what the press said about nursing homes. It seems to me, that if they wanted to bring out the true facts of our business, they would not only seek out a few of the substandard homes, but they would also visit some of the good ones, and these are the majority, and tell the public through the press that there are dedicated, responsible people doing a fine job in caring for our State's aged.

(1) Last year the Indiana Association of Licensed Nursing Homes together with the University of Indiana Medical School set up a program for nursing home operators to take a 1-year course in nursing home administration. This course covered all facets of good operating procedure. On January 28, 1965, the first group of these students was graduated, and I am very proud to say I was one of them.

(2) There is now established through efforts of the American Medical Association, the National Council for the Accreditation of Nursing Homes and at the last report there were nearly 800 applications from nursing homes seeking accreditation, I was one of those applying, and very shortly our survey will be completed.

(3) The nursing homes of the State of Indiana have the lowest insurance rate in the country, based on past experience relative to malpractice, owner and tenant liability, workmen's compensation, and so forth.

(4) We now have in operation a campaign of advertising backed by the Indiana Association of Licensed Nursing Homes and the American Nursing Home Association, which will acquaint the populace of the State of Indiana with the image of what good nursing homes are and should be. I am chairman of this committee. Already we have contacted television, radio, and local theater mediums, and we hope the press will also join with us in this endeavor. This program will be statewide and will have the complete backing and effort of every member.

(5) We have in our association, contrary to what the press said yesterday, many educated operators that were successful contractors, merchants, professional people, and educators for many years before entering the nursing home field.

It must be said here that many of us are not motivated by a profit motive. Some of the press might be surprised and startled to learn that there in this business of caring for the aged there is an inner gratification far more compensating than any dollar or cent could ever bring.

We have in Indiana will go forward with the help of good people such as you. There is no doubt in our minds that the State of Indiana's nursing homes will always be right up there at the top of the list.

May I again express my sincere thanks to you for your untiring effort in bringing out all the true facts of this hearing. I look forward to again meeting you.

Very truly yours,

THEODORE R. MOSS.

FORT WAYNE, IND., *February 8, 1965.*

Re public hearing, February 11, Indianapolis, Ind.

Senator FRANK E. MOSS,
Subcommittee Chairman, U.S. Senate-Joint Subcommittee of the Special Committee on Aging and Long-Term Care, Washington, D.C.

DEAR SENATOR MOSS:

DECEMBER 18, 1964, NURSING HOME FIRE, 20 PATIENTS DEAD

Will this catastrophe be the basis for making decisions on health, safety, and welfare in nursing homes in the State of Indiana and elsewhere? I sincerely hope not.

The Coconut Grove Night Club fire in Boston back in the 1940's took over 450 lives. Indiana and other States are living with statutes that were enacted in haste as a result of this disaster, and no more inane laws can be found today, than these.

I served 25 years as a fire official, as an officer in charge of the rescue operations on rescue units, and later as the chief of the fire prevention bureau in Fort Wayne.

Later, I founded, owned, and administrated a 32-bed nursing home in Fort Wayne for 5 years.

I doubt if you can find an individual who has had the varied experience in safety and welfare, as it pertains to nursing homes, that I have had. I say this, not boastfully, but as one who has had to live with and administrate laws that were born with rash haste out of the ashes of a disaster.

Many hundreds of nursing home administrators who have safely and wisely carried the burden of caring for the aged and sick could be made to suffer because of one disaster that never should have been allowed to happen.

One thing alone can prevent such calamities as the Fountaintown Nursing Home fire. Safety regulations supervised rigidly by well-trained and qualified personnel is your front line of defense against fire.

The State fire marshal's office in Indiana is woefully understaffed, underpaid, and untrained. The department is dominated by the whims of the politicians. Many of the deputies are ex-firemen who know the fundamentals of firefighting, but very little of fire prevention. They have vast territories to police. They make one inspection annually of nursing homes, schools, etc. They make sure that each nursing home has the required fire extinguishers, but don't have the

time to ask if anyone knows how to use them (which is seldom). Indiana had one boiler inspector for the entire State in 1960. I doubt if they have hired anymore since.

