CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

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TUESDAY, FEBRUARY 23, 1965

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

The subcommittee met at 9:30 a.m., pursuant to call, in the auditorium, United Fund Building, Denver, Colo., Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senator Moss.

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

Senator Moss. This hearing will now come to order.

We are pleased to be here. I am Senator Moss, chairman of the Subcommittee on Long-Term Care of the Special Committee on Aging of the U.S. Senate.

I have with me this morning the staff director, Mr. Frantz, and the staff director for the minority, John Guy Miller, who are sitting here on the panel.

We are holding hearings in a number of cities over the United States and we are pleased to be in Denver this morning; a brisk morning, I would say, here, but one that certainly ought to keep us on our toes today.

Senator Allott, who is a member of this subcommittee, unfortunately is not able to be present this morning. However, he has prepared a statement which will appear in the record at this point.

(The statement follows:)

STATEMENT OF HON. GORDON ALLOTT, A U.S. SENATOR FROM THE STATE OF COLORADO

All of us are aware that within the next couple of years some sort of Federal program will most likely be initiated to financially assist persons 65 and older to acquire medical care. The obvious result will be a sharply increased strain upon our already overburdened hospital facilities—an increase which our hospitals will very probably not be able to absorb.

Many aged patients will not require the strict and more costly discipline of hospital facilities, and attending physicians may favor direct admission to a qualified nursing home rather than to a hospital for the benefit of the patient, due to the difference in atmosphere and level of discipline. To permit the direct admission to nursing homes will alleviate some of the anticipated hospital congestion. Therefore, may I suggest inquiry into the matter of mandatory transfer agreements between hospitals and nursing homes.

The establishment of Federal standards enforced by the Department of Health, Education, and Welfare may cause many acceptable facilities to be unavailable under federally financed programs during the early stages. This is due to the

necessity of extended administrative procedures, which experience teaches us usually require several years. Further, Federal intervention in this field might not only have adverse effects but may well be a foolish duplication.

I should like to invite the attention of the subcommittee and interested persons to the fine work being accomplished by the National Council for the Accreditation of Nursing Homes. While the Council is a comparatively young organization as compared to other professional organizations designed to establish standards of conduct and promote adherence to those standards, it has done a remarkable job in so short a time. Therefore, may I suggest that consideration be given to the utilization of the existent National Council for the Accreditation of Nursing Homes as an established organ for the maintenance of proper standards for quality of care and physical safety.

Senator Moss. I understand that Mr. Lloyd, the representative of Senator Dominick, is here this morning. If he would like to join us at the table, he is very welcome. We are happy that he is here.

It is a pleasure to hold this hearing in Denver, which is the fourth in a series of public hearings which we are conducting throughout the country.

The problem of making available to our aged citizens the kinds of services and the quality of care which they need, and which our helping and healing professions can provide, is a national problem—a problem of immediate concern in every State. In recent years we have heard a great deal about the shortage of nursing home beds and about the fact that most people who need nursing home care cannot themselves pay the cost. To help meet these problems, the Congress has, from time to time, enacted programs designed to relieve the shortage of nursing home facilities and to help pay for the cost of services.

These programs have responded to needs as they appeared in a somewhat primitive context of institutional arrangements and ways of providing services. They have been, to use an old expression, grease applied to the wheels that were squeaking. Although these efforts by the Federal and State Governments have accomplished much good, it is now time to review our programs and reappraise the role of the Federal Government in the light of present trends in the giving of long-term care and of the services and facilities needed by the long-term-care field to meet the demands being made of it.

We often hear it said that there is a national shortage of 500,000 nursing home beds. Personally, I recoil from the thought of building institutional space to contain half a million beds for people to lie in. If this proves to be what is really needed, I shall do my best to see that it is provided, but at this point I think that we must be able to do something better.

It seems to me that there is great unrealized potential in noninstitutional services—home care, visiting nurse service, and homemaker service—which can reduce the need for institutional beds. Out-patient and day-care services possibly could meet a larger share of the needs. Some, now considered candidates for nursing homes, might be better served in residential homes where some help is available for personal care. Nursing homes themselves could give more emphasis to the goal of restoring patients to the point where these noninstitutional services would meet their needs. If we shift our sights from meeting needs according to the way long-term patients have been treated in the past to the challenge of what is possible for them in the future, the pattern of needs to be met changes dramatically.

Among the conditions which we have noted is that nursing homes usually are isolated from the complex of health services in their communities. Physicians, while they may be concerned with particular patients of nursing homes, tend to ignore the nursing homes themselves. The medical community is just beginning to be concerned with the nursing home as a health care facility. Nursing homes receive patients from hospitals and send patients to hospitals, but have developed little professional communication with hospitals.

On the basis of the testimony this subcommittee has received, it appears that our present programs look to the past. Both our programs for construction and for payment for services contemplate traditional institutional arrangements derived from the period when nursing homes were strangers in the health care community used chiefly for warehousing those who did not fit in with the interests and modalities of the active treatment oriented professions. And the operation of our programs does little to encourage—if it does not actually discourage—the development of a balanced pattern of institutional and noninstitutional services and the integration of nursing homes with the armamentarium of professional services available for the care of aged infirm patients.

These conditions are reflected in the care and quality of professional ism in our present nursing homes. In any field where services are so personal and vital, and, at the same time, so remote from control by the consumer, regulation is necesary. Standards of care and safety and the quality of enforcement vary greatly from State to State. In all too many areas deplorable conditions exist.

It is our understanding that enforcement of nursing home standards is better in Colorado than in many other States. But, speaking generally, standards of care and safety must be raised and enforcement must be improved. I believe we can strengthen the hands of public health authorities which largely carry this responsibility, and I believe we can promote a climate in which their task will be much easier by encouraging, through the design of our programs, professional involvement in long-term care facilities and their free communication with the whole family of providers of health services.

So, I have indirectly described the task of this subcommittee. At the same time, I have indicated some of the preliminary conclusions which are developing from our hearings. If there are witnesses here today who disagree with what I have said, I hope you will take this opportunity to make your views known. Our only objective is to constructively assist you who are on the frontlines of service to our aged citizens.

This is an official hearing of the U.S. Senate and everything which is said here will be taken down by our reporter and made part of the permanent record of our committee. It will guide the legislative committees and individual Members of Congress who must develop and act upon legislative proposals in this field. I am sure that those who are scheduled to speak to us here in Denver this morning will add much to the store of information and expert advice which we are compiling.

We are pleased to have scheduled this morning many outstanding witnesses who will appear and give their testimony. As witnesses are called we will ask them to be seated at the other table on the platform

here this morning so that they may speak into the microphone and be heard clearly not only by the committee here, but by all who are in the hall and are interested in the subject this morning.

We are pleased to see that there are quite a number here who have come this morning to observe the proceedings and to listen. This indicates a concern with the problem and we are glad that many are concerned with the problem that exists and one about which we are inquiring in these hearings throughout the country.

Our first witness this morning will be Dr. Roy L. Cleere, who is director of the State Department of Public Health of Colorado. We are very pleased to have you, Dr. Cleere, and we look forward to having your testimony before us here.

STATEMENT BY DR. ROY L. CLEERE, DIRECTOR, COLORADO STATE DEPARTMENT OF PUBLIC HEALTH

Dr. CLEERE. Senator Moss, members of the Subcommittee on Long-Term Care, I wish to thank you for this opportunity.

There are five phases of progressive or comprehensive patient care—intensive, intermediate, self, long-term and home. My remarks will be limited to long-term and home care. Most of the inpatient care for the chronically ill is rendered by nursing homes in Colorado. There has been a remarkable improvement in the quantity and quality of care in these health establishments during the past 5 years. The number of homes has increased from 157 to 176 and the total beds from 5,365 to 9,254 since 1960; however, only 20 of these homes with a bed capacity of 578 are physically connected with hospitals; 139 homes are privately owned with a bed capacity of 7,827. During this 5-year period 16 newly constructed homes with a bed capacity of 531 have received Hill-Burton funds, 5 with 566 beds, FHA assistance, and 8 with 347 beds, SBA assistance.

Exclusive of the hospital-connected units the number of registered nurses employed in the homes has increased from 70 to 519 during the past 5 years. There are also 772 licensed practical nurses on duty in the homes.

Long-term illness presents a complex of problems that cannot be solved by conventional health planning. Chronic long-term illnesses distinguish themselves from acute short-term illnesses primarily in three aspects:

(1) Complexity of multiple causes and the insidious onset of most chronic diseases.

(2) The prolonger, and often downhill, course of the disease.

(3) The necessity of increased community responsibility for prevention of disability and for care of its chronically ill citizens.

These aspects of chronic disease necessarily imply that comprehensive programs must be developed to meet the needs of people with long-term illnesses. Educational programs are needed to increase knowledge of early symptoms and promote the use of early case-finding procedures.

I thought I would take just a minute to discuss the role of the Colorado Department of Public Health in nursing home care.

The authoritative role is rather definite, as the health department is charged by law with the responsibility for both establishing and en-

forcing certain minimum standards for the construction and operation of nursing homes, just as it does for hospitals. This is a large task, involving the annual issuing of licenses to those homes which meet the standards and the refusal to license homes which cannot or will not meet these standards. Obviously, this responsibility must be shared with others such as consultants who help to develop the standards, and local health departments which assist with annual inspections of nursing homes in their respective jurisdictions.

The licensing program not only includes compliance with established standards for sanitation, construction and fire safety, but also includes an evaluation of nursing and other services.

Our chief objective has been to have standards and appropriate licenses for three types of homes for the increasing population of oldsters who need institutional care: "home for the aged"—for those who require no nursing care; "basic nursing home"—for those who can help themselves to a considerable extent but require some nursing care; and "nursing home"—for those who need nursing care most of the time.

Recognizing the importance of education and consultation in improving nursing home care, the State health department has added the following consultants to its staff: a physical therapist, an occupational therapist, a dietitian, and a nurse with special training in patient rehabilitation. These persons are available to any of Colorado's nursing homes on an invitational basis, but they have, perhaps, worked most effectively as part of a formal educational program developed cooperatively by the State health department and the Nursing Home Association. As part of this program, 1-day workshops have been held in geographic regions of the State, using topics selected by the nursing home administrators. Another part of this program has been an intensive course on rehabilitation nursing, using the OT and PT consultants as part of the faculty. This course requires 26 hours and is likewise presented on a regional basis to both local nursing homes and small hospitals. The staff has recently published a comprehensive manual of the course content, "Elementary Rehabilitation Nursing Care."

The dietitian consults with the nursing home administrators on an individual or group basis, and her suggestions for improving and simplifying food purchase and service have been in great demand.

Home-nursing care is a vital part of the concept of progressive patient care and can mean a considerable reduction in the cost of illness. It makes it possible for patients to remain at home or to return to their homes under the supervision of their physician and receive part-time care from qualified nurses.

In Colorado 12 counties, covered by 7 health departments and 2 county-nursing services (representing 70 percent of Colorado's population) have home-nursing care as part of their public health nursing program through a combination agency (VNA and local health department). We propose to develop new programs within the State so that nursing services for the care of the sick at home will be available to every citizen in Colorado. Home nursing services appropiately used can save money for almost any type of medical or health care program but particularly one for the ill aged.

In the past, visiting nurse services have been supported by governmental agency funds, fees for services, and by voluntary funds (community chests and endowments, et cetera. Third-party vendor payments are being developed as evidenced by the expansion of payments for visiting nurse service of early discharged patients by Colorado Blue Cross; the State department of welfare pilot study for visiting nurse service care for old-age pensioners, and the increasing number of commercial insurances that are including home-nursing benefits.

The Blue Cross study done in Denver in 1961 revealed an average of 10.2 hospital days saved per patient at an estimated saving per patient of $305.48. Colorado Blue Cross believes that in addition to the savings the "continuity in patient care resulted in improvement of the quality of overall care."

Similarly, the old age pension nursing study in Boulder County in 1962 showed a saving of 104 total hospital days, 2,173 nursing home days, at an average saving of $232.76 per patient. Therefore, Colorado's participation in the Kerr-Mills Act should make some provision to include payments for visiting nurse services.

As a classic example of progressive patient care and the coordination of short- and long-term facilities, I would cite the program of stroke rehabilitation in the Denver area.

The program was a demonstration in depth in four voluntary hospitals in the Denver metropolitan area of comprehensive restorative care for the stroke victim. It was a cooperative endeavor sponsored by the State health department, the Colorado Heart Association, local health departments, and medical societies.

Financing was primarily from a special project grant from the U.S. Public Health Service and by funds supplied by the Heart Association and the State and local health departments.

The program was established to demonstrate that comprehensive rehabilitative care for stroke patients admitted to private hospitals could be made an integral part of private medical practice.

In addition to intensive hospital care during the acute phase, the program involved post-hospital, home, and nursing home care. Appropriate care is offered under the private physician, according to the patient's needs at various levels, during the course of the disease.

While the special project funds for the 3-year demonstration were terminated on December 31, 1964, the guiding principles evolved will continue to be utilized in comprehensive care for stroke victims in in the Denver area. Other Colorado communities are initiating similar stroke programs.

I will take just a minute to speak on the need for areawide planning.

The Colorado State plan for hospital and medical facilities is prepared annually by the State health department and is a written guide for the development, improvement, and modernization of hospitals and related health facilities. This plan guides communities in developing modern health facilities of appropriate size, location, and community service purpose. The State plan also establishes an equitable and objective basis for departmental action in allocation of Federal funds.

There is a great need for a research study for the development of a plan for hospitals and related health facilities, including community mental health and mental retardation centers on an areawide basis.

Colorado Blue Cross supported by the State health department recently submitted an application to the Public Health Service which, if approved, will make this possible in Colorado. As you know, a recent amendment of the Hill-Burton Act by Congress has made funds available for this purpose. We are also thankful for another revision that allows a limited amount of Federal funds to the States for administration and carrying out of the intent of the act.

Another worthwhile change authorizes funds for modernization of existing older hospital buildings. No doubt some of the buildings will be converted to long-term care facilities.

In addition to benefits derived from the Hill-Burton Act in providing additional long-term care facilities, the chronically ill in Colorado have received additional services through provisions of the community services, chronic disease, heart, cancer, tuberculosis control, and general health services Federal grants.

In my opinion, we should devote increasing attention to preventing and retarding chronic diseases, to establishing and extending home care services, to rehabilitation of chronically ill patients in their own homes and in nursing homes, to better coordination of acute or short-term and long-term care and to areawide planning for hospitals and related health facilities.

Thank you very much.

Senator Moss. Thank you, Dr. Cleere, for a very excellent statement. It contains much information that is most encouraging. It would appear that Colorado is, indeed, doing very well in this inspection and licensing of nursing homes. I noted that you said the State health department issued the license and was responsible for inspecting not only the service available, but the facilities of the home itself. Is that correct?

Dr. CLEERE. Yes, sir; that is correct.

Senator Moss. Do you do this in cooperation with the fire marshal or any other State department?

Dr. CLEERE. Unfortunately, Colorado does not have a fire marshal. However, we do receive excellent support from the fire departments throughout the entire State. As a matter of fact, before issuing the license a report or a recommendation is specifically received from the fire department, where there is one in a community, and also from the zoning commission in the larger cities, and also a specific recommendation from the local health department. The State health department takes all those factors into consideration prior to issuing of the license.

In addition, where local inspection and consultation facilities are not available the State health department renders those services directly to the homes.

Senator Moss. I see. I notice that the local health departments make periodic inspections after the license has been issued. Do the local fire departments also make periodic inspections to make sure that the standards are being maintained?

Dr. CLEERE. Yes, sir. I would say that is definitely true in the larger municipalities. Sometimes it does present a problem in the more sparsely populated areas where there are not adequate fire protection services through an organized department. I do feel there is a need for a State fire marshal or some similar type of State official.

Senator Moss. To coordinate overall?

Dr. CLEERE. Yes, sir.

Senator Moss. Do you have a license for boarding homes in Colorado?

Dr. CLEERE. No, sir; there is no State law at the present time that requires any type of license for boarding home operations. We don't have specific data with respect to the number of patients that are receiving treatment in boarding homes. However, the health department in recent years, I would say particularly in the last 2 years, has received some complaints that nursing home patients are receiving care in boarding homes.

Senator Moss. One would tend to shade into the other, since older people who go to boarding homes become ill and may remain there at the boarding home. You would think, therefore, that it would be desirable, also, to have inspection and licensing of boarding homes. Is that true?

Dr. CLEERE. Yes, I would say so.

Senator Moss. Mr. Frantz has a followup question.

Mr. FRANTZ. On the boarding home question, Dr. Cleere, can your department go in and inspect a boarding home to determine whether it is a boarding home and thus out from under licensing requirements or should be licensed as a nursing home?

Dr. CLEERE. We do not have that authorization at the present time. However, some of the local health departments through city ordinances do have the authority to inspect boarding homes, and from the viewpoint of certain safety features, such as the boilers and heating equipment, there is a limited authority vested in the State industrial commission for periodic inspection of those facilities in a boarding home, the same as other types of public buildings. But there is no organized program, I'd say, at either the State or local level with the exception of a few local health departments, for the periodic and routine inspection and supervision of boarding homes.

Mr. MILLER. Dr. Cleere, in your use of the term "boarding homes" in response to Senator Moss' question, I understand in Colorado you refer to some homes as basic homes and others as homes for the aged. Are you in this response on boarding homes covering both types of homes?

Dr. CLEERE. From the viewpoint of boarding homes I was speaking of a separate class entirely, separate class of buildings and service. In other words, separate from homes for the aged, basic nursing homes, and nursing homes.

Now, we distinguish, from the viewpoint of the licensing of these three types of health establishments, that homes for the aged do not require any type of an organized nursing service, and are not supposed to be treating nursing home or bed patients.

The basic home—realizing that some States use a different nomenclature for that type of establishment—requires limited nursing service for some ambulatory patients, and many of the patients do not require bed care around the clock.

Nursing homes are classified as those homes where patients, for the most part, require nursing care and bed care.

Mr. MILLER. You do license the basic homes?

Dr. CLEERE. Yes, sir.

Mr. MILLER. And the homes for the aged?

Dr. CLEERE. That is correct, and the nursing homes.

Senator Moss. If a patient became chronically ill when he was in a home for the aged, would he then be required to move on to one of these other homes that have the additional nursing services? Is there some kind of supervision to require that?

Dr. CLEERE. I'd say it is not adequately supervised. In other words, we would have to depend on the integrity of the operator or administrator, and also on periodic visits by Health Department staff to determine whether this transfer of patients is actually occurring. Ideally, of course, there should be the opportunity for a flow of patients, you might say, from nursing homes to hospitals and back again, and also from homes for the aged to nursing homes.

Senator Moss. In your statement you talked about the number of beds involved where there is a physical relationship between the nursing home and a hospital, and this was a rather small number of the total. I wonder how extensive is this hospital connection and how it can be fostered and extended by all of the nursing homes. In other words, I would assume that your recommendation would be for affiliation or at least a close connection between a hospital and a nursing home; is that true?

Dr. CLEERE. Well, we have been encouraging at least informal affiliations or agreements between nursing homes and hospitals. There is no legal requirement at the present time. I mentioned those hospitals in the State that have added chronic disease or nursing home units during the past 5 years. Interestingly, in Colorado the first hospitals to add nursing home units were in rural areas. We anticipate there will be more in the future in metropolitan areas that will have nursing home units as part of their hospital operation. There have been one or two of the larger hospitals in Denver just during the past year, for instance, that have completed plans for nursing homes or chronic disease units. One is under construction at the present time in Denver, affiliated with St. Luke's, and constructed within two blocks of this hospital.

Rural area hospitals have added nursing home wings or units. In northeast Colorado, three hospitals have in the last 5 years. As I mentioned previously, it seems to have developed more rapidly in rural areas than in metropolitan areas, but I think the trend will certainly develop at a more rapid pace in the larger cities and metropolitan areas in the future. In the meantime, or independent of this type of physically connected and definitely affiliated units, I think there should be some type of working arrangement between a nursing home and one or more hospitals, and some, of course, have already developed this type of agreement in Colorado. I am not indicating that there should be a legal agreement or affiliation necessarily from the viewpoint of the everyday operation and administration of private nursing homes and hospitals. I don't mean to imply that they should be administered, necessarily, by the same board and by the same administrative staff.

Senator Moss. I understand. Is there a problem, any problem you have encountered, in the giving of medication to the nursing homes not under direct supervision of qualified staff?

Dr. CLEERE. I would say it is a decreasing problem in Colorado. The problem was much greater 3 to 5 years ago than it is now. It still

presents a problem in some homes and in some areas of the State but, with increasing nursing services and nursing supervision, the problem is not nearly as great as it was several years ago.

Senator Moss. Has the inspection function of the Health Department accelerated this improvement—this functioning of care under medical and qualified nursing supervision?

Dr. CLEERE. Yes, sir; it has. We have put the emphasis, as long as 10 years ago, on safety of nursing home buildings in the State. We concentrated on that need earlier than we did no the need for improved nursing and medical services but, in the last 3 to 5 years, the emphasis has been on improved professional services in the nursing home and we have received excellent cooperation from the nursing home administrators and their own association. We think these district workshops have made a real contribution toward improving the quality of care in nursing homes.

Senator Moss. Thank you, Dr. Cleere. Mr. Miller has a question.

Mr. MILLER. Is my understanding correct, that you do not permit a general or intensive skilled nursing unit as a part of a home for the aged?

Dr. CLEERE. That is correct.

Mr. MILLER. You do, however, permit and encourage, where indicated, inclusion of this type of service in a hospital complex; is that correct?

Dr. CLEERE. Nursing home or chronic disease care, yes.

Mr. MILLER. This raises a question in my mind. It appears to me that this puts the nursing home patient in an illness-oriented situation rather than a living-oriented situation. Do you feel that the flow, of a patient, from the home for the aged to the nursing home and back to the home for the aged, at a later date, is a better approach in every instance than involving nursing services in the home for the aged so that this movement is unnecessary?

Dr. CLEERE. Yes; I do. That is my own personal feeling. One reason I say that is because of the fact that nursing homes are more than domiciliary care units. We look on them as facilities for the care of the sick and infirm and disabled; whereas, a home for the aged we look on as being primarily a self-care unit for the aged, ambulatory patients.

For instance, an older person in a home for the aged falls and fractures a hip, we don't think that that home for the aged should have all the facilities, of course, that are needed to take care of that fractured hip. That patient, of course, should be transferred to a hospital.

Now, during the convalescence that patient could go to a nursing home, then, later on, back to the home for the aged. But it is difficult to expect a home for the aged to have all the acute care facilities that are needed to case of accidents or injuries or to have all the facilities that might be neded for another types of complications for those that are medically ill and those that are requiring nursing services.

I do think in the future we will see more so-called hospital complexes in which you might expect to have the entire comprehensive care rendered in the one unit or one complex of care facilities from the intensive and intermediate, self-care, long-term, and, also, affiliated home care services. But I think that will be sometime in the future.

We are encouraging, for instance, the development of community mental health and community mental retardation facilities, either on hospital grounds or adjacent to hospitals, promoting a better coordination and integration of inpatient and outpatient care. I think, for the most part, in most sections of the Nation and in Colorado, there is a rather wide gap presently from the viewpoint of coordination of acute or short- and long-term care for patients.

Senator Moss. Mr. Frantz, do you have any questions?

Mr. FRANTZ. Just one. Viewing, as you do, the nursing home as a place for the treatment of the chronically ill and infirm, what are the requirements of your department, if any, with respect to physician care of nursing home patients? Do you require that each patient have the physician, for example, that each patient have a workup at the time of his admission, and things of this kind?

Dr. CLEERE. Yes; and there are standard record forms required, medical record forms, and charts on the individual patients, and they do have, either their own family physician, personal physician, or in some instances the larger nursing homes have a medical consultant for those that do not have their own personal physician at the time of admission to the home.

Mr. FRANTZ. Do you have ways of following up to see that each patient has, in fact, an active relationship with a physician?

Dr. CLEERE. There is no rigid supervision, meaning that there is no organized followup service or adequate supervision to determine in all instances that each patient is receiving adequate services from a physician, but certainly, for the most part, in my opinion, they are receiving medical supervision. Again, I think there has been remarkable improvement in the amount of physicians' services rendered to patients in nursing homes in the last 3 to 5 years.

Senator Moss. Thank you very much, Dr. Cleere. We would like to question you much longer, but we have many witnesses to hear. I particularly was heartened by your description of what you are doing now in home nursing and trying to increase this type of care. As I indicated in my opening statements, I personally think this is the direction that we should be placing in the forefront now, that there is so much to be gained not only economically—and even economically is true—but so much to be gained for the elderly person if he can live in his home and have adequate care in his usual surroundings rather than be taken away to someplace that is strange to him.

Dr. CLEERE. I can certainly support your views in that respect, Senator Moss. Thanks again for this opportunity, and I hope you will make a return visit to Denver.

Senator Moss. I will, sir. Thank you, Dr. Cleere.

We are now going to hear from Mr. Thomas Bell and Mr. Peter Samac. Mr. Bell is the director of the State department of public welfare, and Mr. Samac is coordinator of medical services. Will these gentlemen come forward?

We are pleased to have you here this morning and we look forward to having your testimony here.

Mr. BELL. Thank you, Senator Moss. Mr. Samac will make the prepared presentation for the department.

Senator Moss. Very good. You may go right ahead, Mr. Samac.

STATEMENT OF PETER SAMAC, COORDINATOR OF MEDICAL SERVICES; ACCOMPANIED BY THOMAS G. BELL, DIRECTOR, STATE DEPARTMENT OF PUBLIC WELFARE

Mr. SAMAC. Senator Moss, committee members, I want to thank you for the opportunity to participate in these hearings.

We have prepared a statement concerning the use of nursing homes in Colorado to provide inpatient care for eligible recipients under our old-age pension medical care program and the program for medical assistance for the aged.

First, I would like to define what in this State is identified as a nursing home and to distinguish this from what is called a basic home and a home for the aged.

By definition, a nursing home is a health establishment which provides nursing care, under the direction of a Colorado licensed physician, to patients who for reasons of illness or physical infirmities are unable to care for themselves.

A basic nursing home is a health establishment which provides personal services and simple nursing care under medical supervision for the comfort, safety, and health of persons with limited capacity for self-care.

The basic homes are to meet all requirements set forth in the minimum standards for nursing homes, with the exception of those parts relating to types of patients admitted and services relating to medical and nursing care.

A home for the aged is an establishment which provides lodging, board, and personal services other than medical or nursing care for the health, safety, and comfort of aged persons.

The differentiating factor between the basic home and the nursing home is the element of professional nursing care available to be given.

While we have, in the main, three classes of licensed facilities for the care of the aged, we in the medical division of the State welfare department deal with two classes: the basic home and the nursing home.

In Colorado, there is one licensing agency, the department of public health. This department licenses hospitals, nursing homes, basic homes, homes for the aged, and other types of medical facilities. The standards for these institutions have been established by the State health department. In the standards that have been established for nursing homes, persons with the following conditions are not to be admitted or cared for:

(*a*) Communicable disease, including active tuberculosis.

(*b*) Alcoholics, chronic convulsive type.

(*c*) Children 15 years of age or younger.

(*d*) Persons who have been adjudged to have acute psychotic conditions and who are dangerous to themselves or others.

Within the classification of nursing homes, the department of public welfare has group rated the homes. This rating serves the purpose of compensation based on the hours of nursing care provided, and, hopefully, the degree of skill. I will not go into detail for purposes of this presentation as the manual material is available for the committee's perusal.

A summary of our grouping is as follows:

We had, at the last count, 126 group IV homes. These are homes with licensed nurse supervision around the clock with a registered nurse as the director of nurses, plus aids and orderlies to assure an average of 2 hours of nursing care per patient per day.

Thirty-three group III homes: These are homes with licensed supervision around the clock with an LPN (licensed practical nurse) as director of nurses, plus aids and orderlies to assure an average of 2 hours of care per patient per day.

No group II homes: These homes have the same requirements as group III homes with the exception that only 1½ hours of care per patient per day are required.

Five basic homes: These are homes with a licensed nurse in charge of nursing and an aid or orderly awake and on duty at all times.

We have found there is a large number of patients who do not clearly fall in the structural patterns to which the homes have geared themselves. As an example, we find ourselves facing the question time and time again, "Does this person need basic care instead of nursing home care?" This is a particularly vexing problem with many of the dischargees from our State (mental) hospital. Their need appears to be largely custodial and with supervision needed. Yet we find them discharged to group IV and group III homes.

The practice of having all types of patients in these facilities is not only costly, but the big question is, "What are we trying to achieve? What is the medical and social plan for the patient placed in our nursing homes?"

We have not clearly differentiated in our medical-social planning how to best use the nursing home, or long-term facilities, by whatever name we wish to call them. I will not go into the medical aspects of long-term care as this is not in my province, but there seems to be the need to establish levels of long-term care.

(1) Intensive care: This I see as a hospital-based unit for diagnostic, therapeutic, and restorative types of care.

(2) Maintenance care: This to provide care to the individual at his present level of function as his disability and limitations permit.

As of February 8, 1965 (and there have been some homes licensed since that time) there were 173 nursing homes in Colorado providing 9,305 beds. There are 164 homes participating in the welfare program; that is, they have signed an agreement to take welfare recipients and to adhere to the rules and regulations set forth by the State welfare department. The 164 homes provide 8,964 beds. Sixty-five of the participating homes are in the Denver metropolitan area and provide 4,210 beds. On a statewide basis, there are 5,243 welfare recipients in the 164 participating homes, or approximately 57 percent of the beds are occupied by welfare recipients. There are 2,094 of these patients in the 65 participating homes in the Denver area. Therefore, approximately 49.7 percent of the Denver area beds are occupied by welfare recipients. In a survey made of the Denver area in January, we found there were 960 vacancies, or almost 1 out of every 5 beds available were vacant, so that the percentage of welfare occupancy is considerably higher in the Denver area when measured against occupied beds. At the present time, the Denver area has a surplus of beds available.

UTILIZATION OF NURSING HOMES

For the fiscal year 1963–64, nursing home care was provided to 6,755 recipients, compared to 5,976 persons in 1962–63. The monthly average during 1963–64 was 4,227 cases, compared to 3,618 during 1962–63.

Payments from the old-age pension medical care fund for nursing home care totaled $3,916,768.54, an increase of $517,879 over 1962–63, which was $3,398,889.02. The old-age pensioner paid an additional $5,241,632. The total payment to nursing homes amounted to $9,158,400.54.

I might add here, sir, that the 5 million was made from their old-age pension stipend award; they had to contribute $105 of the old-age pension grants. If there was any other income they might have had, that was also contributed.

In 1963–64, 170,296 prescriptions were filled for a total cost of $485,-008.03, an increase of $54,431 over the previous year.

We estimate that our nursing home expenditure for fiscal 1964–65 will approximate $10 million and that of drug cost for fiscal 1964–65 will approximate $550,000.

PAYMENT TO NURSING HOMES

Payment to nursing homes is based on patient classification and the group rating assigned to the nursing home.

Maximum allowable rates to be paid are as follows:

1. Basic nursing care—$120 for a patient in any group type of home.

2. Technical care—$170 in a group II home, $185 in a group III home, $195 in a group IV home.

These amounts are paid to supplement the recipient's income which is then deducted from the vendor payment to the nursing home. In OAP, the recipient is required to make payment of $104 (which is now $105) from his OAP grant and/or other income to the nursing home. The difference is then paid by vendor payment.

Payment for nursing home care has been a source of discussion between the nursing home administrators and the Department for a long period of time.

The Medical Assistance Act enacted in 1964 states:

The State board of public welfare shall establish a price schedule or schedules for nursing homes and other medical facilities, related as nearly as possible to the cost of such service rendered to the recipient, or the level of necessary services utilized by the recipient.

In July 1964 the Department undertook a pilot study of 20 nursing homes to try to ascertain their cost of operation. This study became the basis of discussion with the Nursing Home Association and has resulted in the adoption of a financial statistical report to be submitted annually to the State welfare department and is to be used to determine rate of payment for nursing home services. We are in the process of implementing the program of cost reporting. There are, however, still some dissenting nursing homes that do not wish to go along with the association's officers and the concept of reporting their costs.

HOW QUALITY IS CONTROLLED

As mentioned previously, the State department of public health is responsible for licensing nursing homes. With licensing, an enforcement of standards is an integral part. These standards are oriented to the physical plant, maintenance, sanitation, and fire safety. The department of health also prescribes standards for nursing supervision, but not for the quality or quantity of other staff members. The quality of medical care is not regulated except as it pertains to records and orders for care. This element is solely within the dictates of the profession and the conscientiousness of the individual nursing home practitioner. In Colorado we do not have medical review teams operating out of county welfare departments or the local medical society. Each patient is to have a doctor of his choice and can be seen by the physician as often as is medically indicated. This system provides a varying degree of effectiveness. The medical discipline found in hospitals and other institutions with organized medical staffs is conspicuous by its absence in nursing homes.

The State department of public welfare carries on an audit of the nursing homes. Our interest is in the management and administration of the home, checking to see that medications we are providing have been ordered by the physician and are being charted as administered, and that there is adequate nursing staff to provide care to patients. We try to work in close liaison with the State health department in the enforcement of standards in these institutions. Our staff inspects participating nursing homes at least twice yearly.

It is this department's belief that incentive to good care can be incorporated in a payment system based on uniform cost reporting.

In addition to the system of reporting, we believe that central planning is needed for all health facilities, especially to define the levels of long-term care, the development of standards for these institutions, and a strong and fearless enforcement of standards. The allied professions in the health field—physicians, nursing associations, health departments, VNA groups, the Nursing Home Association, and the citizenry—need to review what we want to accomplish in long-term care. The standards and objectives that come from this source coupled with an equitable system for reimbursement, plus a professional review of patients' needs and a constructive placement service should meet the demands for better care in nursing homes.

Senator Moss. Thank you, Mr. Samac. That is a very fine statement and would indicate that you are, indeed, making some notable progress in this field of the care of the elderly in nursing homes.

I notice in your statement you comment that the degree of medical discipline found in hospitals and elsewhere is notably absent in nursing homes. Some of the testimony we have received in other areas has been to the effect that the medical profession has oriented itself so strongly to treatment and remedy of acute matters that it has tended to overlook long-term chronic illness of the type that we have in nursing homes, and that there has been relatively little interest or emphasis placed in that area. Has that been your observation, too?

Mr. SAMAC. I would say generally that is a pretty fair observation. I think there are probably reasons for it, though, because generally the doctor is oriented to the acute-type illness. He is also oriented, gen-

erally speaking, to voluntary nonprofit institutions in which he works, in which he has some voice in the medical management of that institution. He may not feel he has all the prerogatives he would like to exercise in the nursing home that is owned by a private group or is a proprietorship.

Senator Moss. Isn't it true, also, that his medical education is directed to the acute patient and treatment of the acute diseases and has placed relatively less emphasis on chronic and long-term illnesses?

Mr. SAMAC. Senator Moss, I think I should defer that question, of course. I think the medical education field is not in my province, but I think the literature I have read seems to indicate that this is true.

Senator Moss. I was interested in your pointing out that together with the Nursing Home Association you have been able to make a start on uniform cost reporting of the care of patients in nursing homes, and you said there is still some resistance to it. How extensive is the resistance among nursing home operators to the uniform cost reporting?

Mr. SAMAC. Well, I would say it is not too extensive at this point. We have had a real fine working relationship with the legislative committee of their association. We have recently held institutes discussing the method of reporting with the nursing homes throughout the State. I would say out of the 164 participating homes we have had 30-some-odd nursing homes that did not attend the meeting. I would say that there was a small number of those 30 homes that are really against cost reporting, and I think the reason perhaps is because some of them don't fully understand it, and secondly, there probably is a fear of it. But I would say that the resistance is, at this point, not too great.

Senator Moss. Are there many nursing homes in Colorado who will not take old-age assistance patients because of the amount that is available for their care?

Mr. SAMAC. Well, as I mentioned, there were 173 that we considered as licensed nursing homes. There were 164 paritcipating with us. So there is a difference of nine.

Senator Moss. That is a very high number, I would think, from the reports we have had in other areas, and this would indicate either that you come very close to paying the full way or a particularly public-spirited attitude toward including welfare assistance patients.

Mr. SAMAC. That is what we hope to do with our cost reporting. We have always had discussions as to what is cost and what is fair reimbursement, we are implementing this program this year, and by the first of 1966 we feel that we will have data that we can examine to find out just what is the cost of caring for the patients in nursing homes.

Senator Moss. You are utilizing the Kerr-Mills medical assistance program?

Mr. SAMAC. We put this into effect in July of this year, sir.

Senator Moss. Are these funds going primarily to old-age assistance recipients, or has your MAA program picked a new, larger group that have not been served before?

Mr. SAMAC. It is primarily going to old age pension recipients in our State. We picked up very few new recipients as a result of our Kerr-Mills Act in Colorado, and I think that our eligibility requirements from the standpoint of property and resources are identical to those with our Old-Age Pension Act.

Senator Moss. Mr. Frantz has a question.

Mr. FRANTZ. One point on your cost reporting. I wondered if you had reached agreement with the nursing-home field in Colorado on this question of what is a fair return on investment?

Mr. SAMAC. I imagine that is going to be a real topic of negotiation, Mr. Frantz, sometime after the first of the year.

Senator Moss. I was interested that you have a surplus right now of nursing-home beds. Is this concentrated in any particular area, or is it concentrated in any particular type of nursing home?

Mr. SAMAC. It is concentrated in the Denver area and the Denver metropolitan area.

Senator Moss. Do you have any speculation, if not factual information on why this has come about?

Mr. SAMAC. I would rather not speculate. I do think it might have been predicated on the number of welfare recipients that might be eligible for this type care, and this hasn't fully materialized. It might have been predicated on the Kerr-Mills Act that was enacted in Colorado, with maybe more liberal eligibility requirements anticipated. Whatever the reason, I think it points up the need for good community planning not only for nursing homes but for hospitals and any other inpatient facilities.

Mr. MILLER. Persons who are clients of the department of public welfare and are residents of homes for the aged or boarding homes, what is the maximum rate monthly that you are able to pay for their care?

Mr. SAMAC. We do not pay for care in homes for the aged. If this person be an old-age pension recipient, he is to receive to a maximum of $114 a month. He can utilize that money and reside in a home for the aged if there is a home for the aged, or he can reside in the boarding home. This becomes his personal choice.

Senator Moss. Thank you, Mr. Samac and Mr. Bell.

Mr. Bell, do you have anything to add to this?

Mr. BELL. No, Senator. I just accompanied Mr. Samac on this one.

Senator Moss. Very good. We are glad to have you and pleased that you came to appear with Mr. Samac. We appreciate your testimony, sir, and this copy of the nursing-home care general provisions here in Colorado will be made a part of our file and we will refer to that here. Thank you very much.

Our next witness will be Dr. Schapire, who is the director of the Division of Psychiatric Services, Department of Institutions, here in Colorado. I understand that he will be accompanied by Mr. Ewing. representing the superintendent of the Colorado State Hospital at Pueblo, and Mr. George Tippin, director of the Geriatric Release Center of the Colorado State Hospital. Will these gentlemen come forward, please?

We are pleased to have you here to appear before this committee and we look forward to your testimony.

Dr. Schapire, you organize it any way you want to among the three of you.

Dr. SCHAPIRE. Thank you, Mr. Chairman.

STATEMENT OF DR. HANS M. SCHAPIRE, DIRECTOR, DIVISION OF PSYCHIATRIC SERVICES, DEPARTMENT OF INSTITUTIONS; ACCOMPANIED BY JACK EWING, REPRESENTING THE SUPERINTENDENT OF THE COLORADO STATE HOSPITAL; AND GEORGE TIPPIN, DIRECTOR, GERIATRICS RELEASE CENTER, COLORADO STATE HOSPITAL

Dr. SCHAPIRE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Dr. Hans M. Schapire, chief of psychiatric services for the Colorado Department of Institutions. I have with me, to my left, Mr. Jack Ewing, who represents Dr. Charles Meredith, the superintendent of Colorado State Hospital in Pueblo. Dr. Meredith regrets his inability to be here today because of a previous obligation with the Naval Reserve.

I also wish to introduce to you Mr. George Tippin, a psychiatric social worker, who, for the past few months, has been in charge of the geriatric placement and release program of Colorado State Hospital.

With your permission, I shall give a brief overall presentation of our program. Mr. Ewing and Mr. Tippin may wish to give you more detailed information. All three of us will be available to you for any questions you may have at the end of our formal presentation.