Fireproof buildings are not your answer alone. Some of our worst catastrophes occur in fireproof buildings. A fire in our largest and tallest fireproof building in Fort Wayne sent 17 firemen to the hospital and caused $50,000 in damage (Lincoln Bank Tower). I have grafted skin, scars, and the memory of an 8-week stay in the hospital to remind me of this fact.

I could write all day on the problems of supervision in the fire marshal's office and the office of local fire prevention bureaus as they apply to nursing homes.

Suffice it to say, there will be much expert testimony given by experts at your February 11 hearing who won't have the first concrete thoughts on how to improve nursing home safety and welfare.

Sincerely yours,

STEPHEN L. MARSHALL.

FEBRUARY 11, 1965.

DEAR SENATOR MOSS: After hearing the morning session of the Senate hearing in Indianapolis a few nursing home operators talked it over and felt we would like to make the following notations to the committee:

There is a difference between the senile patient and the sick senile patient. Most nursing homes are concerned with the problems of the sick senile patient. They are not patients for which a recreation program could be planned because, for example, they are not physically able and they don't want to be bothered with it. Neither are they people who will tolerate some of the diets which the nursing homes must serve. Spending time on recipes for patient's likes and dislikes takes time away from patient care.

Nonprofit homes must be defined from custodial and privately owned. The rates are higher in the former but at the same time they are tax free, and receive surplus food.

A member of the Senate committee wanted to know why more Hill-Burton homes were not built in Indiana. Their requirements are to costly. A beautiful stone 50-bed nursing home was built in southern Indiana for less than $100,000 that would have cost over $350,000 under Hill-Burton requirements.

Senator Moss asked whether or not medicare would help the situation financially. Under the present proposal only a very few in Indiana would be eligible.

GILBERT BRADFIELD,
President, Southwest District License Nursing Homes.

APPENDIX A

HAVE THEY DIED IN VAIN?

Fires Teach Better Nursing Home Protection[1]

(By Rexford Wilson, field representatives, National Fire Protection Association)

Six patients die in nursing home fires for every one killed in a hospital fire. Nursing homes are by far the most serious killers of institutional occupants. Since the start of 1960, 129 nursing home patients have died from the effects of fire. What can we do about these unnecessary annual fire deaths? The most economical and most effective solution must be sought. This economical and effective solution can be found if we look at and learn from previous fire experience.

The record cited above is by no means solely the responsibility of nursing home operators. Conscientious operators have tried to provide safe conditions by following the advice of fire protection engineers. It has taken years of experience and many fire deaths for engineers to fully comprehend the full problem and to devise positive, effective defenses. So it is the engineer, and the owner, as well as architects, legislators, and others who share the responsibility for the past record.

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[1] Prepared for delivery to 15th Annual Convention, the American Nursing Home Association, Oct. 20, 1964.

Twenty years ago the fire protection engineer attacked the nursing home fire, in what we now know was a naive way. We thought then that a fire alarm system could give us warning in time. We thought then that the attendants could move patients effectively. We thought then that evacuation of the home was possible. We thought then that fire-resistive construction would give us some measure of time to act and some limitation to lethal smoke. We looked on sprinklers as a successful but not necessarily essential alternative.

Now, 20 years later and over 500 fire deaths wiser, we look at nursing homes from a different standpoint.

What were the fires that changed our thinking? What were the fires that taught us something about nursing home protection? From 1948 to 1953, we began to get messages. In this period, there were a number of serious fatal nursing home fires (slide 1). The fire near Largo, Fla., is a good example. This normal fire spread through the one-story building in the early morning hours. One woman patient, who was removed several times, kept climbing back into the burning building and eventually died. Thirty-two other persons were killed with her. This fire illustrated clearly that there simply is not enough time, in the normal fire, to react. It also illustrated one of the difficulties in handling older persons in a serious fire situation—reentry.