As in most other States, our State hospital had been used for many years as a human warehouse for all those individuals for whom their own communities had failed to provide adequately. A large portion of all our admissions was represented by a group of patients who were suffering because of old age, of various degrees of infirmity or financial dependence, and who were therefore in need of some protective care. Some of these people showed typical manifestations of old age, such as forgetfulness, sleep reversal, and emotional instability. Others had developed frank psychotic symptoms. However, whether or not a patient found his way into a psychiatric facility or into a nursing home depended upon criteria not necessarily related to the medical or psychiatric condition of the individual. Such factors, as economic status of the family, the ability of the family to tolerate various degrees of abnormal behavior, the social mores of the community, the presence or absence of local facilities for the care of the aged in the patient's community—all these factors played an important role in the determination of whether the patient went to a mental hospital or to a nursing home. We established this fact early in 1961 when staff of the Fort Logan Mental Health Center conducted a simple survey which indicated that a large number of geriatric patients who were then being cared for in private nursing homes throughout the State did not differ in their symptomatology from the geriatric patients who were present within our State hospital.

We were helped in our determination to do something about this undesirable situation by an amendment to article 24 of Colorado's State constitution which, for the first time, established a health and medical care fund which put the State welfare department into the business of providing welfare recipients with payments for medical care, including care in nursing homes. This program, initiated in 1956, had a slow start but almost immediately resulted in a diminution of the admission rate to our mental hospital of patients 65 and over.

While in fiscal 1957 a total of 490 patients 65 and over were admitted to Colorado State Hospital, representing 35.3 percent of the total number of admissions for that year, in fiscal 1960–61, this number had been reduced to 370 patients, representing only 19.5 percent of the total number of admissions. By fiscal 1964, this number had been further reduced to 270 admissions, representing only 13.4 percent of all admissions. These figures indicate that a large proportion of elderly people, if given economic help, can be maintained either in their own homes or in various long-term facilities outside a mental hospital.

Our actual nursing home placement program was initiated in December of 1961. It was preceded by careful negotitations involving the department of public welfare, the Colorado State Hospital, and staff of the department of institutions. Ground rules for the placement of geriatric patients in nursing homes were established. It was agreed upon that every patient, in order to be eligible for welfare payments in a nursing home, would have to have evidence of a medical condition requiring continued nursing care. In line with Federal regulations, these patients were no longer considered to be patients of the State hospital and they were to have the right to leave the nursing home and move elsewhere as they saw fit. An attempt was to be made to place patients in nursing homes located in their own communities, or close by. In case of major medical or surgical illness, the State hospital agreed to accept the patient back for proper care and treatment, thus reducing the financial burden to the department of public welfare. If the patient's psychiatric condition became worse he could be returned to the State hospital at any time, thus giving assurance and support to nursing home operators who initially were quite concerned about accepting patients from mental hospitals.

This program, by and large, has worked out very well. Close to 1,200 patients have been placed in the last 3 years. The number of patients over 65 at Colorado State Hospital has been reduced from 2,099 on June 30, 1961, to a present low of 753.

From the very start, we have attempted to maintain at least a minimum of supervision and control to make sure that patients placed in nursing homes would receive at least as good care as they had been receiving at the State hospital. Initially, this was not much of a problem because of the limited number of nursing homes which were being used for placement. As the number of patients placed increased, however, this has become a major task, and it may well be that we have not always been completely successful in supervising each and every nursing home and the progress of each and every patient placed as adequately as we would have liked to. We feel that, basically, such a program of supervision should be part of a network of aftercare services in each and every community. Our effort to provide this supervision with staff based at the State hospital represents a temporary solution to the problem pending the development of more adequate community-based mental health services. If the proposed comprehensive community mental health centers become a reality, the care and supervision of geriatric patients placed in nursing homes and other long-term facilities such as boardinghomes, homes for the aged, and so forth, would certainly become an essential function of their staff.

This leads me to a final thought in my formal presentation. I would like to question whether the nursing home is truly the most appropriate

facility for the long-term care of these patients. Undoubtedly, there are some who have serious physical infirmities and require expert medical and nursing home care around the clock. However, many more of these people do not need this kind of setting at all. They should be ideally in a living situation where the primary concern with them is as persons rather than as patients; a setting in which, in addition to basic creature needs, emphasis would be placed on social and rehabilitative services. There are a number of reasons why we have not made use of facilities closer to this model. First of all, they do not exist. Secondly, vendor payments to nursing homes would not be available for a facility whose primary purpose would not be medical and nursing care. We had to take advantage of what was available to us. But, in the future, it would be nice if something could be worked out to provide for the elderly in a setting appropriate to their needs rather than to force them into existing models such as a mental hospital ward or the nursing home.

Senator Moss. Thank you very much, Dr. Schapire. We do appreciate that, and we would like to hear from Mr. Ewing or Mr. Tippin. Mr. Ewing.

Mr. EWING. Dr. Meredith, the superintendent of our hospital, couldn't be with us today, but he did ask that we read a letter, and with your permission, I will.

Chairman and Members, U.S. Senate Special Committee on Aging:

GENTLEMEN: I regret I am unable to be with you to participate in this significant hearing. At the present time I am on 2 weeks of active duty as a Naval Reserve medical officer with the U.S. Marine Corps, Camp Pendleton, Calif., orders having been issued prior to my notification of today's hearing. Representing me are several key members of Colorado State Hospital staff who are fully conversant with our programs, particularly our geriatrics programs as they relate to the psychiatric services rendered the citizens of Colorado.

I believe we in Colorado have made an important breakthrough as regards the care of the chronically ill and the aged person. We are beginning to realize the results of the efforts of many devoted persons and interested agencies in Colorado during recent years.

I commend Mr. George Tippin's paper to you. It outlines our philosophy, program rights, and look at the future. We constantly attempt to examine and to explore better ways of approaching these age-old problems.

Sincerely yours,

CHARLES E. MEREDITH,
Superintendent, Colorado State Hospital.

Senator Moss. Very fine. You have a paper, Mr. Tippin, and we would like to hear it.

Mr. TIPPIN. Mr. Chairman, in the interest of time and the fact that some of what I have prepared has already been covered quite well by Dr. Schapire, I would like to present only excerpts of the paper I presented to the committee.

Senator Moss. I will say in the first place that the entire paper will be placed in the record, as though read in full, but you go ahead and highlight it, emphasizing parts as you wish to do.

Mr. TIPPIN. The Colorado State Hospital has accomplished the community placement of elderly patients through the development of a geriatric release program. This program is based on the premise that the Colorado State Hospital is a psychiatric treatment hospital and that custodial care is not a function and not an economic use of treatment funds. It is appropriate to use local community reserves;

that is, nursing home, public assistance fund, and other forms of individual income, and that placement of patients in nursing homes in or near their county of residence and near family members, whenever possible, is to the best interest of the patients. The geriatric release program has as its primary function the screening preparation, referral, and placement of elderly hospital patients in facilities outside the hospital, usually nursing homes.

THE ELDERLY POPULATION PRIOR TO THE RELEASE PROGRAM

This program was started in 1961. At that time 36 percent of the 5,708 patients in the hospital were 65 years old or over. Many of these patients could leave the hospital, if some plans could be made for their care in the community. A great many of these patients were admitted as young adults and had grown old in the hospital. Since the beginning of the release program through December 1964, there has been an overall reduction of hospital census of 2,341 and a reduction of the elderly population of 1,346.

THE FATE OF THE ELDERLY IN THE HOSPITAL

The elderly population of the State hospital has been greatly reduced since the beginning of the geriatric release program. The fate of the elderly patient who has either grown old in the hospital, or the new admission, has improved. This is due to decentralization of the hospital into geographic and special care units, the geriatric release program and the forward looking philosophy of the State hospital. Through the treatment programs of the geriatric release center, the fate of the elderly population in the State of Colorado has also improved. Since 1961 there has been a doubling, if not tripling, of the modern, well-equipped nursing home. This has helped to reduce the numbers of elderly patients being admitted to the hospital by providing a facility for care within the patient's own area. In fact, this admission rate has been reduced by 100 patients. The activity of the release program has played a part in this development.

PATIENTS PLACED BY THE RELEASE PROGRAM

Between 1961 and December of 1964, 1,183 patients have been placed by the geriatric release program. This does not include those elderly patients who have been placed by the geographic divisions through release to their own home, homes of relatives or placed in foster or boarding homes. Not all of the patients placed by the release program are elderly and, while patients planned for by the release program were placed mainly in nursing homes, some were placed with families or in boarding homes. Of the 1,183 patients planned for by the release program, about 75 percent are age 65 or over and 1,070 were placed in nursing homes. The others were placed in boarding homes or with their families.

OLD-AGE PENSION PLANS IN COLORADO

Placements were facilitated as Colorado has a unique old-age pension plan. In addition to the federally matched grant known as the class A pension, those persons who meet the usual financial standards

but who are 60 to 65 years of age and who have lived in the State 35 years, may receive a State financed, or class B, old-age pension. All persons who are eligible for class A or B pensions may receive a State-financed or class C pension while they are inpatients of the Colorado State Hospital. This is important for two reasons: First, those eligible for public assistance are already identified and, second, when the patients leave the hospital, the class C pension can be changed to class B or class A, or medical assistance for the aged, without the necessity of age, residence, or financial investigations.

THE GERIATRIC RELEASE PROGRAM IN THE BEGINNING

In the beginning the release program had to demonstrate that patients could be placed in nursing homes. The inauguration of the program was preceded by many conferences with the State Department of public welfare, local county department of welfare, communities, and nursing homes. Initially the patients selected were the so-called better patients who could easily adjust to the change. The patients are placed on conditional release from the hospital and may be readmitted to the hospital, if necessary, without formal recommitment. Initially two nursing homes were used as a pilot project.

After decentralization in March of 1962, the release program became a physical entity and 60 beds were assigned as the geriatric release center on the north campus. The purpose of this center was to serve as a transition area for patients prior to their placement in nursing homes. In 1963, 60 more beds were added. Later a second release center was opened to serve the south campus. The emphasis during this period was the continual placement of the ambulatory and better patients. At the peak of this operation, April to July of 1963, 310 elderly patients were released from the hospital.

In September of 1963, the south release center was closed, having served its purpose. Between September of 1963 and July of 1964, all patients placed by the release program were first moved to the geriatric release center. By now, the placement task involved patients requiring more preparation through resocializing activities; patients with more severe physical problems, so that emphasis was needed in even more evaluation of the patient and his special needs. Planning is done with the patient, not for the patient. The patients who are being worked with by the release program staff are involved in a type of group therapy as well as the casework treatment of one-to-one interviewing. The purpose is to help the patients understand where they will be going and what they may expect in the nursing home. The needs of the patients are determined, the relatives of the patients are brought into the planning and the patients, in the majority of cases, are referred to the department of public welfare for planning and financial arrangements.

In January of 1964, instead of the hospital making the selection of the nursing home, the patients were referred to the department of public welfare and, unless the patient, the family or the hospital had specific recommendations, the county department of welfare was asked to make the selection of the nursing home. The department of welfare not only determines the rate of the care for the patient, but will also give casework services to the patient in the home and, in addition,

has better knowledge of the nursing homes in their area than does the hospital.

RELEASE PROGRAM PROFESSIONAL STAFFING

The professional staff of the release program has undergone many changes. The program was started by a professional social worker and other staff members were not added until early in 1962 when a case aid and a full-time secretary joined the program. Later in 1962 an additional case aid and secretary were added.

Early in 1963 the social worker, who established the program, left the staff but was quickly replaced and a third case aid joined the staff; however, in the summer of 1963 this social worker also left the staff and the release program was reduced to three case aids and the two secretaries; however, a full-time medical consultant had been added. During the period when there was no social worker on the release center, the case aids were supervised by the director of the social service department.

The staff of the release center continued to be reduced until January of 1964, when the present social worker was assigned. Thus, in early 1964 the staff consisted of one social worker, one case aid, two secretaries, and the medical consultant. Gradually the staff expanded until it reached its present strength in October of 1964. The staff now consists of a registered nurse and a part-time social group worker in addition to 2 case aids, 2 secretaries, a full-time medical consultant, and about 24 nursing personnel and nursing supervisors.

THE GERIATRIC RELEASE PROGRAM AT PRESENT

In July 1964 the release program made further modifications. The primary reason was to reach more patients. The release program staff screens the referrals for the divisional social workers in individual interviews with the patients and, if thought acceptable as a possible nursing home placement, the release program staff begins the preparation of the patient. When it is believed that the patient is sufficiently motivated, preparations are completed on the geographic division. If the patient is in need of intensive resocialization or remotivation, the patient is transferred to the release center. The nursing staff of the release center has been oriented to treat the special needs required by these patients. To date this appears to be a valid program and, as experience is gained, it is anticipated that more patients can be placed.

From the time this process is started until the patient is referred to the Department of Public Welfare, the patients have been involved in about 30 to 60 days of specialized treatment. Also, during this time the patient receives a physical workup, dental evaluation, and any necessary physical treatment as well as a final psychiatric evaluation. The patients are provided with basic clothing needs.

Patients are prepared in a time-limited program. This has been found necessary as elderly patients, as many other elderly persons, have a very limited future orientation. By anticipating a concrete date that an event will happen, the patient had something to hold on to and to look forward to. This time-limited program also added a dimension of reality to the preparation. It has been found from experience

that the normal time required for the Department of Public Welfare to process an application is between 30 to 60 days. Thus, the anticipated date of placement is correlated with the time usually required for processing the application. As the time of anticipated placement approaches, the patients reach a point of readiness. If, for some reason, this anticipated date is not met, the patients often show signs of depression and, if the date of placement is postponed for long periods, the patients become distrustful of the staff, withdraw and, in a few cases, have died. While there is no knowledge of evidence to support this, the elderly as a population group seem to have little regard for excuses. They tend to look at excuses as rejection and, having already been so often rejected, they defend themselves by withdrawing.

SOURCES OF MAINTENANCE OF PATIENTS PLACED IN NURSING HOMES

As indicated previously, the majority of the patients placed in nursing or boarding homes are being maintained by public assistance. Of the 218 patients placed in nursing or boarding homes in 1964, 162 are being totally or paritally maintained by public assistance funds. Thirty-five are maintained by private funds, and 21 are maintained by private funds supplemented by hospital funds.

RATES FOR CARE IN NURSING HOMES

The cost of care outside the hospital is dependent on the need of the patient and the type of facility used. While the Department of Public Health licenses the home and defines the class of the home, the Welfare Department sets the cost of care and determines the need of the patient based on information received from the treating physician. This procedure does not vary for patients who have been in the State hospital. The maximum rate set by the Department of Public Welfare is $195 plus $10 personal spending money and limited medical services, doctors' calls, and hospitalization in a general hospital. The minimum amount is $120 per month with the same additions. The family may supplement the amount paid by the Welfare Department up to $55. Thus, $250 is the most that a nursing home may receive for public welfare patients. Generally the nursing homes have set their charge from a minimum of $250 to a maximum of $450. This places some nursing homes out of the reach of the public welfare patients and the second best facility must be chosen. This is particularly true of the $120 a month patient.

EVALUATION OF ADJUSTMENT OF PATIENTS IN NURSING HOMES

A research project completed in the spring of 1964 by a hospital staff member developed and tested an instrument to evaluate the patient's adjustment after placement in a nursing home. Twenty patients who had been placed in the Denver area between February 22 and May 1, 1964, were chosen for this study. These patients were rated as to their level of adjustment before and after placement. The patients were divided into two groups: Those who were rated 4 weeks after placement and those rated 8 weeks after placement. The results show that, based on the statistical information gathered, there was no significant change in the adjustment of the total group before or after

placement. There was also no statistical significant change in the adjustment of the group whether rated 4 weeks or less, or 8 weeks after placement. It was noted, however, that there was a difference in the individual scores of the group before and after they had been placed for a period of 4 or less weeks and the scores of those individuals before and after they had been placed for 8 weeks.

These findings are inconclusive due to the limited number of patients studied and the short period of the study. However, these findings do tend to support the hypotheses that there is no change in either the well or poorly adjusted patient within the first few weeks after placement, and that those patients who make a good hospital adjustment will make a good nursing home placement while those patients who have a poor hospital adjustment will make a poor nursing home adjustment.

HOSPITAL FOLLOWUP OF PATIENTS PLACED

While the patient from the hospital is placed on conditional release, the prime responsibility for the public welfare patient in the nursing home rests with the Department of Public Welfare. However, the hospital retains a continuing interest in the patient. In order to more adequately meet this need, the release center added a registered nurse to its staff in October of 1964. The chief responsibility of the nurse is to visit the nursing homes where the patients have been placed to help the nursing home and the patient make the best possible adjustment. Her role is becoming that of a consultant to the nursing home staff. This is believed necessary as the placement of patients has posed some special problems for the nursing homes. The largest of which is that of psychiatric medications, particularly the tranquilizers. Nursing homes seem to have little experience in the use of tranquilizers as an adjunct in behavior modification. The second largest problem is that of establishing and conducting goal-directed therapy and rehabilitation treatment programs.

The nurse also rates the nursing home as to the care, treatment, and program that is apparent. The homes are visited periodically and the condition of the patient, both physically and emotionally, is evaluated. Complaints brought to the attention of the hospital by the patient, family, nursing home, welfare department or department of public health are also looked into. While the hospital has no jurisdiction in the licensing or supervision of the nursing homes, an attempt is made to cooperate with those agencies that do, and to help those nursing homes who wish it, to improve their standard of care.

Since October 1964, 43 of 63 nursing homes caring for hospital patients have been visited. In these homes a total of 675 patients have been seen at least once. Twenty-eight homes caring for 480 patients are, in the hospital's opinion, exceptional or acceptable in treatment and care programs. Eleven homes caring for 178 patients have been rated as marginal and 4 homes caring for 17 patients were found unacceptable. In the homes that were found marginal or unacceptable, repeated visits have been made to help the nursing home staff improve the quality of care. When and where this is deemed impossible, or the nursing home staff is uncooperative or resistive to such help, steps are taken to help the patient move to an acceptable home. In these cases the patients are referred to the welfare department.

In some cases the patients may be returned to the hospital for reevaluation.

BOARDING HOME PLACEMENTS

In evaluating the needs of a patient prior to placement, some patients do not require 24-hour nursing care but can make an adequate adjustment with a minimum of supervision. These patients are placed in boarding homes. These are unlicensed nursing care facilities, but are licensed boarding homes—licensed by local ordinances. Boarding homes offer room and board, limited-type nursing care and minimal social supervision.

The patients receiving public assistance receive casework services from the department of public welfare. However, since the majority of these homes are in the Denver metropolitan area, the Denver representative arranges some followup care. This includes arrangements for medical supervision through public hospitals and clinics. Services are given 1 day a week by one of the psychiatrists from the State hospital. Referrals are made, when necessary, to public health nursing, public health clinics, and to other social agencies as needed.

PATIENTS REMAINING IN NURSING HOMES

Perhaps one indication of an adequate treatment and placement program is reflected by the large number of patients remaining in nursing and boarding homes. Of the 1,183 patients placed, there is said to be 951 patients still in nursing and boarding homes. This figure is approximate, but just how many of the patients placed are still in the nursing and boarding homes is in question. Some patients have left these facilities to live in their own homes, others have moved to live with relatives and, of course, many have died. It is believed that the death rate in the nursing homes will be surprisingly low. In 1964 it is known that the hospital police returned only 28 patients from nursing or boarding homes. Relatives and the nursing homes themselves returned another 10 to 15 patients. Between December of 1963 and March 1964, about 30 patients were returned for purely financial reasons. It is estimated that between 100 and 150 patients who were placed by the release center have been returned to the hospital. Of this, about two-thirds have been again placed, the others have either died shortly after return or still remain in the hospital.

ELDERLY PATIENTS ADMITTED TO THE HOSPITAL

During the summer of 1964 the release center also conducted a small research project to determine who were the elderly patients admitted to the State hospital. Of the 283 patients admitted during the year July 1, 1962–June 30, 1963, only 107 were in the hospital at the time of the study. The remainder had either been placed outside the hospital or had died at the hospital. Of the 107, a random sample of 53 patients were chosen for detailed study. Of the sample studied, persons previously living in nursing homes accounted for the largest number of admissions. Over half of these patients were known to the welfare department. Table I gives the person or agency requesting commitment and the means of the patient's income, if any.

TABLE I.—*Random sample of the patients remaining in the hospital in June of 1964 who were admitted to the Colorado State Hospital for the year July 1, 1962–June 30, 1963*

Agency requesting commitment:	Total patients in sample
Relatives	7
Nonrelatives, friends, neighbors, etc	7
Nursing homes	18
Police department	3
Criminal offenses	2
Self (voluntary)	3
Agency or person unknown	7
Total	53

Means of financial support:	Total patients in sample
Welfare–OAP	18
Social security and OAP	7
VA benefits	4
Social security	8
OAP–VA–SS	4
No pensions	8
Financial unknown	4
Total	53

Only four of the above samples were seen in psychiatric hospitals prior to admission, and only five had been seen in general hospitals. Thus, fully one-third to one-half were known to some agency prior to hospitalization. Also, over one-half were known to the department of public welfare. Half of these patients were found to be nonpsychotic upon admission to the State hospital, but rather were disoriented, confused, untidy, bedridden, or unable to take care of themselves. After reviewing these patients, it is believed that at least one-third did not need psychiatric hospitalization at all.

RECOMMENDATIONS

The Colorado State Hospital, through its geriatric release program, is giving leadership to the advancement of treatment and community planning for the aged who are patients or prospective patients of the hospital. The foregoing documentation presents strong evidence of the implications for statewide planning and State-local relationship to better individualized care and to meet the needs of the elderly. The State hospital will continue to be available for consultation to nursing homes, agencies and families as well as work toward continued refinement of its program.

Senator Moss. Thank you very much, Mr. Tippin, for that very fine paper. This placement program of the hospital is a most heartening thing. It is one of the finest examples that we have come across yet of a positive effort being made to get people to the type of care that is suited for them. Dr. Schapire mentioned you still are limited to sending patients to nursing homes, I believe, and you would like to have a broader range of facilities to which your patients might go rather than being limited to a nursing home, is that right, Dr. Schapire?

Dr. SCHAPIRE. That is correct. I feel that many of these patients could very adequately be cared for in boarding homes or homes for the aged, but if they were placed in these facilities there would be no public assistance money available to help them in such placement.

Senator Moss. The financial support is the limiting factor there?

Dr. SCHAPIRE. That is correct.

Senator Moss. Might it be possible even that some of them could go home and simply have out-patient care if we could solve this financial support problem?

Dr. SCHAPIRE. I am sure some of them could. Perhaps Mr. Tippin, who is acquainted with individual cases, could give a more elaborate answer to this question.

Mr. TIPPIN. This would be particularly true with the more recent admissions to the hospital, those people who were admitted in, say, the last year. Many of the patients that have been placed through the release center and those whom we are now currently working with, are residents of the hospital from 35 to 40 years. Home ties have been lost, homes have been lost. Perhaps more importantly, while certainly this is important, is that these people have become totally dependent on a very structured, very sheltered environment. The simple needs of buying clothing, of buying and preparing food, is something that has been lost to them. Personally, it is my feeling that to turn these people out without a good deal of structure would be quite detrimental to them. From experience, I have been privileged to take patients for their first automobile ride. We take automobiles for granted. We take supermarkets for granted. We take a dial telephone for granted. This is quite an ingenious invention and these people need a great deal of help in just coping with these types of things.

The patients at the hospital are used to nice grounds where traffic moves slowly for them. Conversely, I don't think the doddering octogenarian stands much chance at Colfax and Broadway. In fact, neither does a doddering 30-year-old, for that matter.

Senator Moss. I was about to add that for you. That is very interesting and I am glad to have you elaborate that for us. But of those recent admissions, if they could be released, there are some of them, at least, who might go to their homes if available to them was some out-patient nursing care on a regular basis to give them some assistance?

Mr. TIPPIN. That's right. They could also go to the less structured environments.

Senator Moss. You indicated that in the followup that the hospital has with these patients who are released, where you found a home that was unsatisfactory or marginal, you might then move the person somewhere else. Now, I wonder how that fits in with what Dr. Schapire said about when the person has been released from the hospital, the State hospital, he then has his own choice of nursing home and as to whether he will stay or move. Is that inconsistent there?

Mr. TIPPIN. No, we do not move the patient. The patients are placed on conditional release. The hospital has the authority to direct the patient's return to the hospital, if deemed necessary. If, in our opinion, the patient's care is unsatisfactory, we will attempt to work with the patient, with the nursing home. If this cannot be done, then we will ask the welfare department who, by and large, is financing the patient, to help with other types of planning.

Senator Moss. I see. This would be done largely through the welfare agency in seeking a placement somewhere else for that patient?

Mr. TIPPIN. That's right.

Senator Moss. He wouldn't return to the hospital and come out again to another?

Mr. TIPPIN. Only if we on the hospital staff felt there was a need for an intensive psychiatric reevaluation.

Senator MOSS. Other than the general area which you have pointed out that you have tried to prepare these people to go to, is there any other selection to be made by the patient himself of a nursing home?

Mr. TIPPIN. We try to give the patient as much knowledge of the nursing homes in the area as possible so they can make some selection from the knowledge we give them. Some patients pick a nursing home, if you will pardon me, that way [indicating closed eyes]. They have been in the hospital 30 years, there was no nursing home in their community when they came, and now there are five. They pick from brochures, on what we say; where their friends are in many instances is a determining factor.

Senator MOSS. But you respect the selection that they do make?

Mr. TIPPIN. That's right. And this is included in our referral to the department of public welfare, if there is such a referral.

We also respect the wishes of the family and the families are brought into our planning.

Senator MOSS. A very good program.

Do you have a question, Mr. Frantz?

Mr. FRANTZ. Mr. Samac mentioned in his statement that most of the patients discharged from the hospital, State hospital, go into group IV and group III homes, which are those that have the heavier nurse staffing. Why do you use those homes in preference to the group II and the basic homes where you can also get the welfare department payment?

Mr. TIPPIN. Well, quite frankly, personally, I prefer patients to be placed in the higher rated homes because the quality of care is somewhat better, due to the fact they have a better staffing pattern. In addition to the nursing care, they might or should or can receive, there is a possibility for the ancillary therapies, occupational therapy, recreational therapy, these types of things, which, in my personal opinion, the elderly patient needs as much, if not more than just a chair and a bed. There are more available or more likely to be available in a class IV home. You have more staff in a class IV home.

Mr. FRANTZ. Even though, as Dr. Schapire pointed out, the professional nurse service available in the home might not itself be needed, the home which has that is better from other points of view, is this correct?

Mr. TIPPIN. That is correct. If I may, I think, Senator Moss or Mr. Miller, I am not real sure which asked the question, by placing an elderly patient in a class IV home to begin with, oftentimes solves the problem of a move later on. If you start out with a minimal care environment, you may move yourself up to a nursing home and this makes the patient adjust three and four times to three or four different facilities. Elderly people do not take well to change as a rule.

Mr. MILLER. If I may pursue that for a moment, Senator Moss, the question has been raised, as you point out, and I would be interested in your comments and Dr. Schapire's comments about this movement of patient from institution to institution. Is it desirable in a large

home for the aged complex to have both the normal living section, and right at hand, within the home, adequate class IV or III nursing care services and facilities? I would be very much interested in any comments you gentlemen may have on that.

Dr. SCHAPIRE. If I may take a crack at it, I do feel that there ought to be a spectrum of services available, with a maximalization of continuity of care. You could, for example, have a home for the aged with an infirmary section in which you have specialized nursing care available and the patient, when he becomes ill, moves into this area, but he would not be separated from the friends that he has made and these people could come and visit him. If, on the other hand, he is sent to a nursing home on the other side of town, this may not be possible. So I certainly seem to be in disagreement with the previous witness here, but this is my firm conviction, that this would be preferable.

Mr. TIPPIN. I really have nothing to add to that.

Senator Moss. Thank you very much. I am glad to have that observation from Dr. Schapire.

I think that's all, then, gentlemen. Thank you very much, Dr. Schapire, Mr. Ewing, and Mr. Tippin, for your appearance and information that you have given the committee. It has been most helpful.

Our next witness will be Miss Margaret Lewis, who is director of the Visiting Nurse Service of the city and county of Denver. We are very pleased to have you, Miss Lewis. Go right ahead.

STATEMENT OF MISS MARGARET LEWIS, DIRECTOR, VISITING NURSE SERVICE, CITY AND COUNTY OF DENVER

Miss LEWIS. Senator Moss, Mr. Frantz, and Mr. Miller, my comments will be brief because many of the points that I want to make have been very ably presented in your introductory paper.

Senator Moss. Thank you.

Miss LEWIS. I think we are sadly in need of a new and dynamic approach to care for long-term patients. As a general rule, nursing homes do not admit patients with a goal of eventual return to the home and the community.

The nursing home is a deadend street for the vast majority of patients, regardless of the potential of the patient and the family for eventual assumption of care. If the agencies who are responsible for financing of care for the long-term patients were willing to put as much money into providing home care services as they are for maintaining patients in nursing homes, we could expect to see many more patients rehabilitated to the point where self-care could be realized.

I do want to make a point here that I did not originally include. We have heard today that it is cheaper to care for a patient in the home. I think this may be a false assumption. It need not always be cheaper, but it certainly is the more humane thing to do for people. I think there are some cases, as we have proven in our Blue Cross study, for whom care can be provided cheaper at home but others will require care at greater cost before they can assume care for themselves.

Some of the developments which are essential in this area before we could ever hope to have a goal of home care as one part of the con-

tinuum of care are the evaluation of the home environment, physically and emotionally, early in hospitalization. At the time the patient is admitted to the hospital little thought is given to where he is going until the day comes for him to be dismissed.

I think before a patient is placed in a nursing home he should have an evaluation of his home regardless of whether he is being placed directly from his home or from a hospital. The public health nurse could do much to help families see how they could handle the care of the patient. I do believe that while the patient is in the nursing home we should have an evaluation on an ongoing basis of the patient's medical condition and of his home situation to see at what point he can leave the institution and go back to his home.

I think we need a reassessment of the nursing home role in the care of patients. If the nursing home is to be used as an adjunct to hospital care, providing an interim step from hospital to home, then considerable effort must be directed to communications. A referral system similar to those we use between our hospitals and our home care services should be developed to insure continuity of ancillary services and written medical orders.

I think, also, that we should move to the point of having written communication from the nursing home to the home agency. We have some problem areas, as I see them, at the present time. We do not have firm policies regarding written confirmation of doctors' orders, or evaluation by doctors of the patient's progress and condition at stated intervals. Any plan for eventual return to the home would depend upon medical evaluation at periodic intervals. The majority of the communication between doctor and nursing home, as we experience it, is by telephone.

I believe that the quality of nursing staff in many of the nursing homes is distressing. We may or may not on a given date meet the quantity figures, but quality is our great concern. Nurses' aids who are poorly prepared as a general rule are assigned duties far beyond their capabilities.

Part of this problem, I do believe, lies in the fact that the nursing homes, many of them, are noncompetitive in their personnel policies and practices. I believe that we need a mechanism for evaluating the educational experience that the nurse aid has when she is employed by a home.

We are very weak in the areas, in many homes, on physical therapy, occupational therapy, speech therapy, and diversional therapies. In some homes they are nonexistent. The patients come in and you watch them gradually deteriorate for lack of anything to do. Dental services are generally not available.

I think there is a point which may be controversial but one which I feel very strongly about and must speak to. Nursing home owners must come to recognize that health care facilities and the care given to patients are a proper concern of the public and that cooperation with the agencies responsible by law for inspectional services is essential. The nursing home which provides a safe level of nursing should have no quarrel with the standards which are established to that end. By directing our joint efforts to improve services, the patient and the public will benefit. At the present time we encounter hostility, resent-

ment, and resistance in some of the homes when we go in to do our inspectional services.

We often hear of accidental injury, death, and poor nursing care only through the families. I think we need legislation which spells out much more explicitly than it does at the present time what is a safe level of nursing service in a nursing home. We have a nurse and a half (if you can have half a nurse) working in our nursing homes in Denver and they spend a great deal of their time doing what I call putting out fires—answering complaints from families of patients.

We have additional problems in the area of boarding homes, and this has been talked about some this morning. We have approximately 70 known boarding homes in Denver and we have a true lack of inspectional services and good legislation in this area. Residents who have lived in these homes become ill and are maintained in the home and proper patient care is not available. We know of some instances where patients have been brought into boarding homes by ambulance on a stretcher. We know of outright neglect of patients and mistreatment. Some boarding homes will move their patients from the Denver area when we visit to see what we can find out about what's going on.

One thing that we are concerned about in the boarding homes is that they are licensed as a hotel would be and our sanitation and environmental health men can go in to inspect the eating facilities. We sometimes get a nurse in the homes in this way, but we have no prerogative as far as insisting that we go in to see what kinds of patients are in the home and try to help the people make some decision about moving.

Thank you.

Senator Moss. Thank you very much, Miss Lewis, for your enlightening comments on the observations you have made working in this field. Your opening comment about nursing homes being really a dead end street, usually with no consicous effort being made to rehabilitate and restablish the patient so that he could go home or could have a lesser type care, is one that I think needs to be underlined. In order properly to carry out its function the rehabilitation area ought to be paramount, shouldn't it?

Miss LEWIS. Yes; in my opinion.

Senator Moss. I am sure it is not, in many instances. I am glad you came back to this boarding home problem. I understand, then, boarding homes are licensed but they are licensed under the hotel section rather than under any laws relating to health care facilities.

Miss LEWIS. In the city and county of Denver; yes.

Senator Moss. In the city and county of Denver. I gather that your recommendation would be strongly that they be included for inspection and supervision in the health care field and not left just to the hotel section.

Miss LEWIS. That's right. The problem we are encountering is a difficult one and we have not found an answer. Who says who is a patient? Sometimes a person we feel is really a patient requiring 24-hour skilled care is determined by a member of the family not to be that ill because it is cheaper to maintain them in the boarding home. This is one of our primary problems—who can define a patient and say this person is one and must be moved to a better facility?

Senator Moss. Do you have a system for accreditation of nursing homes here in Colorado?

Miss LEWIS. It has been started. I am sure Mr. Davis can talk to this later.

Senator Moss. I see. We will get that from him. You have encountered a considerable degree of hostility from nursing homes on inspection visits, is that right?

Miss LEWIS. I would say in certain nursing homes. We have some who are very cooperative. We have others who really resent having the nurse come in to see what kinds of care the patients are getting; even in following a complaint we sometimes meet resistance.

Senator Moss. Do you have a question, Frank?

Mr. FRANTZ. Yes. We have heard a great deal, it is almost a commonplace statement now that nursing homes can't really meet desirable levels of staffing because they can't find the qualified personnel. If I interpreted your comment a few minutes ago correctly, you would feel that qualified personnel are available if salaries and the working environment were adequate in nursing homes, is this correct?

Miss LEWIS. I certainly think they would be more available and a better quality of person.

Mr. FRANTZ. What is the chief problem—speaking from the viewpoint of someone in the health profession—what would be the chief problem, the salary levels, or the atmosphere and the working environment?

Miss LEWIS. Well, I don't think we can deny that not everybody wants to take care of old people day in and day out in a facility where you see little movement of the patient toward his own home and out of the facility. But I will give you an example of what I think is indicative of some of the personnel policies, not all. I asked a homeowner 2 years ago, "Do you have a sick leave policy for your employees?" And he said, "Yes; I do have. They can go home and they can be sick and I won't fire them."

I think this gives you some indication of the fact that much needs to be done in the matter of personnel policies.

Senator Moss. Thank you, Miss Lewis. We appreciate it very much.

The next witness is Mr. W. Dan Bell. I am informed Mr. Bell called this morning and he is unable to be here, but he has presented a statement that will be included in the record. We regret that he has been unable to come but we are very happy to include the statement in the record for the use of the committee.

PREPARED STATEMENT OF W. DAN BELL, PRESIDENT AND GENERAL MANAGER, DENVER AREA BETTER BUSINESS BUREAU

My name is Dan Bell. I am general manager of the Denver Area Better Business Bureau, a voluntary nonprofit association maintained by more than 1,000 business and professional firms in this area for the purpose of encouraging higher standards of business and professional practice and to protect the public from misrepresentation, deception, and fraud. This Better Business Bureau provides the public with its services free of charge, and in the course of its activity receives an average of 300 requests for service daily. These requests are generally in the form of inquiries as to the reliability and reputation of specific business and professional firms, or complaints concerning transactions which have been allegedly misrepresented in some manner.

In the course of recording and investigating these many public expressions, the Better Business Bureau has received inquiry and complaint on nursing homes and homes for the aged. While we do not feel that the number of such ex-

pressions would indicate the situation to be extreme insofar as malpractice is concerned, our investigation does lead us to believe that some community housecleaning in this field is needed. Our particular areas of concern are those of misrepresentation and unfair practice.

The misrepresentations presently occurring appear to be mainly in the offerings made by boarding houses who advertise and list themselves under "nursing homes" or "homes for the aged" when in fact they are not licensed by the State to perform either of these functions. Further misrepresentations occur, and such homes imply facilities and care that they do not actually provide.

Other areas in which elderly people can be victimized, or at least their care may be conducted by irresponsible parties, are in the offering of room, board, and care by persons who have one or two rooms in their homes—and as long as they don't take in more than two they may not be subject to supervision by any governmental agency.

In our inquiries among the various supervising State and municipal agencies, we find the unlicensed and unsupervised boarding homes to be the areas of greatest concern.

The better business bureau has, in the past, received complaints from guardians of elderly persons that involve unfair requirements that drugs be purchased from a designated and sometimes house-owned pharmacy; or that promised refunds on unused portions of housing and care have not been made; or that charges were made for services not rendered; or that specified care was promised but not given. These complaints, however, do not seem to have evolved into a pattern and have been quickly rectified when brought to the attention of the administrators of the homes. We have a continuing problem of boarding-house operators sneaking their advertising into newspaper and telephone classifications of "Nursing homes" or "Homes for the aged" when in fact they are not licensed as such. Again, these advertising transgressions are corrected, either by direct contact with the advertiser or through the cooperation of the media carrying the ads.

Our conclusions are as follows:

1. We believe the community needs to develop more awareness of the basic reasons why the problems in the care of elderly people exist. This can be accomplished by greater communication between the interested and involved agencies, possibly through the Governor's commission on aging.

2. There needs to be more intensive community housekeeping and housecleaning in the problem areas such as the unlicensed boarding house situation, misrepresentation in advertising, the definitions of a patient, etc.

3. Most of all, we believe that there is a need for continuing public education activity to inform people as to the standards required of the various types of homes caring for the elderly, and possibly some guidelines as to what people should have a right to expect as well as what they should avoid. By such informative and educational material, the public could do much toward assisting in the improvement of care of the elderly as well as to get the most for the money which they put into it.

Senator Moss. We have now Dr. I. E. Hendryson, Dr. Robert H. Hughes, and Dr. Walter E. Vest, representing the Colorado Medical Society. We would be very pleased if these gentlemen would come forward.

Dr. HENDRYSON. Senator Moss, I am Dr. Hendryson. I am a private practicing physician in Denver. I am a member of the Council on Medical Service of the American Medical Association, and also chairman of the council on medical service of the State medical society.

I would like to introduce to you Dr. Walter Vest, who is a member of our council on medical service, and Dr. Robert Hughes, who is chairman of our committee on aging. They have statements that they would like to present to you. My function here is a little bit ambiguous. I am in the position of being the Devil's advocate, I believe. My colleagues have taken the position that if you have questions to ask, they would be delighted to have me answer them.

Senator Moss. Thank you, Dr. Hendryson. We will try to think up a couple.

Dr. Vest, we will be glad to hear from you first.

STATEMENT OF DR. WALTER E. VEST, COLORADO MEDICAL SOCIETY

Dr. VEST. Senator Moss, gentlemen of the committee, insofar as it is generally acknowledged that much of the increase in lifespan in the 20th century is related to the efforts of physicians and surgeons in their everyday performance of medical services may we state that the medical profession feels peculiarly knowledgeable and concerned in matters pertaining to health protection.

Present Federal laws, such as the Kerr-Mills law, are moderately good laws. They have not achieved full usefulness, at least in part, apparently because of the interpretation and philosophy prevailing at some levels of the Department of Health, Education, and Welfare. For instance, there has seemed to be a fairly consistent tendency to downgrade the Kerr-Mills law in the public statements emanating from this Department.

One need, then, would seem to be for prompt and responsible attention to the measures already enacted into law by the Congress of the United States. A case in point is the Medical Assistance to the Aged Act passed in 1964 by the Colorado State Legislature. This bill was written with full consultation with the regional office of the Department of Health, Education, and Welfare for compliance with the Federal law and with the Colorado attorney general for compliance with State statutes. Then, almost 10 months later, and at a time that seemed governed by political expediency, Colorado's Medical Assistance to the Aged Act was declared unacceptable.

So much has already been given that I would like to take the opportunity of answering the questions that have been posed with other witnesses this morning.

First of all, I would like to point out that in the nursing home there will be patients who have no recovery or rehabilitation potential and, no matter where they are placed, these patients are not going to assume responsibility in the way we would hope that they might and it isn't fair to blame the nursing home for the decline in many of these patients.