More nursing home fires occurred. We were beginning to question evacuation as a sound, positive concept. Then on February 27, 1957, the fire protection engineer learned a great, but costly, lesson. The large nursing home in Warrenton, Mo., a converted college building, housed 149 patients on 2 floors. It was Sunday; there were 9 employees on duty and 50 visitors—a ratio of approximately one able-bodied person to each two and one-half patients. The fire was discovered by a patient in a closet in the rear annex (slide 2). The fire had to spread from the annex through a narrow passageway into one wing of the building. Then it spread from this wing to the front and then out the other wing. Evacuation was attempted by all the able-bodied people in the building. Of the 149 elderly patients, 71 were killed within 15 minutes and 1 more died 2 days later from the effects of the fire. Of the able-bodied persons—not one was killed. We learned—we learned cruelly, harshly, and expensively—that the ratio of able-bodied attendants to patients and evacuation procedures in a normal fire are simply not enough, and we received a strong hint that patients could not save themselves (slide 3).

Again we learned on January 30, 1959, in Glen Ellyn, Ill., with the death of eight patients, that the time for rescue is insufficient and attendants are often helpless under the normal spreading fire. More nursing home fires were occurring around the country, three fatal fires in 1960, seven in 1961, and five in 1962. It was one of these, December 20, 1962, in Hudson, Mass., where the fire protection engineer got the confirmation of all his previous feelings about fire protection for nursing homes (slide 4).

This two-story dwelling had been converted into a nursing home. Under the urging of the local fire chief, it had been completely equipped with a heat-actuated fire detection system operating a master alarm box and ringing through the municipal alarm system to the local fire headquarters. This auxiliary system, as it is called, is the fastest form of alarm transmission known today. The building was being enlarged and the fire chief was concerned about it. He instructed the workers on their cleanup responsibilities and the protection procedures to be taken during the construction operation. Every night on his way home from work, this chief walked through the downstairs, up the back stairs and through the second floor to check on cleanliness and housekeeping. The fire started in a rear closet on the second floor completely divorced from the remodeling. Ignition was possibly due to the carelessness of a patient or possibly due to an electrical failure in the nonmetallic sheathed cable leading to a dumbwaiter motor. This fire was spotted promptly by a detector 36 inches from the open door of the closet. The alarm simultaneously signaled the two attendants in the building and alerted fire companies. The nurse arrived on the floor to find a closet fire; she took a patient downstairs. On returning, she found fire in the hall. The fire station was six blocks from the home and the trucks arrived promptly only to find the rear of the second floor already involved, and the building heavily charged with smoke. One inch-and-a-half line was promptly strung up the rear stairs and firefighters knocked the fire down immediately and quickly, easily extinguishing it. But it was too late, two patients were already dead and seven others would die in the next few days from effects of the smoke. One of the dead was 10 feet from outside stairs—the other 15 feet from the same stairs.

The rescuers who worked on the second floor described being hit, kicked. They told of trying to carry old persons down narrow stairs, having them brace their feet, scream and pull at the man's clothing. One firefighter was able to go up three times to the floor. The others were exhausted after two trips.

The firefighter who went up three times told me his story. He had groped around in the thick smoke of the second-floor hall and found three persons. He grabbed one woman and threw her over his shoulder while he felt for the stairs. He carried her down, then went back up again for a second person. He finally found a male patient and threw him over his shoulder. The man, stiff with arthritis and in pain, fought his rescuer. Breaking the man's grip on the door frame and unwedging his feet from the handrail, the firefighter struggled down the stairs. It was slow work, because the man was heavy and because no one could see. The firefighter returned to locate the third person, an old woman, whispering weakly for help. He threw her over his shoulder and again started down. She had little strength to resist. By the time he reached the first floor, he was exhausted and unable to continue rescue operations.

We learned from this that normal fire spread even with prompt alarm does not give us enough time for effective evacuation under normal fire conditions—a condition we had begun to suspect.

Now I have used the phrase "normal fire spread" several times. What is a normal fire? What may we expect from ordinary combustibles burning inside buildings? Let us examine the "normal" development of three fires (slide 5). One we will examine is this small wooden crib burning in a large auditorium. The fire found no combustibles to which to spread and, thus, provided little temperature increase in the large volume of the room. A comparatively slow fire (slide 6). Another is the fire generated when these wooden pallets in the stairway were ignited by a cotton igniter (slide 7). Finally, this storage room with ordinary wood, paper, and cardboard storage after it was ignited by a cotton igniter. It was an interesting sidelight of this storage room fire test that two men in the building were almost killed by the irritating quality of the smoke even though they were experienced firefighters and they were there to record test data. One of the two even gave the order to light the fire. Fortunately, they could be rescued by ladder, but it was a close call even though firefighters and ladders were on the premises and this fire was extinguished completely 5 minutes after ignition (slide 8). This is an enlarged graph of the initial time-temperature curves for these three fires during their first 7 minutes. The flattest curve is the result of the small wooden crib fire in the large auditorium. The low temperature is indicative of no fire extension. Next is the curve for the wood pallet fire. Then comes the standard time-temperature curve used in fire-resistive testing. And finally the nearly vertical curve of the storage room fire. Notice the speed of involvement in these latter three fires. Even the heavy chunks of wood in the pallet fire test were exhibiting a 500° F. temperature in 5 minutes. In the standard time-temperature curve, this 500° F. point was reached in about 2½ minutes and in the storage room fire this point was reached a few seconds over the 1-minute mark. This is normal fire spread. Five hundred degrees in the first 5 minutes in plain wood.

How much time does it take two of the attendants in your home to move one patient from his room to the outside under ideal, nonsmoky conditions? If this is a troublesome patient, it may take more than the burning time we are talking about. During a fire (slide 8A), how many people and how long does it take to assist one man out? (Slide 8B.) How many people and how long does it take to carry this woman out by chair? (Slide 8C.) How many people and how long does it take to improvise a stretcher and carry this man out? (Slide 9.) On February 1, 1961, in a Washington, D.C., nursing home seven patients were killed on the fourth floor from a fire originating in a first floor closet. This slide shows six men working on one patient's rescue. A fairly realistic ratio for this type of ladder operation. How long did it take to get her down? Five hundred degrees Fahrenheit in the first 5 minutes in wood.

Let's pursue our fire behavior study a little further. The influence of the amount and type of combustible in a building is shown by British tests on two dwellings (slide 10). The homes were both of identical construction, but one had its interior finished with combustible fiberboard. In the other home, the interior finish was ⅜-inch thick plasterboard nailed directly over the fiberboard. Both living rooms were furnished identically right down to the placement of the furniture. Both fires were started in the same location by igniting the same easy chair. The pictures on the top of the slide show the

burning of the fiberboard house at the start and 19 minutes later. Look at that upper picture on the right. If you had been asked 2 minutes ago how long it had been burning, would you have said less than 20 minutes? The top graph shows the gas levels recorded in the second floor bedroom as well as the time of the flashover 4 minutes, floor collapse 14 minutes, and roof collapse 19 minutes. Flashover at the bottom are pictures of the plasterboard home at the start and 24 minutes later as well as a graph of the bedroom gas level. Note that flashover does not occur until 24 minutes—5 minutes after the roof had collapsed in the fiberboard home.

While these graphs and pictures illustrate the importance of interior finish on the time for fire spread, this same amount of combustible might be present in other forms such as: furniture, rubbish, or the storage room we saw before, The important point here is fire spread can be radically slowed by the removal and control of combustibles. Each scrap of paper, each stick of wood, each unnecessary piece of combustible material that can be removed is important.

To those who feel that fire-resistive construction will offer protection, let me remind them that interior finish and contents of buildings—paper, rubber, textiles, cardboard, and lumber are the same things we burn inside our "fire-resistive" incinerators. In fact, crematoriums are fire resistive. Thus, fire-resistive construction itself cannot provide life safety, particularly in instances where the building occupants have difficulty responding to and moving from the fire threat.