Dr. Schapire said he wished there were many nursing homes which could provide a broad spectrum of possibilities for patient care. We have nursing homes in Denver that have intensive care units. We have nursing homes in Denver that have good physical therapy departments. We have ones that have good occupational therapy departments. I am sure Mr. Davis can tell you this better, but I would like to say it from the medical standpoint, first of all.

Regarding the difference between licensing and accreditation of nursing homes, it is true that the licensure has very little to do with the quality of service in the homes and I would like to commend the nursing homes themselves for their accreditation program which they have undertaken. A number of the homes in Colorado are now accredited and more will be accredited. This is a program that really has to do with the quality of service, not necessarily the physical standards.

Something that hasn't been brought out, as I listed this morning, is the limiting factor of the amount a family can pay to supplement the care a member of the family may receive in a nursing home. You

have heard what the welfare department will pay and, if some wealthy cousin in Rhode Island wants to supplement this, they can supplement it only so far without this patient losing what they would get from the State welfare department. So this is a limiting factor in the possibility of care for some patients.

The welfare department outlined a plan which I was more or less unaware of but, as I listened, it sounds like a cost-plus proposal for paying for patients in nursing homes. We saw World War II cost a tremendous amount on a cost-plus basis. In fact, this kind of program frightens me when applied to nursing services in the State of Colorado.

The question has been raised about whether doctors and medical education are oriented toward long-term care of older people as versus the more entertaining acutely ill patients. This is certainly true. The average doctor has the specter of long-term care burst upon him as sort of a bombshell after he gets out of medical schools. There are only three medical schools that have shown real interest in geriatrics. Most of these have been on a research basis. The student gets a brief view of geriatrics; suddenly then he is faced with it. I think this is being rectified. So I hope in future years the doctors now in training will know a great deal more about all facets of long-term care.

May we respectfully suggest certain medical facts and humanitarian guidelines for future Federal legislation relating to health care of older persons:

(1) No older person needing health care should be unable to obtain it whether or not it be active medical care or merely protective care.

(2) The older citizen needs, if anything, health care of a higher order of excellence than at other ages.

(3) It is unrealistic to provide piecemeal for health care. If you finance a nursing home or hospital bed for an individual, but do not provide for supporting personnel, from the cook to the nurse, administrator, or physician, you have provided an inadequate solution to a human need.

(4) The administration of health care of older persons should be close to the area served since only there is it likely that needs can be quickly appreciated and appropriate action quickly be undertaken.

(5) (And I am not sure whether this is a medical fact or a humanitarian guideline, with the possible exception if we are thinking of our grandchildren.) In the face of longstanding deficit spending and negative balance of payments abroad even in the delicate area of health it would seem unwise, yea, almost amoral, to subsidize those who do not need subsidizing.

In closing may I say that by providing complete assistance where needed by older persons would be most appropriate in a society characterized by individual initiative, individual opportunity and yet a willingness to care for those who are not fully able to provide for their own health needs.

Thank you for the opportunity of speaking at this hearing.

Senator Moss. Thank you, Dr. Vest. We appreciate that very much and we are glad to have in the record some of your observations. I particularly noted your statement that we all must recognize that some of the older people in nursing homes, of course, do not have a potential for rehabilitation. I think what we were directing our dis-

cussion to was the fact that in many cases no effort was made for those who did have a potential. But, it is well to remind us that we also are concerned with those whose condition makes it impossible for them to improve under any circumstance.

I noted your comment about the efforts that are being made to work out a cost basis and your disapproval of it, wondering if this wasn't getting into the cost-plus field. Would you expand on that? Do you think it is more desirable just to have a flat rate without any basis of judging the amount involved in the cost of caring for the patient?

Dr. VEST. I think most of the knowledgeable nursing home administrators can tell you what it costs to keep a patient in their home for a month and I think whatever you say you will find the State welfare department will, of necessity, look askance at that figure. This means they are going to have to go in and audit the books of every nursing home in the State, as I see it. This doesn't sound plausible to me.

Senator MOSS. Don't you think it is possible to work out a reporting system whereby there is a breakdown that gives the State department of welfare an opportunity to review costs without extensive auditing, as you say?

Dr. VEST. Yes, I am sure that they are visualizing a reporting system, and I feel sure they can't believe it without audit verification after they get the report, with due apologies.

Senator MOSS. Well, we will leave that problem. Do you have a question on that?

Mr. FRANTZ. I just wanted to ask if this would really be very different from what Blue Cross does to reimburse hospitals. Blue Cross reimbursement is negotiated on a cost basis, and Blue Cross audits from time to time to ascertain that these are the correct costs. Is this very different?

Dr. VEST. Different only in the fact that hospitals have well-developed systems of cost accounting, and there are very few hospitals to deal with. There will be well over a hundred nursing homes to deal with by an organization that probably isn't as well organized for looking into cost accounting as Blue Cross is. That is the only difference I see.

Mr. FRANTZ. This isn't a condition in nature. These cost accounting systems can be improved and the staffs can be improved to cope with this problem if it is necessary.

Dr. VEST. Yes; and I suspect you would put a lot of nursing homes out of operation by forcing an expensive cost accounting system on them, really.

Mr. MILLER. Dr. Vest, do you feel a part of this problem relates to the size of the institution? That a large nursing home might be equipped to do this?

Dr. VEST. The large nursing homes will be the more recent nursing homes and they will not only have the better plant and the newer plant embodying the refinements that are now available in construction, I would suspect those homes will also be better able to provide good cost accounting. I am not sure this is true.

Senator MOSS. Dr. Hughes, we would like to hear from you, sir.

STATEMENT OF DR. ROBERT HUGHES, COLORADO MEDICAL SOCIETY

Dr. HUGHES. Thank you. The report which I have placed before you, as Dr. Vest has mentioned, much of it has been covered already, and I think what I will try to do is to approach this from the four main categories that were submitted to us and attempt—although I don't speak for the medical society in general, or at least specifically—attempt in general to convey some of the feelings that they have relative to these problems.

(The prepared statement of the Colorado Medical Society follows:)

REPORT SUBMITTED BY THE COMMITTEE ON AGING OF THE COLORADO MEDICAL SOCIETY, REPRESENTED BY ROBERT H. HUGHES, M.D., IRVIN HENDRYSON, M.D., AND WALTER E. VEST, M.D.

INTRODUCTION

In view of the subject being discussed today and the vital concern of physicians for this problem, the Committee on Aging of the Colorado Medical Society appreciates the opportunity of offering their comments on the four main categories that have been submitted relating to long-term care of the aged.

I. Available facilities and services in Colorado for long-term care of the aged

Such facilities include the following:

Various nursing homes.

Visiting Nurses Association.

State homes at Trinidad and Monte Vista, Colo.

Spalding House in Denver.

Rehabilitation programs of various hospitals.

Graduated medical care in the hospital.

Physician services in such facilities under the Medical Assistance Act and the State old-age program.

An organized stroke program routine.

Denver Metropolitan Health Resources Center.

By way of comment, it is felt that by and large nursing homes in the area provide a better than average number of beds in physical plants varying from fair to excellent. The Visiting Nurses Association does an excellent job of home coverage in the metropolitan area. Spalding House is a private, nonprofit institution nearing completion in Denver as a geriatric hospital providing an intermediate type of care. Several general hospitals offer specific rehabilitation programs and graduated medical care where practice has a particular application to the aged. A previously well-planned stroke program has been organized and now is offered as specific supplementary therapy when requested in certain hosiptals. Physicians, it is felt, have shown a significant interest and cooperation in most of these areas.

Unique in the Denver area is the Health Resources Center. This privately conceived referral source is designed to help the chronically ill and aged as well as those with unusual problems to find the proper social or medical facility for serving their particular need. Because the center takes each patient individually and pursues his case until settled, it has provided a tremendous service with a minimum of redtape.

II. Quality of services for people requiring long-term care

The quality probably varies, particularly in nursing homes, but it is felt that the conscientious efforts of certain operators in this field has led to much improvement and that these people deserve special commendation for attempting to establish a nursing home accreditation program. As implied, most of the other programs enumerated are of good and productive quality. It must be emphasized, however, that quality is not measured entirely by tangible standards, but perhaps even more important by the sincere intentions of the many people in the area who give truly highly motivated and dedicated services.

III. How Federal laws help or hinder such services and facilities

Generally, Federal legislation designed to operate at the local level has the inherent defects of bureaucracy. A specific case in point has been implementation of the Kerr-Mills plan in Colorado. When the plan was accepted by the State, it was designed to comply with Federal requirements and there was con-

crete implication of acceptance by the Department of Health, Education, and Welfare. Months later the State was informed of certain deficiencies in their plan and funds were curtailed. Such action can only be construed as being pure inefficiency or plain politically inspired harassment.

IV. Recommendations for improvement in services

These can be divided into the general categories of local and national.

Local:

1. Pursue the plan of nursing home accreditation and establishing of nursing home codes. This would probably involve operators and the State health department working together.
2. Initiate plans that encourage more nursing home patients to have better physician contacts.
3. Continue to improve and broaden rehabilitation programs.
4. Improve the coordination involved in the transfer of patients from hospitals to nursing homes.
5. Encourage and promote the training of personnel in this field so as to provide more and better people to meet the growing needs in the area.

National:

1. Provide the psychological stimulus and act as a resource center for those areas where help is needed.
2. Design legislation that allows for State administration of any laws or plans passed. This should be more economically advantageous and specifically permits administration by a group better acquainted with the local situation.
3. Consider at all times the vital concept of free choice of care by the patient.
4. Give careful attention to the present eldercare bill.

This last request is prompted by our firm conviction that the King-Anderson (medicare) bill is a poorly designed piece of legislation which does not answer the real needs of the aged. We further believe we have substantial support for such an assumption as based on the results of a comprehensive survey of the problem recently conducted in Colorado. This survey which shows an overwhelming preference for the eldercare type of approach will be presented to the Colorado Medical Society House of Delegates this afternoon and we would request that we be allowed to obtain a copy and forward it to this committee to be incorporated as a part of the record of this hearing.

Dr. HUGHES. I have enumerated in this report some of the facilities which are available in Colorado and you have heard many of these already mentioned. I think I would like to join Dr. Vest in defending somewhat of an implied criticism of the nursing homes in that we are impressed by the fact that there are many, many very good homes with real dedicated people who are running them. At the same time I think that commendation is certainly due the Visiting Nurses Association, in that we are impressed by the very high type and conscientious type as well as well-organized type of care that they do give in the home and the coordination between the patient going from the hospital to the home under their supervision has been very good.

You may have heard Dr. Cleere mention a rather unique type of establishment constructed in this town. He did mention this, I think, as a high-grade nursing home. I would like to say that this is a geriatric-type hospital that perhaps borders between a nursing home and the hospital, and this is a private institution named "Spalding House," which is being constructed here in Denver. I think this offers some real potential for unusual, constructive type of care which is designed to rehabilitate people.

Along this same line, there are a number of hospitals that do have rehabilitation programs, and some that have graduated medical care which, I think, is something of value and I believe that I can safely say that, by and large, the physician cooperation in these ventures is good.

Now, one other thing that the Denver area has which I think bears mention, and this is the so-called Denver Metropolitan Health Resources Center. This is a privately conceived referral source, is designed to help the chronically ill and aged as well as those with unusual problems to find the proper social or medical facility for serving their particular need, and because this center takes each patient individually, and pursues his case until it is settled, it has provided a tremendous service with a minimum of redtape.

With reference to the general topic of the quality of services for people requiring long-term care, it is obvious that this varies, but I would like to say that this cannot be measured entirely by tangible standards and that very important is the sincere intention of the many people in the area who give truly highly motivated and dedicated services. I think these people must be recognized, and I think it is apparent, by the thought that has been put into the preparation of the reports this morning, that there is a lot of thought going on along this line in the State of Colorado.

Under the general category of how Federal laws help or hinder such services and facilities, I hope I may be pardoned by interjecting a somewhat politically oriented concern here but it is our feeling that generally Federal legislation which is designed to operate at the local level does have certain inherent bureaucratic defects and we are concerned about the implementation of the Kerr-Mills plan in Colorado. It is our understanding that when this plan was accepted by the State, it was designed to comply with the Federal requirements and that was a concrete implication of acceptance by the Department of Health, Education, and Welfare. However, months later the State was informed of certain deficiencies in their plans and the funds were curtailed. We are concerned that there may be some type of inference here or even some politically inspired harassment involved.

Now, along the general recommendations for improvement in services, I think this has been covered in many fields and part of what I may have to say is a reiteration of this but, from the local level, we feel the plan of nursing home accreditation with which we are familiar and the establishment of nursing home codes has greater merit. I am sure this will be mentioned by the nursing home representative. I am sure that this type of plan can be worked out best by the operators and probably the State health department working together.

I think you have had the implied problem presented, with reference to physician contacts with nursing home patients, and certainly this is a problem that needs encouragement. I think that along this same line we must emphasize the importance of preventive medicine and this may go even into the much younger age group where people have to learn how and what it is to become older and prepare accordingly.

We certainly feel that the various rehabilitation programs can be improved and broadened, and we believe that there is a factor of coordination that can be improved in the transfer of patients from hospitals to nursing homes or perhaps to homes, to a lesser degree.

Certainly there is a definite need to encourage and promote the training of personnel in this field so as to provide more and better people to meet the growing needs in this general area.

From the National or Federal category, which involves legislation, certainly, we feel that the Federal Government can provide the psy-

chological stimulation and act as a resource center, particularly for those areas where the help is needed or where the impetus is not as strong.

We certainly are anxious that legislation passed by the Federal Government allow for State administration of such laws or plans because we feel that this is not only economically advantageous but that it is going to lead to administration by a group that is better acquainted with the local situation.

We feel that the element of concern for the vital concept of free choice of care by the patient should always be kept in mind.

We would respectfully ask that this committee, insofar as it is able, give careful attention to the present eldercare bill, and we would like to say that this last request is prompted by our firm conviction that the King-Anderson bill does not answer the real needs of the aged and that we have now being introduced today to the Colorado Medical Society House of Delegates, the results of a rather comprehensive survey, which leads us to feel that there is an overwhelming preference of the eldercare type of approach. We would like to ask, since this report has not been officially released and we do not have the details, that we might be permitted to forward a copy of its results to you and that they might be incorporated as part of the record of this hearing.

Again let me emphasize Dr. Hendryson's and Dr. Vest's feelings that we certainly appreciate this opportunity to speak.

Senator Moss. Thank you, Dr. Hughes. We would be very pleased if you would send us the report of the house of delegates so it will be available to this committee, and we appreciate having your statement here this morning, you and your colleagues who have come here to appear before this committee.

In some of our earlier hearings we have heard that one of the needs is organized medical staff supervision over the care that is given in nursing homes. Is that a need here in Colorado?

Dr. HUGHES. Dr. Hendryson.

Senator Moss. He has to take all the questions. I see.

Dr. HENDRYSON. Senator Moss, indeed it is a need, and I should say we are completely aware that this need exists. On the surface it would seem to be a very simple matter to write guidelines for physician care and physician services in nursing homes. Actually, the thing isn't quite as simple as it would seem to be. The committee on medical facilities, for example, of the American Medical Association, has been working at this very problem for the past 18 months. Some of the problems that are encountered in trying to write these guidelines are, of course, attendant to some of the problems that have been pointed out in the discussions this morning.

In the first place, even in nursing homes we are faced with the fact that there are patients who are ambulatory, that there are also patients who would fall under the category of requiring medical care, and certainly skilled nursing care.

The problem comes down to this. Should a physician see an ambulatory patient a given number of times during the month? Should he see the bedfast patient or the patient requiring skilled nursing services a given number of times during the week?

There is no ready answer for this because, obviously, it depends on what the patient's condition is, what his diagnosis is, and all of the rest of it.

We are also very much aware that if you go to this kind of arbitrary system you are increasing the cost of medical care, and here again is an area in which we are all concerned. Everyone here this morning is concerned with it. So that we don't have a simple solution to this problem. An effort is being made to resolve it, however, and even in the Denver area the task force of the Metropolitan Council for Community Services is considering this, and there is physician participation with the idea of trying to establish a reasonable approach to what is best to do.

At the present time in Denver it is hit or miss, as it is in most cities across the country. Some physicians, in consultation with their patients, establish a working relationship of how frequently they are to be seen. In other instances it goes more to the responsibility of the nurse or the nursing home operator to contact the physician by telephone when need arises. In other instances, there are so-called medical directors in the nursing home establishment who will make rounds or see patients on a daily basis, and if it seems that someone is in need of medical attention, this physician sees them with the permission of the attending physician and the patient's family.

We recognize that there may be better ways of coming to grips with this problem, but as yet they have not been solved, and I would imagine that the first guidelines that are written will probably be inadequate and I would assume that over a period of time they will finally be found to contain flaws.

I suppose the answer to the question, sir, is that, yes, we are very much aware of this, we recognize the need for it, and we really are trying to do something about it.

Senator Moss. Thank you, Dr. Hendryson.

Do you have any questions? Mr. Frantz?

Mr. FRANTZ. If I could pursue this point just a little bit more to enlarge upon what you have said; admittedly the frequency of a physician's visit, in fact, what the physician does for his patient is not the sort of thing that can be written out in guidelines for universal application. But aren't there a great many things in the nursing home program which are susceptible of establishing guidelines which should be established by medical people?

For example, the requirements as to the clinical records, what kinds of information must be included, and by whom, and with what regularity; what procedures must be done by a registered nurse, what other procedures may be done by a less highly trained person; this kind of question. Usually these are policies set by the medical staffs in other kinds of health facilities. What would you think about that?

Dr. HENDRYSON. Well, Mr. Frantz, you have identified one of the very cogent problems that exist between physicians, nursing homes, and hospitals at the present time. I would say that I think from the medical point of view, medical records in nursing homes at the present time are inadequate. I say this only because I feel it does not go in the direction of the quality control that we would all like to see this thing take.

Here again, it is obvious that a nursing home record cannot or should not contain all of the information that a well established hospital

record should. So it is a question of sifting things that are essential, things that are important, and trying to establish some simple form of recording this material so that it will be usable and so that it will also be of value for future need in trying to evaluate quality control.

In this direction I would like to just step aside from the things that we have all been talking about this morning and make this point. Basically, we are talking about long-range care and all of its implications and all of its coloration and all of its facets. The thing that interests me most is that as you look at the total picture this is a recent concept. For the most part, all of the programs, all of the philosophies, all of the things that are going into these have come about within a period of the last 5 to 10 years. We are on a frontier in this concept. We are obviously faced with growing pains and I think that the tender points in all of these, the inadequacies may be frequently enough seized upon and true evaluation is lost in terms of the total picture at the present time.

Obviously, there are problems here today that projected 10 years from now will be no problem at all. I think it is a question of being in the position of having one hand on the elephant and not knowing exactly where the other ancillary group may have his hand on the elephant that magnifies problems. Not being able to communicate, or communication being poor, some of these problems don't come to their logical and reasonable solution. However, I must say that I think in this area improvement of solving the problem is much better than it was 4 or 5 years ago. I believe this is true nationally, too.

I should also say that specific legislation, to legislate these matters, would lead only to chaos. None of us have all of the answers at the present time as to how best to do this job. However, with all of the people here this morning, their primary concern is to see that this thing is done well and that it be done as best we can all do it. I believe as long as that kind of an attitude pertains and continues, then the knotty problems that we are faced with are going to resolve themselves and I think we will be able to present reasonable solutions to them.

Senator Moss. Thank you, Dr. Hendryson, Dr. Hughes, and Dr. Vest. We do appreciate your being here. You have added a great deal to our record. This information will be most helpful to us and we are grateful for your coming.

Dr. HENDRYSON. Thank you, sir.

Senator Moss. We still have four very important witnesses to hear and I am going to call them right away, but we are going to have about a 10-minute break to stretch our legs and let the reporter put some new tape in the machine.

(A short recess was taken.)

Senator Moss. We will now resume our hearing. I appreciate your cooperation while we had this brief interlude.

Dr. Alfred C. Nelson, who is chairman of the Colorado Commission on Aging and Mrs. Stephen H. Hart, chairman of the Metropolitan Committee on Aging, I understand they will come together to the stand. Thank you for being here, Dr. Nelson and Mrs. Hart. We look forward to hearing from you.

STATEMENT OF DR. ALFRED C. NELSON, CHAIRMAN, COLORADO COMMISSION ON THE AGING

Dr. NELSON. Mr. Chairman and members of the committee, Mrs. Hart and I decided to take the liberty of sharing the testimonial chair here. We have been teaming up for several years in some of these matters and it seemed more appropriate for us to have our comments come together because they will dovetail to a certain extent. I am going to make my comments concerning the Colarado commission first, and then give Mrs. Hart the last word, in spite of the fact that normally the man gets it by saying, "Yes, dear."