Now let's study for a moment the automatic sprinkler system. Just to review how it works and what it does. The automatic sprinkler system is a piped distribution system for water with nozzles called sprinklers distributed throughout the building. Each sprinkler is individually operated. The one nearest the fire is usually the one which operates. But the sprinkler is an extremely reluctant device. To those of you who have had the experience of standing waiting for one to operate under test conditions will know you wait a long, long time. There is plenty of time for effective manual use of extinguishers, for effective carrying and throwing of water, for effective, prompt action. But if for some reason this action is not effective, if this action is not taken, if the fire is in an unoccupied room or closet, if the fire is not contained, then the sprinkler will eventually open to control it before the critical or dangerous period is reached. The automatic sprinkler system is actually then, an automatic time control mechanism.

You remember the fire in the wood pallets and the curve it made on our temperature chart (slide 11). This slide shows two identical fires in similar wooden pallets in a three-story building with open stairways. The fire on the bottom is without sprinklers and the one on top with. Note that without sprinklers, the fire grows rapidly reaching its maximum temperature of approximately 1,100° F. in about 8 minutes. Between 3 and 7 minutes the heat in the upper corridors over the fire is above the maximum tenable temperature. And the smoke in all three corridors is untenable between 3 and 6 minutes. In this type of fire, approximately 3 minutes are available to complete rescue after ignition.

What happens in the same fire with sprinklers? The buildup is approximately the same. However, when the fire reaches about 250° F. the sprinkler nearest it is finally heated to 165° F. and it lets go, delivering water to the fire and returning temperatures directly over the fire to a tenable level. While smoke is not controlled and does reach untenable levels at one end of the corridor on the first and second floors, smoke development time is shortened and lethal quantities are rarely reached. Those of you that have had that unfortunate circumstance of lighting a fire in your fireplace with the damper closed know how little fire it takes to cause a large obnoxious, but not lethal, amount of smoke.

The important point about a sprinkler is that its reluctant operation combines the functions of detection, alarm, response, arrival, set up, control, and extinguishment. Thus, the sprinkler which operates when the temperature in an area is critical brings the desired response, water, in a quick, direct manner. In other words, the sprinkler shortens the burning time. (No one ever drowned or caught pneumonia from sprinklers—even babies have been soaked by sprinklers in a hospital nursery—the doctor reported that it was all right—they are wet anyway.)

Now what have we learned about fire by this brief review of basic fire behavior? First, we know that fires in ordinary combustibles can burn so rapidly that we are unable to provide proper protection. And second, we know that

from a time standpoint, life safety in these fires is primarily up to the occupants of the building.

As the last piece in the jigsaw puzzle picture of nursing home fires we are building, let's study this occupant of a nursing home. This patient is usually in there because he is unable to cope for himself. Patients need help, companionship, friendship, assistance, and dignity. During the day, when they are not under the influence of drugs, your staff is kept busy handling, moving, dealing with these people. I would ask you the next time you have to move Mrs. Jones outside, that you look at your watch when she is first touched by your staff and then keep track of the length of time it takes to get her to and out the front door. All this under perfect, ideal circumstances—no smoke, no heat, no confusion. I think you will be surprised to find that the length of time needed to handle these old people is a lot longer than any time we can expect to have in a normal fire.

So what does the fire protection engineer think, now that he understands normal fire a little better, and he understands the real difficulties of operating and owning a nursing home? For the fire protection engineer, like you, is looking for the most economical effective protection for the homes you operate.

He has learned that alarms, regardless of how fast, cannot possibly give notification in time to do anything effective about the normal fire because of the physical characteristics of people we have occupying our nursing homes as patients. He has learned in studying your operation that you cannot possibly afford one attendant for every patient, just for the possibility of fire. He has learned that regardless of the speed and efficiency of your evacuation plan that the nursing home just simply cannot be evacuated in time. Even if it could be, we cannot stop these old people from wandering back into the building unconscious of the threat to their lives that the fire presents.