We, I think, both of us, would say that we are really here to learn rather than to inform because as laymen we have limited experience and we were very much interested in the information which has been developed during the morning, which was relatively specialized, whereas our remarks are going to be quite general and relate more to the implications of some of the specifics of long-term care as they may be a phase of the overall pattern of the needs of the aging.

For your information and that of the audience, Governor Love appointed the Colorado Commission on the Aging on July 8, 1964, to implement his recognition of the need for a statewide official government-related body to obtain the facts relating to the interests, problems, and needs of older people in the State, and to interpret these to all individuals, agencies, and organizations in the public and private spheres of influence and responsibility pertaining to the many areas of concern pertinent to the welfare of the aged.

Since the commission has been operative for a relatively short period of time, it has made only limited progress in terms of specific matters which it has under consideration. However, it is currently conducting a comprehensive inventory of all available services and facilities for the aging in the State as a basis for evaluation and planning on a statewide level. In addition to the inventory project, three other subcommittees are: (1) exploring the means by which the Governor's recommendation that the commission become a permanent commission through appropriate legislative action, can be achieved; (2) investigating the status of housing for the elderly, and (3) making plans for a Governor's conference on the aging.

In light of the above, it can only be anticipated at this time that the inventory will reveal the complex of facilities and services now available for long-term care. We have heard from agency representatives participating in the current hearing information in the areas of public welfare, public health, housing, nursing homes, et cetera, which will ultimately become a part of the complete inventory. Further, the commission is not in a position to evaluate the quality of services available to meet the needs of people requiring long-term care. Also, welfare or similar agencies are better able, than is the commission as of the present, to evaluate the extent to which present Federal laws help or hinder the development of services and facilities to meet patients' needs.

An important factor which will play a part in the statewide efforts of the Colorado commission to assess the many concerns related to the aging, is the experience of the Metropolitan Council for Community Service, Inc. in its metropolitan planning project for older

people which is included in the report of the metropolitan committee on aging to be given by Mrs. Hart. It is implicit in the planning of the work of the commission that some means be found to encourage and achieve the formation of comparable community committees in a number of strategic areas of the State. As such committees are formed, a comprehensive picture of local conditions and their interrelationships will be available to the commission for purposes of coordination and evaluation.

The areas of unmet needs and present gaps in services which are revealed in the report of the metropolitan committee on aging can, I am confident, reasonably be assumed to exist to some degree in other areas of the State. Therefore, though the short period of time, during which the State commission has been operating, prevents a formal listing or commentary on unmet needs in the State as a whole, there is every reason to accept the validity of recognizing that those elements evident for the Denver metropolitan area are equally valid as needs in other areas of the State.

There are, however, some areas of concern which those among the commission members, who have been discussing these matters, have noted as worthy of the attention of the Senate Special Committee on Aging. Foremost among these, it seems, are the problems faced by those individuals who, for some reason, cannot qualify for the several forms of public long-term care but whose private resources and family status are inadequate to provide a satisfactory type of long-term care in nonpublic facilities. It appears that there is a gap created by the limitations, due to legal or other factors, imposed upon publicly maintained facilities and the potentiality of services by private agencies to which those mentioned above must turn. The possibility of some provisions which would make it possible for private agencies to come into the picture and fill needs not being met by public agencies, is worthy of careful consideration. Among such could be some provision for grants to private agencies to provide funds for grants-in-aid, administered by the agencies to individuals who find themselves between the two extremes of those eligible for public welfare and those who have adequate resources of their own to meet the expenses of long-term care.

Another aspect of this problem is involved in the desirability of devising some means of providing assistance to families in such a manner as to eliminate the necessity for abandonment of responsibility for older members on the part of the younger members of a family in order that the elderly may qualify for public assistance. There seems to be many cases in which a family is placed in an untenable position in trying to care for an older member of the family by virtue of limited resources but still sufficient to prevent the older person from qualifying for appropriate forms of assistance to relieve the younger members of the family of the, in some cases, impossible burden of financial responsibility.

Another aspect of long-term care for the elderly is related to the policies of institutional care. There seems to be inadequate flexibility and variation in the types of either public or private agencies for placement of those needing some type of institutional care, often resulting in placement in a mental or similar hospital when some type of nursing home or inliving facility more suited to the needs of

the individual might be made available. In this area of concern, it is desirable that encouragement be given to the establishment, or expansion, of services in both public and private agencies to provide preventive and rehabilitative services which may make possible volunteer or other activities on the part of some of the older persons who are presently limited in their opportunity or capacity for such endeavors.

As I have indicated, this is quite general, but I think it may give some background for some of the considerations which are engaging our attention.

I turn the microphone to Mrs. Hart.

Senator Moss. Thank you. We will hear Mrs. Hart and we may have a question or two.

STATEMENT OF MRS. STEPHEN H. HART, CHAIRMAN, METROPOLITAN COMMITTEE ON AGING, METROPOLITAN COUNCIL FOR COMMUNITY SERVICE, INC., DENVER, COLO.

Mrs. HART. Mr. Chairman and gentlemen, thank you for permitting me to make this brief statement. Some of the things I say may not only dovetail with what has gone previously, but for emphasis, overlap.

The Metropolitan Committee on Aging, which I represent today, is appointed by and responsible to the board of the Metropolitan Council for Community Service, Inc., an agency of the Mile High United Fund.

This lay committee is concerned in and with the entire scope of planning for the aging, in improving and coordinating services, providing for needs which have been unmet, and in the prevention of deterioration physically, mentally, and socially in later years. It is not a direct service agency.

A demonstration project, previously mentioned by Dr. Nelson, financed by the Ford Foundation was the antecedent for this committee, which selected certain priorities for action that were appropriate and timely for this community. To mention two or three of its priorities, a Conference of Non-Profit Housing for the Aging was established which is pioneering in the exchange of thinking and cooperation for future plans. In cooperation with the National Council on the Aging, this group initiated an institute on nonprofit housing in Glenwood Springs, Colo., in 1963 which was of national stature.

This project worked closely with the Denver Housing Authority in its plans for housing the elderly. The Denver Department of Parks and Recreation has assumed responsibility for a Federation of Organizations for Older People.

I notice that in similar hearings held in 1963, Senator Williams' Subcommittee on Frauds and Misrepresentations Affecting the Elderly met jointly with you. The problem of protective services is one with which the Committee on Aging is struggling. Protective services is a two-sided coin; protection of the individual, in this case the elderly, over 62, from himself whether through incompetence, neglect, or ignorance, and the other side is protection of the individual from society or other individuals whether through fraud, neglect, or ignorance.

One way to approach planning for long-term care is by way of out-of-hospital services. This is also being studied by the Committee on Aging. These services include physical therapy, registered and practical nursing care, provisions for proper nutrition through some meals-on-wheels plan, for instance, and the various many social services.

Associated with the housing of the elderly for long-term care is a deep concern felt by this committee and also the Commission on the Aging over boarding homes, foster homes, as has been previously mentioned many times this morning. There is no adequate provision for control, supervision, or licensing of these.

With the legal or statutory limitations naturally imposed on the public welfare departments, it seems important to us that in planning for the aging, which field we are concerned with today, private or so-called voluntary supported agencies must be involved. Beyond physical plant construction and use, there are the numerous services to these people. The private agencies usually function at the local level, are able to and should, through their boards, interpret to the citizenry the problems, programs, and plans which are part of long-term care. These agencies are more free to act and react in a rapidly changing social society, and are and should be ready to undertake projects for demonstration in new areas. They need financial support, however. If you take a welfare dollar, a dollar to be spent in caring for people as they need it in this country, about 80 cents of this money is raised by taxes, is public money, a little less than 20 cents of this hypothetical dollar is given voluntarily or privately. The public welfare budget is a tight as any budget I know, but there is a great amount of money being offered and spent by the various National or Federal agencies which could effectively be used in this field.

The Metropolitan Committee on Aging looks to the State commission for broad planning in caring for and providing for the needs of the aging, and the committee intends to be able to supply the commission with the specifics.

Thank you.

Senator Moss. Thank you, Mrs. Hart and Dr. Nelson, for your statements here today. I commend Colorado and the Governor for the appointment of this commission and for your work in the planning field. That is really what you are examining, long-range planning in this area, and certainly that is something that we have great need of. That is one of the major reasons we are working as we are now, trying to outline the areas where there are gaps or ineffective aid being given and to define them, and that is basically the purpose of your commission and also of Mrs. Hart's metropolitan council.

We appreciate your coming. I don't knowing that I have any specific questions. I think your statements were comprehensive. Maybe my staff members might have a question or two. Frank.

Mr. FRANTZ. I wanted to ask one thing about the inventory which you now have underway, the inventory of long-term care facilities; are you doing this in such a way that the facilities will be classified according to the type of service that is available and the levels or intensity of care that is available?

Dr. NELSON. I am quite sure this will be true. We have a subcommiteee working on it and they have sent a questionnaire to the health

department, the welfare department, and many other agencies, statewide, asking what the facilities are, what the nature of them is, how they are administered, and so forth, and I am quite sure that out of that will come the answer to some of the questions you have. If not, we then will take the next step to attempt to ascertain that. Our objective is to try to get a picture that isn't limited to the Denver metropolitan area, because we recognize that in many areas, especially in the rural areas, there has not been too much consideration given to many of these problems except maybe on a sporadic basis. We are hoping to synthesize this into an overall statewide concept of how best to achieve it not only in the long-term care area but in many other areas as well.

Mr. FRANTZ. Did you have a target date for the completion of this inventory?

Dr. NELSON. Yes, we are shooting for about the first of June or the first of July for the completion of it and preparation.

Senator Moss. Thank you very much, Dr. Nelson and Mrs. Hart. We appreciate it.

Mr. H. Virgil Davis, member of the board of directors of the Colorado Nursing Home Association, we will be glad to hear from you.

STATEMENT OF H. VIRGIL DAVIS, MEMBER, BOARD OF DIRECTORS, COLORADO ASSOCIATED NURSING HOMES

Mr. DAVIS. Senator Moss and staff members, I am H. Virgil Davis. I am a member of the board of directors of the Colorado Associated Nursing Homes, Inc., also legislative chairman of region VI of the American Nursing Home Assocaition, and president of Davis Nursing Home, Inc., 1440 Vine, here in Denver.

I would like to preface my remarks by stating that great advances have been made in the nursing home profession nationally, and particularly in Colorado, during the past 5 to 7 years. This has been achieved primarily by efforts within the profession toward self-improvement through (1) promotion of educational courses for administrators and nursing home personnel, (2) new construction, (3) renovation of existing facilities, (4) cooperation with governmental agencies on all levels, (5) and the elevation of standards both of physical plant and staffing patterns.

Of the above, the most important and significant have been the educational programs. It is a well-stablished fact that regardless of rules and regulations or type of physical plant, the care given in a particular nursing home is only as good as the particular administrator along with the quality of staff employed. I would be quick to add, however, that titles alone are not the entire answer. Inservice training of the right type of individual often produces a superior result.

During the past several years our Nursing Home Association has sponsored courses for administrators, head personnel, and nurses' aides. Subject matter has covered the fields of administration, personnel management, accounting, nursing service, nursing techniques, rehabilitation techniques, recreational therapy, and nurse aid training. These courses have been carried on with the joint cooperation of the University of Colorado's School of Nursing and Department of Continued Education, the University of Denver's Community College, the State

department of public health, Opportunity School of the Denver Public Schools, and the Fort Logan Rehabilitation Center. These programs will be continued in the future.

As a result, a large number of homes in Colorado are presently using a uniform system of accounting which was developed jointly by the U.S. Department of Health, Education, and Welfare and the American Nursing Home Association. Also, many homes now employ either a full- or part-time recreational therapist. A number of homes have established departments of rehabilitation and many homes have someone on their staff capable of doing simple rehabilitative procedures. Others call in a licensed therapist on an as-needed basis.

I am very happy to report that in my own home during the past fiscal year, through the use of our completely equipped rehabilitation departments, we were able to return to their own homes 94 persons out of 283 admissions.

Administrative practices, personnel policies, and nursing services have experienced a vast improvement in recent years.

At the present time the Colorado Associated Nursing Homes and the State department of public health are conducting a series of district educational conferences for directors of nursing services in nursing homes under a U.S. Public Health Service grant. Also, a nurse's aid program and licensed practical nurse program are in progress under the Manpower Act.

Construction of new nursing home facilities has mushroomed in Colorado. In fact, so much so that in several areas of the State we are experiencing a surplus of nursing home beds. In a telephone survey conducted in the 4 counties of the Denver metropolitan area on February 19, 1965, it was found that in the 61-home survey, representing 4,255 beds, there were 853 vacancies.

I think you will note from previous testimony that has been given here we were not able to cover all of the homes in the metropolitan area. So there are additional vacancies to the ones reported here.

This is a vacancy rate of 20 percent, a rate too high for economical operation. In fact seven homes have ceased operation in the metropolitan area during the past 2 years. I understand that statistics concerning the number of new homes constructed, their bed capacities, the program utilized and the change in staffing patterns is to be covered in the statement to be presented by Dr. Roy Cleere, director, Colorado State Department of Public Health so I will not repeat them here.

After nearly 10 years of effort, the American Medical Association joined with the American Nursing Home Association to establish an accreditation program for nursing homes. The AMA did this same thing for hospitals in 1918. Today the National Council for Accreditation of Nursing Homes accredits nursing homes throughout the country. Sixteen homes were accredited in Colorado last year and 10 more are presently being surveyed. It is anticipated that at least half of the homes in Colorado will be accredited before the end of this year. This has been a tremendous step forward toward improvement of nursing home care and serves as the only qualified measuring stick of nursing homes on a national level.

I would like to point out that the accreditation program does provide for a medical consulting staff and written medical policies. We feel that the medical profession is doing a good job of supervising the care in nursing homes.

From the standpoint of facilities available, quality of care, enforcement of standards, the nursing home situation in Colorado is excellent. There is, however, one area in which the aged are being sadly neglected. There are numerous, in fact literally hundreds, of aged persons living in so-called rest homes or boarding homes. Whereas there are a goodly number of legitimate boarding homes which do an excellent job and confine themselves to those types of individuals who can properly benefit from their kind of service, there are many more who do not. These are the ones who daily misrepresent themselves to the public, either in newspaper advertising or word of mouth, as being nursing homes or as giving nursing care without the benefit of any type of license, any kind of supervision, or meeting any kind of standard.

An all too typical case is the true situation described below: A retired Army nurse decided she needed something to do. She had extra rooms in her home so she proceeded to care for elderly persons. When the situation came to my attention she was caring for five persons. She was cook, maid, and nurse. She had no assistants. One of her "patients" was a person who had been adjudicated, walked only with the assistance of a walker, was a diabetic, was incontinent of both bowel and bladder, and suffered from glaucoma. Another one was a lady confined to a wheelchair who needed assistance with dressing, a special diet, and quite often psychological attention. I was not advised as to the condition of the other three guests. The nurse shared her own bedroom with the first "patient."

Another example, and much worse situation, is the lady and her ex-convict son who have gone into the business on a mass scale. They own three adjoining buildings into which they stuff old people into every available corner. Many are quite infirm, some incontinent, need assistance even to walk, and are senile. For rates as low as $75 per month the people receive very poor food, poor sanitation, and inhuman treatment. Some of these persons are even so bold as to advertise in newspapers under the "Nursing Home" heading. Nursing homes who are licensed as nursing homes are getting a little bit tired of this type of facility being referred to as nursing homes. There are also skid row hotels who care for large numbers of these people.

Both of the above situations have been reported to the health and welfare authorities repeatedly. They have visited but admit that they are helpless to do anything about the situation without further legislation. There is a need for a definition of what types of patients can properly be cared for in a boarding home and which types cannot. Authority must be granted to someone capable of making this determination. It is our opinion that no one less than a licensed physician is capable of making this determination.

It is also our opinion that facilities caring for elderly persons in numbers of more than two should meet the same standards for floor square footage (space) and safety requirements as nursing homes. In fact, space for the ambulatory of this group is more important than for those in nursing homes and safety factors become more important because there is less supervision.

In closing, I would like to make some general comments on the various bills for medical assistance which are presently before Congress. Our association has never supported medical care under social

security. However, if this is to be, there are several areas which we consider a must to make this program workable:

(1) In the definition of the "extended care facilities" to be eligible under the program we suggest that those homes which have been accredited by the National Council for the Accreditation of Nursing Homes as either an intensive care or a skilled care facility or which meet comparable standards should be eligible without further qualifiation.

(2) The provision for transfer between hospital and nursing home and nursing home and hospital is entirely unnecessary since it is not the prerogative of either a hospital or a nursing home to decide the kind of care an individual patient needs. This is the sole prerogative of the attending physician who I am sure is always on the staff of several hospitals and can admit patients to any nursing home any time, thus making the requirement of transfer agreements between nursing homes and hospitals null and void.

Nursing homes and hospitals already freely transfer their records between themselves so that the information concerning the patient and his past history will be known.

It is also the prerogative, and the prerogative of the physician only, to decide when a patient should return home.

In title III of H.R. 1, which is presently before Congress, are the provisions for Kerr-Mills funds to be made to State facilities for mental and tuberculosis. We feel that this would be a step backward.

I would like to refer to the testimony of Dr. Schapire on the excellent program that we have had in Colorado, transferring patients from our State hospital to nursing homes, in the past. We feel that if Federal funds are made available to State institutions this may well reverse this very fine program. There will be no incentive then for getting these persons out of State institutions into other types of facilities and it might even encourage the building of more institutions.

(3) Any bill giving medical assistance should have some provision for a means test.

Our association supports the eldercare bill which is being cosponsored by our own Senator Allott.

One last statement I would like to make. It is our feeling that a nursing home should always remain first a home and, second, a medical institution. However, they should be equipped to give intensive care if needed. This is a trend in the profession today and is encouraged by our American Nursing Home Association, that more facilities of the multicare type will be advanced, a facility that can give all elements of care from personal to intensive care.

I wish to thank you for this opportunity to appear before you.

Senator Moss. Thank you, Mr. Davis, for a very fine statement. We are glad to have it.

I was pleased to note that you stated 94 of your patients have been returned to their homes. Was this in the past year's operation?

Mr. DAVIS. Yes; that was from January 27, 1964, to January 27, 1965, when we made the survey.

Senator Moss. That is most commendable. We have been commenting on that earlier in this hearing, about the objective remaining to rehabilitate wherever that is possible on elderly persons, and the mark of rehabilitation is their ability, of course, to return to their own homes. I commend you for that.

I was interested in your opinion on the accreditation of nursing homes. I see that you approve of that and so do I. I think this is a fine objective. I did understand you to say that the program of accreditation by the American Medical Association and the American Nursing Home Association was the only qualified measuring stick of nursing homes on a national level. Are you familiar with the national accreditation program that is sponsored by the American Hospital Association, the American Association of Homes for the Aging, and several others?

Mr. DAVIS. Yes; I am. The one advanced by the Hospital Association at this time is merely a listing program. If there are any standards to qualify for this, they certainly are not as high as those advanced by the National Council.

Senator Moss. You then think that the other program is much superior to that that is being sponsored by the Hospital Association?

Mr. DAVIS. Definitely. This accreditation program is over and above licensure. I think licensure must necessarily set minimum standards below which a nursing home may not fall in order to be a licensed facility but, in order to be accredited, you must meet not only the licensing standards but additional standards. The licensing program is geared primarily to physical plant and safety and that sort of thing; whereas they do have some emphasis on staffing patterns, and so forth, it is primarily on physical plant; whereas, the accreditation program is geared more to what's going on in the nursing home, the kinds of records that are kept, the kind of personnel policies that are kept, the administration, the kind of nursing service that is given, et cetera, et cetera, et cetera.

Senator Moss. I think it was Dr. Vest who had some question about whether there ought to be uniform systems of accounting or cost breakdown in nursing home care. I understand that you think this is proper and desirable; is that correct?

Mr. DAVIS. I think it is very desirable that uniform systems of accounting are used in nursing homes and I feel that, really, it is only a matter of time until this will be a fact.

Senator Moss. What do you think is the cause of the overbuilding in the nursing home field here in the Denver area?

Mr. DAVIS. That would only be speculation. Possibly there were some individuals who felt there was a fast buck to be made. I think that building that was done by persons who were already in the field knew that this was not true or possible and were doing it more from a self-improvement standard. But some of the newer people who have come into the field, who have not been in it before, may have had this in mind when they built.