What is the solution? The solution is built around the automatic sprinkler system. With automatic sprinklers, an economical number of attendants, a reasonable control on the amount of combustibles, and proper smoke divisions, the nursing home can be a fire-safe place for old people to live. For instance, (slide 12) in February 1959, at the New Haven Nursing Home in Des Moines, Iowa, while a patient was smoking in bed, the bed became ignited and fire spread to a built-in cabinet, and to the combustible fiberboard ceiling. The fire was extinguished by three sprinklers before arrival of the public fire department. The $90,000 home suffered $1,500 insured loss, and continued in operation.

In the Mid-Columbia Nursing Home in Oregon, July 1960, a 60-year-old patient set fire to the clothes in his closet. He shut the closet door and retired to the hall shutting the room door. He wanted to see what would happen. Within a minute, the sprinkler alarm bell began ringing. At first, the supervisory personnel thought it was a test of the system, but a nurse soon saw water coming under the door of the room. The fire had been extinguished by the single sprinkler in the closet and the damage amounted to $35 and no loss of life, no injury, no interruption of operation, no loss of income, and no black eye for nursing homes. A far cry from the closet fire in Hudson, Mass.; the closet fire in Washington, D.C.; and the closet fire in Warrenton, Mo.

Just 1 month ago, in Lexington, Mass., at the Fairlawn Nursing Home a newly installed automatic sprinkler system extinguished a fire in a patient's third floor bedroom when a match ignited his bathrobe and extended to the overstuffed chair and wood floor nearby. The two sprinklers which operated confined the fire to the room. The half-million-dollar nursing home continued in operation for its patients uninterrupted.

Following the example of the leading nursing home operators in providing automatic sprinklers in their institutions, city after city around this country is requiring complete automatic sprinklers. In the cities of Toledo, Ohio; San Antonio, Tex.; in the entire State of Iowa; Boston, Mass., and in Los Angeles, Calif. nursing home operators are finding that the compulsory sprinkler system is not as expensive as they had feared and also that it practically guarantees their continued operation. Those away from good water supplies are finding that an effective sprinkler system is still available through the use of a pressure tank. Some nursing home operators are locating near good water supplies for both health and fire reasons.

In summary then, what have we learned? We have learned that the nursing home is a special fire problem needing the most economical and effective solution. We have learned that the nursing home is presently the prime location for loss

of life in all U.S. institutions. We have learned that the early solutions of alarms, attendants, and evacuation are unsatisfactory in the light of present-day nursing home fires. We have reviewed certain nursing home fires which caused a change in fire protection thinking. We have reviewed the normal development of fire and the speed of this development. And we have looked at the normal operation of sprinklers.

Through this study we have learned that the only implement for nursing homes presently at our disposal that will cut fire growth at the critical stage; that will block the generation of dangerous quantities of heat; that will chop the development of thick, choking smoke; that will give time to move patients if moving patients is necessary—the only implement is the complete automatic sprinkler system.

With this automatic sprinkler system our joint efforts to control combustibles, to limit interior finish, to train staffs, to plan evacuation will be effective.

With this complete sprinkler system nursing home life loss from fire will be reduced over 98 percent, a saving that would have affected at least 126 lives in the last 4½ years.

Without a complete automatic sprinkler system all our efforts at strict control of combustibles, severe limitation of interior finish, intensive staff training, practical evacuation plans, all our efforts will continue to fail as they have in the past. The unnecessary life loss from nursing home fires will continue.

The needs of your profession are great. By 1985 there will be over 25 million potential patients. Your job is relatively new and exceedingly vital. The flood of elderly has created a growing need for a fire-free, safe environment for these people.

We have learned from fire deaths that sprinklers in nursing homes are vital. Will we heed to this clear lesson or will these dead have died in vain?

Thank you.

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