Senator Moss. Has the overbuilding and the resulting competition for patients had a deteriorating effect on the quality of service available?

Mr. DAVIS. No. This is our good old free enterprise system. Competition is always good. This will do more to elevate standards in general than most anything else. Even those persons who had not had previous experience in the nursing home field, in order to keep themselves solvent, have had to produce.

Senator Moss. So you think it has actually increased the quality of care to have these 20-percent vacancies?

Mr. DAVIS. Yes.

Senator MOSS. I was, of course, very concerned about your report on the fact that many of these rest homes or boarding homes are holding themselves out in various ways as actually being nursing homes. First of all, is there any legal way that they can be prohibited from listing themselves as nursing homes or, if there is no legal way, is there any effort being made by the Better Business Bureau or other voluntary agencies to prevent this?

Mr. DAVIS. We have for a number of years been working toward this means on a public relations-type basis and have been successful to a degree. I am sorry to say that there are still facilities of this type that do purport to be giving nursing care, or loosely call themselves nursing homes, and maybe if they don't actually call themselves a nursing home they give the connotation that that's what they are and the public has not yet learned the difference.

Senator MOSS. I understand you to think the real answer is, of course, to require them to be licensed by the same licensing authority that licenses nursing homes and therefore subject to the same general supervision.

Mr. DAVIS. I do.

Senator MOSS. I notice that you in your comments said there is already complete transfer of records between the hospital and the nursing home. I didn't understand this from the previous testimony. I thought the doctors said you needed much less in the nursing home and shouldn't have a full hospital record.

Mr. DAVIS. It is true the nursing homes do not keep as full a record as the hospital does, for obvious reasons. We don't care for the same acute-type patients that hospitals do. I believe that through the educational programs that we are having and will continue to have, that medical records in nursing homes will be less of a problem in the near future. I feel that a majority of nursing homes do presently keep good records.

Senator MOSS. On page 5 in your comments on any possible national legislation on this health care field you say, No. 3, that "Any bill giving medical assistance should have some provision for a means test." Why do you feel that way?

Mr. DAVIS. Well, I feel the same as Dr. Vest, that giving medical assistance to persons who have the means to provide their own is, I believe he used the word "amoral."

Senator MOSS. Well, for instance, now, a person buys a policy of Blue Cross and pays his premiums for a period of time, then there comes a time when he needs hospitalization, he doesn't have to prove any means test to go in and get it, does he?

Mr. DAVIS. That is an insurance program.

Senator MOSS. Well, if we are talking about King-Anderson, simply as an example, where everybody makes his contribution as long as he is earning; he buys, in effect, a policy so that when he has reached the qualifying age and needs the return, he can go in and get it, is there any great difference?

Mr. DAVIS. He doesn't have a choice of whether he wants to buy that policy or not.

Senator MOSS. No, he has no choice of whether he wants to pay social security now, but when he gets to be of that age and he wants to claim his benefits, he can claim them, is that right?

Mr. DAVIS. That is correct.

Senator MOSS. He doesn't have to pass a means test, in other words. Of course, this is speculative and getting a little afield, but would your opinion be the same, for instance, on social security retirement benefits, do you think that those people who could not pass the means test should be prohibited from drawing social security?

Mr. DAVIS. I think this is a different area than medical assistance. However, I will have to admit that I am inclined to feel that way.

Senator MOSS. Do you have a question of Mr. Davis?

Mr. FRANTZ. Yes, I have one or two.

Senator MOSS. Go ahead.

Mr. FRANTZ. On page 2 you refer to a uniform system of accounting developed by HEW and American Nursing Home Association. If I identify this system correctly, it is that which was used in the pilot study last year, the pilot study financed by Public Health Service and carried out by the American Nursing Home Association and the American Association of Homes for the Aging.

Mr. DAVIS. That is correct.

Mr. FRANTZ. As I remember, there were 50 homes for the aging and 200 ANHA members originally, which dwindled to 150, and the purpose of it was to develop this system. How many of your homes participated in that pilot study?

Mr. DAVIS. I did personally. I don't know how many other homes in Colorado did. I don't have that information.

Mr. FRANTZ. Do you know how many homes are using this system at this time?

Mr. DAVIS. I don't know exactly how many, but I think approximately half of them are, at least.

Mr. FRANTZ. Does this tie in neatly with the uniform cost reporting system whch is being developed by the welfare department?

Mr. DAVIS. Yes, it can be used for that.

Mr. FRANTZ. In your comment on the payments provided in the title 3 of H.R. 1 for care in State hospitals, you said that this would reverse the trend to moving patients out of the State hospitals into nursing homes and referred to the program which we have heard described here. Are you saying that the primary motivation for this program is monetary, to go where the money is to be found to pay for the care?

Mr. DAVIS. I believe that has a degree of credence. This, of course, is not the only factor. I think there has been a sincere desire—well, first of all, to relieve the crowded conditions at the State hospital. Secondly, to return people to their own community in a more homelike situation near their friends and relatives has been another motivating factor.

Mr. FRANTZ. Wouldn't these motivations hold even if money were available to the State hospitals?

Mr. DAVIS. Of course, these factors would always hold, but whereas there has always been precedent that State institutions are supported solely by State funds, there is the monetary factor involved in that the State is relieved of some of this responsibility by getting them out into other types of facilities where Federal funds or other sources of funds are available.

Senator Moss. Thank you, Mr. Davis. You have been very helpful and given us good information. We appreciate it.

Dr. Clark Wood, who is the executive director of the Associated Methodist Homes. Dr. Wood is from Seattle. You are away from home, sir.

Dr. Wood. Not too far. Two and a half hours by jet.

Senator Moss. Very good. I recall your being with us in San Francisco about a year ago and we are delighted to have you again, Dr. Wood.

Dr. Wood. Thank you, sir.

STATEMENT OF DR. CLARK J. WOOD, EXECUTIVE DIRECTOR, ASSOCIATED METHODIST HOMES, SEATTLE, WASH.

Dr. Wood. Senator Moss, Mr. Frantz, Mr. Miller, it is a privilege once again to appear before a subcommittee of this most important Special Committee on Aging. Those of us who are engaged full time in the field of elderly care appreciate the interest and concern evidenced by Members of the U.S. Senate in the problems we face.

I appear before you today to indicate the church's concern for people with special needs, those who because of age and infirmity seek facilities which will grant them continued dignity of human personality in their later years.

As a matter of personal qualification to testify, I will state that I am a clergyman assigned to be executive director of Associated Methodist Homes, Seattle. As such, I carry responsibility for nearly 800 elderly persons in 3 homes located in Seattle and vicinity. Our residents, all with signed agreements assuring them concern and care for the balance of their lives, average 78 years of age. Almost 70 percent of them have one or more classifiable infirmities, that is, minor or major deficiencies in hearing, sight, mobility, digestion, and so forth. Most of them could not live alone. They all require the assurance of responsible care, but they continue to have the fierce independence which will not tolerate regimented institutionalism. Within each of our three homes we have a full-fledged nursing facility (evidently we couldn't do this in Colorado). Thus, we are able to care for most of the long- and short-term illness and infirmity of our people.

We are licensed in the State of Washington as boarding homes for the aged; the infirmary sections are separately licensed as nursing homes.

In the 3 facilities we have approximately 100 beds in this classification.

As our homes have developed, we have become increasingly certain that a nursing home in the larger facility does not dominate the home. It is one of the tools with which we work, but it does not overwhelm. There is a school of thought which says, "If you do have a nursing facility in the home for the elderly, that home will drift—will deteriorate, if you will—to a rest home, then eventually the entire facility will be a nursing home. "Hence," says this school of thought, "you should never have more than an overnight dispensary in a home for older persons; never put a boarding home for the aged and a nursing home under the same roof; keep all infirmities out of the home, lest it deteriorate totally into an infirm facility."

It is this thinking which has led to Federal restrictions on financing of facilities for the elderly. Increasingly there seems to be insistence that money for elderly housing be provided only if the facility does not have a nursing home integrated within it. We have learned, however, that a home without an adequate nursing facility fails utterly in giving to oldsters the thing they require most, the sense of security so desperately needed and desired.

But more than this, we are increasingly confident that a nursing home facility within a home for older persons contributes to the total well-being of the home rather than leading to ultimate conversion entirely to nursing care.

In the light of our experience, I come before you today to seek two things. First of all, as you work on legislation at the national level, I hope you will truly recognize progressive elderly care. Do not insist, by laws and regulations established within laws, that homes for the elderly and nursing homes be separated. (Incidentally, this was all written before I heard the other presentations this morning, and I am amazed that it is so much to the point.)

In our homes we use the nursing facilities as tools for the well-being of our people. We are aware of the disorientation which can take place with elderly people if they are moved. We are so much aware of this that our supervisor of resident well-being, a registered nurse, will always go with the resident who has to go to the general hospital. She becomes the bridge, to be an effective means of bridging this potential disorientation. Our people do go to general hospitals, obviously, but we go with them, we see them in the hospital, and we bring them back home.

The presence of a nursing home under the same roof means that we catch the chest cold before it develops into pneumonia. We find a willingness to turn one's self in, which would not come if the residents were to be moved out of the house any time illness came along.

We do not pretend to be a hospital. We work closely with the general hospitals in our communities, but time and again the physicians taking care of our residents say to those who have been hospitalized, "You will now recover more quickly in your own home (that is, the Manor, the Terrace, the Gardens) so I will release you from the hospital to go to the nursing home facility in your home."

Our nursing homes are under continuous registered nurse supervision. We employ a medical doctor as our medical consultant. We work on the theory of environmental therapy which places our people in a setting which calls forth the best from them. We deliberately keep the barrier between the well section and the infirm section low so that the transition can be made easily either way. This does not depress the well section. Rather, it strengthens the sense of assurance of those therein. Rehabilitation becomes real because there are no great chasms as from one facility to another, no great chasms to overcome.

This, to us, is progressive elderly care. I ask you to recognize the value of such an integrated program. Do not place restrictions which make this pattern more difficult than it already is.

The second thing I seek is this. Please don't penalize progress. Last Thursday two of my supervisory R.N.'s and one of my administrators attended a nursing home conference under the joint auspices of our State department of health and our State welfare department.

Rehabilitation was stressed. In the course of the heavy insistence on getting people up and around, getting them back into circulation, a potential weakness in public assistance was aired.

In our State patients receiving public assistance are classified. Total bed patients earn for the home the highest rate. Compensation for those up and around is at a lesser rate, despite the fact that often it takes more genuine concern and care to keep the patient up and around than for that person to be left in bed.

Here is the dilemma: The insistence is on getting them up and around. In this we fully concur. Yet to make this effort and continue this effort we are rewarded by a cut in compensation. It just does not make sense.

Let me turn for a moment to the matter of financing these large facilities for older persons. Two of my homes are FHA insured under 231. We are convinced (and I can add specific illustrations) that the most adequate package for old people is a comprehensive package supported by lifetime agreements, a comprehensive package which includes three meals a day and good nursing care under the same roof. Yet the tendency in Federal financing, as evidenced by the 202 program, is diametrically opposite to this. Private enterprise can erect the ordinary apartments necessary. Federal financing should be used to encourage places of comprehensive care.

There is yet another phase in financing. One of the bills before Congress in the field of elderly care contains, I understand, the provision that Federal assistance will be given to nursing home patients only if the nursing homes are not incidentally a part of a larger domiciliary care facility for old people. This is manifestly unfair. Persons in our homes would be ruled out of participation, yet they have need of such support, for the cost of their long-term nursing must be prorated to them. Many of them are faced with real difficulties in meeting these costs.

Yours is a most difficult task in formulating the statutes which recognize and care for the needs of many people. Do not neglect the persons in later years. Help us carry the burden by seeing that the statutes, first of all, do not penalize progress, and secondly, recognize the progressive elderly programs which successfully combine homes for the aging and nursing homes in comprehensive concern and care.

Thank you for your attention. [Applause.]

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

Dr. Wood. I regret I did not have this statement for you. I will mail it to Washington.

Senator Moss. Very good. We appreciate it. It is an excellent statement and you make your points very well. "Don't penalize progress" is a very good phrasing of the dilemma that we do face in a number of States where there is a different amount made available to a person who is bedridden as against one who is ambulatory, while we are trying to emphasize the goal of rehabilitating people to be ambulatory or, still better, to be able to care completely for themselves. This is a very good point.

I am glad too, that you commented on whether you should have a nursing home facility within a residential care facility. Apparently in this State and in many others there is an effort to keep them separate. Your recommendation on that is a good one for us to consider.

I don't know that I followed completely when you were talking about the Federal funds made available for the building of nursing homes.

Dr. WOOD. Let me say there that I am not talking about the FHA program for the construction of nursing homes. This is a fine program and needs to be continued. I am saying that the move, seemingly, is toward the 202 financing type—202 financing, of course, requires two things. First, that there be no long-term agreements between the corporation doing it and the individual. Therefore, the individual has no right to expect continued long-term care till death. When you are dealing with people with an average age of 78, what they want is, as we say of our residents, or they say to us, "I can trust my life to you." You can't trust your life to a 202 program because you are out on the street if you are ill. You can't trust your life to a 202 program because they cannot have these long-term-life contracts. Yet the whole trend seems to be, "Let's go toward the 202 type of financing, not toward the 231 financing," which made possible what we feel is a very fine facility, for instance, Bayview Manor, which is a comprehensive program.

Senator MOSS. Thank you. Do you have a question of Dr. Wood?

Mr. FRANTZ. Yes. Under 231, as I remember, the limitations on infirmary beds or nursing care beds are 1 for 12 units of housing.

Dr. WOOD. This has changed back and forth within regulations under 231. I know only that Bayview Manor, constructed under 231, currently has 40 licensed beds in it and there seems to be no objection to that.

Mr. FRANTZ. This is a higher ratio, then.

Dr. WOOD. Yes, sir. We have a potential 237 residents in the house. We run about 232 out of the potential 237, and our maximum load in the nursing home facility would be presumably around 36. You always need some cushion.

Mr. FRANTZ. In your opinion, will the amendment last year extending the 232 nursing home program to nonprofit sponsors be useful in permitting these combined projects? Can you use both sections at the same time?

Dr. WOOD. Yes; thank you for opening the door. We expect in our complex of three homes to add another program, which will be a nursing home, and we will hopefully get major assistance in this. Now, this will take from the three homes some of the extreme senility cases; for instance, it will take the comatose people where we can make our facilities even more specialized for them. It will include a special senility wing which will have its own walled exercise yard, and so forth. This will be within 300 yards of two of our three homes. We expect to look to the 232 possibility to help us in the financing of that. We think that this is but another phase of the total. This nursing home, however, will be open to the public and not just to those who are life-contracted residents of our three homes. It will meet the need of the person who says, "My aunt has fractured her hip. Can you take care of her for a few months until she gets back on her feet again?" We want to meet that need: we can't today.

Senator MOSS. Thank you very much, Dr. Wood.

Dr. WOOD. Thank you, again.

Senator Moss. We have one more witness to hear, Mr. Richard MacLeish, who is the executive director of the Colorado Hospital Association. We would like to hear from you, Mr. MacLeish.

Mr. MacLeish. Senator Moss and gentlemen, may I introduce, on my left, Mr. Frederick Sage, who is a member of our committee on long-term care and the administrator of the Brighton Community Hospital in Brighton, Colo., a small community not far to the north of Denver.

Senator Moss. Glad to have you, Mr. Sage.

STATEMENT OF RICHARD MacLEISH, EXECUTIVE DIRECTOR OF THE COLORADO HOSPITAL ASSOCIATION

Mr. MacLeish. Mr. Harry Yaffe is the chairman of our association committee on long-term care and is particularly qualified for this role because he has been associated for a number of years as the administrator of Beth Israel Hospital, of 150 beds, which has a 50-bed home for the aged in connection with it. Mr. Yaffe has taken the lead in thinking through this problem of how hospitals relate to the problem of long-term care. Mr. Yaffe regrets he could not be here, but asked me to speak for him.

We see our problem as one of almost a current contradiction. A few years ago there was a tremendous drive to get patients out of the hospitals. This lead in part to the emergence both of the separate nursing home as well as the emergence of the hospital-related long-term-care facility. Dr. Cleere and others have testified as to the numbers of licensed nursing homes operated by hospitals. By our count, whether they are called nursing homes or graduated-care facilities or progressive patient-care facilities, we have 26 or roughly a third of the 75 community general hospitals which have some type of organized long-term care facility either as a freestanding unit of the hospital complex or as a wing of the hospital.

We feel that some of the definitions we are talking about no longer are usuable and that among other problems is our search—when I say "our" I don't mean just the hospital, I mean the nursing home people, the health department people, your own subcommittee—for a workable vocabulary to define what we are really talking about so that we can plan intelligently for the future. To a large degree, we are attempting to stop a pendulum which started a few years ago. The general hospital is importuned on every side to be truly a general hospital and accept any patient at any time of the day or night for any type of condition which affects them. Yet, on the other hand, they are being importuned to get patients out.

I will cite just briefly some of the problems that we are trying to wrestle with, and I apoligize to the committee for not having a prepared statement.

We have established and circulated to our hospitals some guidelines for affiliation agreements between hospitals and nonrelated nursing homes. Our hope here is that we could promote continuity of patient care, of transfer of patients between facilities with a minimum of trauma to the patient. Other well-qualified people spoke to the committee this morning on this problem.

We also are trying to think of how we can bring services to the patient outside of the hospital and thus eliminate the need for a transfer into the hospital. We are trying to arrive at some meaningful sense of, "the proper care at the most economical figure."

For example, Colorado is one of nine States where more than 40 percent of the population is enrolled in Blue Cross. We find that our Colorado Blue Cross is under terrible stress these days. Nine percent, approximately, of the Colorado Blue Cross members are over 65, and yet this group of people are utilizing approximately 27 percent of the benefits, which is quite an imbalance. Therefore, because of this situation, in cooperation with Blue Cross and the Colorado Medical Society, we have established a recertification program, which requires the physician to recertify at the end of the 14th day of hospitalization that such patients do need a continuation of hospital care.

We are working closely with our American Hospital Association in the approval program, which up until a month ago was called a listing program. It has now moved into the approval program.

The problem of devloping working agreements between facilities is confused by the problem of objectives. We would hope to get some standardization of forms or procedures to accompany the patient in this transfer. Certainly we have areas in common between accounting and cost allocation procedures. In various areas of the State we find that there is, in fact, a sharing of medical personnel. It may be a "backdoor" type of consultation. We would hope it could be more formalized and have a frank working relationship between the hospital and a freestanding nursing home.

We are going into group purchasing, have achieved considerable economies there, and would hope to make these benefits available to other medical institutions. We think one of the great areas that need help and assistance is to allow the voluntary agencies, as well as those government agencies we work with, sufficient "wiggle" room for experimentation in research, and certainly planning.

Our association was a beneficiary 2 years ago of a research grant from the Department of Health, Education, and Welfare, and we have instituted an areawide planning program which we hope will encompass not only hospitals but nursing homes, other long-term-care facilities, as well as home nursing care.

We think the hospitals and the nursing homes and visiting nurses need help and guidance in experimentation and research because unlike many other industries, we do not have the money out of earnings to put into research, and unfortunately hospitals and the health professions take up in practice where the researchers leave off; what was the end result for the research man becomes a starting point for physicians and administration.

We think in the work your committee is doing, sir, you can be of great help in helping shape the public's attitude toward health care facilities at all levels, for they simply can't operate at less than cost. We find ourselves caught up in a great contradiction between cost and quality. They must be considered together.

I think our last speaker, Dr. Wood, pointed this out. We are aware that legislators must have a weather eye for finances and taxes, and yet we find ourselves caught up in the current, I don't want to call it mania, but tendency to equate quality and need with the dollar sign.

We think committees like yours and the studies you are doing can help all of us a great deal and guide us to the kind of experimentation and research and programs we need, and to help shape the public attitude.

Mr. Sage has some remarks about the actual kind of transfer and the types of patient that are seen in the hospital-related nursing home. Certainly we don't play the dominant role that the nursing home and others do in long-term care but the general hospital is very much in the picture. We are, as I said, pushed one way to get patients out, yet importuned to take them. We are trying to strike a happy balance and truly serve.

If it would be your pleasure, Mr. Sage will give a few words.

Senator Moss. We will be glad to hear you, Mr. Sage.

STATEMENT OF FREDERICK C. SAGE, ADMINISTRATOR OF BRIGHTON COMMUNITY HOSPITAL

Mr. SAGE. I am the administrator of Brighton Community Hospital, which is about 25 miles north and is, we think, quite typical of the group of hospitals in Colorado which have extended care facilities of one sort or another. As Mr. MacLeish mentioned, one-third of the general hospitals in Colorado do have these facilities, which is, of course, a very unusual situation. Most of them are small rural hospitals and these extended care facilities undoubtedly developed because there was no other means to care for the long-term aged patient.

I have here (I won't read it now, I will give it to you) a brief description of each of the patients in our extended care facility. They range from fairly self-sufficient to completely helpless individuals. One woman, her only response is moving her eyes, others are somewhat up and about.

I would believe, in discussing with the other administrators in the hospitals, that we tend to attract a patient needing both more medical attention and having less finances, and that put us in a real dilemma, because from the reports I have, and I have discussed this with practically all administrators who do have these departments, they feel themselves very fortunate even to break even in these departments.

I will just give you this list. You might find it very interesting.

Senator Moss. We will be very glad to have that, and it will be printed in the record. This is a good detailed summary.

(The material referred to follows:)

EXTENDED CARE DEPARTMENT, BRIGHTON COMMUNITY HOSPITAL, BRIGHTON, COLO.

(NOTE.—The dollar figure is the total payment, Welfare pays $195 for the patient so designated.)

1-A B.M. Age 84. Diagnosis: Aortic aneurysm. Admitted December 18, 1962. Welfare $220.

On admission the patient had epigastric pain and discomfort with dark stools. A special diet, medications and X-rays were ordered. A diagnosis of hiatus hernia was made requiring a block put under the bed, and medication for pain, as well as other stomach medications. Periodically has arthritic pains, abdominal complaints and urinary discomfort. On occasion nitroglycerin is administered for chest pains. On occasion has discomfort from hemorrhoids. Patient requires very little help, but does receive medication, and is up and about as he desires. Patient is mentally alert. The patient does oil painting that he sells. Besides the medication listed previously he receives

a cardiac medication, diuretics and medication for the hemorrhoids. Mr. M. goes to the barber shop and goes to visit his daughter in another city.

1–B R.B. Age 66. Diagnosis: Fractured left knee bones. Admitted December 31, 1964. Patient pay $225.

Mr. B. came in with a fractured left knee bone following hospitalization at the veterans hospital in Denver. He had been in a car accident some months previously. Has some palsy following a stroke 1 year ago. His rehabilitation brought him from a wheelchair, to walker, to crutches, to cane and the hall rails. Uses the wheelchair as necessary. Mr. B. has braces on his left leg and knee. Has an open area on the right leg requiring dressings and medication daily. Able to have tub baths with assistance. Is on pain medication as necessary. He is mentally alert. His brother sees him frequently.

2–A E.O., Mrs. Age 79. Diagnosis: Hypertension, ASCVD, healing pinned hip, fractured right elbow. Admitted December 1, 1964. Patient pay $225.

The patient was admitted from the hospital following a successful pinning of her right hip and healing fractured arm. Was hospitalized 2 or 3 weeks following surgery. Husband was a patient in the hospital and unable to care for her at home so came to the extended care department. Mentally alert. She has some arthritic changes that cause her discomfort. Has complete bed baths and care. Is allergic to soap and water and requires special skin care. Patient is up in wheelchair and helped in the walker to learn to reuse pinned hip. Requires help with getting up in the chair, bathroom, and in and out of bed. Requires medication for hypertension and discomforts. Requires blood pressure to be checked frequently.

2–B W.O., Mr. Age 85. Diagnosis: Ulcers. Admitted December 11, 1964. Patient pay $225.

Mr. O. was transferred from the hospital after several weeks with a bout with a very large gastric ulcer. Admitted to the extensive care department and was there for about a week, then readmitted to the hospital for another 4 weeks of treatment for the ulcer. The patient is very hard of hearing. He receives complete bed baths and care. Has palsy. Is up and about as desired. On admission the patient required general nursing care, and a special diet. The diet must be watched closely. The patient receives milk every hour. All eliminations must be watched for signs of blood. The patient has four different gastric medications, and also receives urinary medication. The blood pressure must be checked frequently as he routinely carries a low blood pressure. The patient is a retired auctioneer.

3–A E.C., Mrs. Age 86. Diagnosis: Amputation right leg. Senile. Admitted February 11, 1963. Patient pay $210.

On admission to the extended care department, her circulation was so poor a black gangrenous area developed. May 19, 1964, her right leg was amputated at the hospital. Readmitted to the department June 2, 1964. The patient requires complete nursing care. Is very confused. Unable to do anything for herself. Must be fed all meals. Is incontinent and a Foley catheter was placed and this is irrigated daily. Is gotten up in a wheelchair once daily, if her condition is satisfactory. Her dressings are changed twice a day and it requires one-half hour of nursing care for each. She is on a special diet. It is necessary to turn her every 2 hours or change her position every 2 hours as she has pressure areas that must be watched closely to prevent irritation. This is due to her poor circulation and is worse than the average aged person. Nurses must watch her elimination as she has a problem, concerning regularity. Mrs. C's son sees her frequently.

3–B L.L., Mrs. Age 80. Diagnosis: Amputation right lower extremity. CVA but not paralyzed. Admitted July 1, 1964. Patient pay $210.

Mrs. L. had an ulcerated area on her right leg about 20 years refusing medical care and refused amputation as long as she could walk even as recently as 2 years ago. Before her amputation required 1 hour two times daily to change dressing, also had soaks to the leg. She was admitted to the hospital December 8, 1964, and readmitted to the extended care department January 5, 1965, following the amputation. The patient requires complete nursing care, complete bed bath, and must be fed her meals. She needs help with getting up, dressed, and be supervised as she is quite confused. She must be restrained as she will attempt to get up further in the wheelchair or the bed. Her elimination must be watched closely. Her medication is for pain and she also receives a laxative. Her son sees her frequently.

4–A R.B., Mrs. Age 87. Diagnosis: Stroke. Admitted April 20, 1960. Welfare pay $225.

The patient requires very little nursing help. She has help with bathing mostly. Up and about as desired. She walks with a cane but walks all bent over. Has medication including IM requiring more than the average up and about patient. She receives cardiac medication, diuretics and kidney medication as well as B–12. She, on occasion, has chest pain and arthritic pains. On occasion complains of pain in the upper abdomen. She does have a medication for pain. Her elimination must be watched closely. She goes out with her family once in a while.

4–B L.M., Mrs. Age 84. Diagnosis: Coronary. Admitted June 6, 1960. Welfare pay $195.

The patient requires help with her dressing. Is up and about. Very confused. Is incontinent and wears incontinent pads. She also has no control over her bowels. Tub baths with all other care given her. She has foot soaks three times daily and dressings to her foot. She has a small gangrenous or black area. Her blood pressure must be checked frequently. She is on cardiac medication.

5–A E. S., Mrs. Age 93. Diagnosis: Blind. Admitted April 19, 1960. Welfare pay $195.

The patient needs help with all of her activities, dressing, eating, in and out of bed, etc. Up in the chair daily. Very alert person for age. Is demanding. She requires eye care including medication daily. She is on kidney medication, diuretics, and requires much close observation. Complains of leg pain and on occasion nauseated. She seldom leaves the room and won't try to walk. A niece comes to see her once a month.

5–B A. U., Miss. Age 88. Symptoms: Malaise, chest pain and high temperature. Admitted December 28, 1964. Welfare pay $240.

Before admission, Miss U. had been caring for members of her family who were ill: Became exhausted and symptoms developed. The patient requires help with bathing, getting up in wheelchair, combing hair, encouraged to eat and has an appetite medication. Has some weakness and must be checked that she doesn't become exhausted. Is being helped to walk. Watch elimination carefully.

6–A M. C., Mrs. Age 73. Diagnosis: C.V.A. Admitted October 29, 1964. Patient pay $250.

The patient came here from a Denver hospital following a stroke leaving her paralyzed on her left side. The patient is completely helpless. Does not respond except for moving her eyes. Is tube fed every 4 hours. Indwelling catheter, that must be irrigated every day and changed every 2 weeks, oftener if necessary. The patient is repositioned every 2 hours. She is complete bed care. She must be turned every 2 hours and must be kept in good position to prevent pressure areas. Her gastric tube is changed every 2 weeks. Is on kidney medication and occasional IM diuretics. Her throat must be suctioned frequently. Her temperature, pulse and respiration are taken three times daily as well as her blood pressure taken daily. She has a steamer. Special skin care must be given her. We must exercise her arm and leg on the afflicted side. We also must watch her elimination.

7–A M. S., Mrs. Age 58. Diagnosis: Arteriosclerotic heart disease. Admitted January 5, 1964. Patient pay $225.

The patient requires help with dressing, eating, and all activities. Very confused. Needs much supervision because of the confusion. She must have help with the very simplest of activities, such as she is unable to pull up her hose, button her clothes, and forgets where her room is. Must be helped in and out of the bathroom, in and out of the bed. Up and about but supervised. Because of her mental ability, all of her activities are very limited and needs help. Her family visits her frequently and her husband comes practically every day.

7–B L. Y., Mrs. Age 92. Diagnosis: Old age and arthritis. Admitted January 30, 1964. Welfare pay $225.

Patient requires very little help for her age. Up in a wheelchair as desired. Has an eye medication, diuretics, medication for pain, heart and other medications. On occasion has heart pain and complains of shortness of breath. Oxygen is given as necessary. Her blood pressure must be taken twice weekly. She is on a special diet. She must be weighed daily. She is able to have a tub bath. On occasion she complains of pain in her shoulder and ankle. Hot water bottle is all that is necessary usually.

10 E. W., Mrs. Age 83. Diagnosis: Coronary, arthritis. Admitted June 6, 1960. Welfare pay $210.

The patient requires help with bathing as well as most of her other activities. Up in her room. Up in the wheelchair when we are able to get her to leave the room. Unable to walk very far because of her obesity. Has much arthritis with much swelling of joints. Medications include a diuretic and an arthritic medication. Must have heat on her lower limbs and on occasion one leg must be wrapped with Ace bandage. Her blood pressure must be taken every week. Her family comes to see her about once a month. She spends her up hours making artificial flowers.

11–A R. T., Mrs. Age 88. Diagnosis: Old age. Admitted March 9, 1962. Welfare pay $230.

The patient requires help with all activities, up in wheelchair, helped with dressing and helped with her eating. On occasion has chest pain and has to have oxygen therapy. On occasion an EKG is taken. Her elimination must be watched closely. She has no visitors to see her.

11–B S. B., Mrs. Age 88. Diagnosis: 1° heart block, fractured hip that has been pinned, stroke, blind, arthritis. Admitted February 21, 1962. Welfare pay $195.

Patient requires help with all activities; complete bath care, eating, dressing, getting in and out of bed. She is up in a wheelchair and chair as desired. The patient is very confused. Must have eye care and eye medication frequently as well as cardiac medication. Her blood pressure must be taken daily. Occasionally she has abdominal pain and nausea, shoulder and hip discomfort.

12–A L. V., Mr. Age 78. Diagnosis: Cardiac, emphysema, asthmatic, high BUN. Admitted February 20, 1965. Patient pay $240.

Mr. V. requires complete bed bath and care. He is able to be up in the chair or wheelchair with help. On occasion will walk to the bathroom. He must be helped with his feedings. Confused at times but it is in relationship to his BUN. He receives cardiac medication, tranquilizers, medications for generalized discomfort. He is on a special diet.

16–A R. V. D., Mrs. Age 80. Diagnosis: ASCVD with cerebral arteriosclerosis. Admitted November 2, 1964. Welfare pay $250.

Admitted from the hospital following heart trouble. Patient requires complete care. She has a tube feeding with a stomach tube being changed every 2 weeks, or oftener of necessary. Very confused. Must be helped in and out of bed. Is incontinent. Up in the chair daily. She receives eye medication, as well as two other medications. Must be restrained at all times. We must watch her elimination closely. Her family visits her daily.

16–B E. P., Mrs. Age 89. Diagnosis: Coronary. Admitted August 12, 1960. Welfare pay $195.

Patient needs assistance in bathing, walking, dressing, combing her hair. Up as desired. Oxygen if necessary for shortness of breath associated with chest pain. She is on a special diet. Has many medications. Complains of chest pain and arthritic pain occasionally. Mentally alert normally, but occasionally will forget. Doesn't want to do anything for herself. She says she has worked hard all of her life. Visitors once in a great while.

17–A Y. I., Mrs. Age 76. Diagnosis: Post C.V.A. Post hip nailing. Admitted September 21, 1964. Welfare pay $195.

The patient is Japanese. She does not speak English and is very hard to communicate with. Patient requires complete care. Is up in the wheelchair daily. She has no use of her right arm. Her medications are for pain, bowels, a protein medication. Must have very close watch of her elimination. She is given exercises for her afflicted side, that is arm and leg. Visitors once in a while.

17–B E. K., Mrs. Age 85. Diagnosis: Diabetic, Ca of the vagina. Admitted November 14, 1964. Patient pay $250.

Admitted from Colorado General Hospital following vaginal bleeding and hemorrhage. Patient requires help with bathing, dressing. Up in the wheelchair daily. She is on a special diet. Her urine must be tested daily for sugar and acetone content. She must have supervision of her diet. She has continuous catheter drainage that must be irrigated daily and changed every 2 weeks. Receives insulin, cardiac medication, diuretics, kidney medication, and laxatives. Must be restrained and is very confused. Her family visits her frequently.

18–A W. L., Mr. Age 82. Diagnosis: Old age and loss of hearing. Admitted April 11, 1962. Patient pay $225.

The patient requires help with his bathing and dressing. Up and about as he desires. Has urinary problems and on occasion will have blood in his urine. Receives medications such as vitamins, stomach and pain medication. He does have some arthritis and complains of pain in his legs. He too must have his elimination watched closely.

18–B G. M., Mr. Age 72. Diagnosis: C.V.A., post fractured hip and pinning. Admitted February 22, 1963. Patient pay $240.

Patient requires complete care; helped with bathing, dressing, and eating. Mr. M. has a loss of speech, and loss of use of his right extremities. He must be restrained when up in the wheelchair as he will try to do for himself and falls. He is abusive to personnel and requires much supervision. Is walked with help if the patient will do it. A very determined man. The language that he is able to speak leaves something to be desired. He is nauseated and vomits infrequently. He complains of pain in his legs and in his arms and on occasion in his abdomen but cannot be pinpointed.

19–A H. C., Mrs. Age 96. Diagnosis: Post hip pinning and arthritis. Admitted June 2, 1964. Welfare pay $225.

The patient requires very little help. She is up and about as desired. She does require kidney, cardiac, as well as eye medications. She has arthritic pain in her arms and legs and on occasion an Ace bandage must be applied to the leg. She receives diuretics occasionally. She does receive medication for pain and for discomfort in her stomach. Her blood pressure must be taken every other day. She needs much encouragement. Her family visits her frequently.

19–B G. M., Mrs. Age 84. Diagnosis: Post stroke, post broken hip and pinning, post adynamic ileus and cecotomy. Readmitted December 1, 1964. Welfare pay $225.

The patient requires help with bathing, dressing, eating, and help getting into her wheelchair. She is unable to walk because of her hip. Has many medications. Must be watched carefully for bowel and stomach problems, because of the cecotomy. She will complain of pain in her abdomen and complains of her jaw aching, also occasionally dizziness. She is very depressed much of the time. Her only son died about 2 weeks ago, but she has friends who visit her frequently.

J. W., Mr. Age 54. Diagnosis: Cancer of the liver. Admitted January 19, 1965. Retired pay $225.

This is a very critically ill patient. Requires hypos every 2 to 4 hours for relief of pain. He is turned frequently, given fluids by mouth, and has a Foley catheter. Requires much care. He must be turned frequently and given professional attention. (Expired February 1, 1965.)

B. C., Mrs. Age 79. Diagnosis: Anemia. Admitted December 24, 1964. Welfare pay $195.

The patient requires complete nursing care. Is up in the wheelchair daily. She has an indwelling catheter, that is irrigated daily, and a new one inserted every 2 weeks. She is on a special diet. She requires kidney medication. She must have transfusions every 4 to 6 weeks.

All of the extended care department patients are some kind of medication that requires at least an LPN to administer. The extended care department employees are educated to observe closely for symptoms and untoward reactions, as they would be on hospital type patients. They are conscious of the problems of the aged and the need for rehabilitation.

The financial summary of the Brighton Park Manor Nursing Home (Extended Care Departments of Brighton Community Hospital) for 1964 is as follows: Capacity 30 beds, census 24.

Income	$64,200
Direct operating expense	62,200
Direct gain	2,000
Depreciation	3,300
Operating loss	1,300
Interest	5,000
Total loss	6,300

In addition there was $5,000 paid on mortgage principal (fifth year of 15-year mortgage).

Mr. SAGE. It is probably a typical group of patients. Some comparisons I made to indicate they are needing more medical attention. Of course, in the hospital setting, at the present time we are in the process of running electrocardiograms, X-rays, and laboratory tests on the whole group to see what some of the medical problems are.

A great amount of discussion has been made on this coordination of services, and I will not stress that. We do feel there is a need for coordination of all these various services and facilities for the utmost efficiency and economy.

Senator Moss. Thank you, Mr. Sage. We appreciate your comments and appreciate your providing this summary of the patients that you have in your Brighton Community Hospital. We are glad to have this testimony from the hospital side to understand the pressures on your institutions, as Mr. MacLeish said, pressure to get them in and pressure to get them out. I think our emphasis should continue to be to move the patient as rapidly as possible out of the hospital into a lesser care facility, and into an independent situation, if possible.

Frank, do you have any questions to ask?

Mr. FRANTZ. Mr. Davis, representing the Nursing Home Association, spoke on the subject of accreditation and advocated an accreditation program, but at one point he described the program of the American Hospital Association, the Association of Homes for the Aged, American Dental Association, American Nurses Association, and others, as a listing program. It has been our impression that it is something more than that. I wondered if you would like to comment on that?

Mr. MACLEISH. Mr. Frantz, I have not had opportunity to see the actual survey forms. As you are aware, for a number of years, the American Hospital Association has had a listing program for long-term care institutions other than hospitals. Beginning the first of this year the AHA, together with the other three organizations you named, moved into a more sophisticated, more detailed study and survey type of approval program which will get into the things Mr. Davis mentioned, as the joint commission does for hospitals, to evaluate the quality of service being rendered therein. To date I think they have six teams of surveyors working across the country. They have received over 500 applications for this approval survey.

Mr. FRANTZ. This, as I understand it, supersedes the old listing program, does it not?

Mr. MACLEISH. Yes, sir.

Senator Moss. Thank you, Mr. MacLeish and Mr. Sage, we do appreciate your testimony.

We have gone far over the noon hour, the reason being that we had other commitments to keep this afternoon. I appreciate the witnesses staying on through this rather extended time and all of you who stayed to listen. This indicates great interest.

I have had one or two additional requests from people who were not scheduled here to be heard. I am not able to do that as far as oral presentation is concerned, but I will be most happy to accept a written statement from anyone who would like to put in this record his comment on this subject matter that we have been discussing today. I would like it to be factual and relevant to this subject we have before

us, but we would be most happy to have it and it will be printed as part of the record. It will be included there for the committee to study and for anyone else who reads the record. It needn't be submitted today. It can be mailed to me at the U.S. Senate any time within the next 2 weeks. If it is mailed in, it will then be printed and be a part of this record. We are anxious to hear all relevant comments on all sides of the subject. This is a study as much as anything else. We have no preconceived notions. Oh, we have a few, of course, but I mean we are trying to gather all the information we can, maybe to change some of these preconceived notions if the evidence is the other way; and, of course, I do not sit alone on this subcommittee or the full committee. I am simply one of a larger number of Senators whose views may vary considerably from mine, and what we need before us is the record.

We have had a very fine hearing, I think, this morning. I don't know of any time when a comparable record has been made in this limitation of hours. We have added Denver to a list of several areas that we have visited already and we intend to visit other areas of these United States, getting the information that we can from those who deal with the problem directly, day by day. So I again express my thanks.

This afternoon we had planned to visit one or two nursing homes in the Denver area, or more, if we could. The time is going to be very limited and I don't know how much we can do; but for those who had planned to go on those visits, and I have not been informed who they are, we will be leaving from the Hilton Hotel at 3 o'clock. Any of you who had planned to go and have been invited on this should be there at that time. We will now be adjourned.

(Whereupon, at 1:35 p.m., the hearing was adjourned.)

(The following were submitted for the record:)

GREELEY, COLO.,
February 21, 1965.

SIRS: After much deliberation and deep concern for conditions existing in private nursing homes I feel I must speak out and make what I have observed known.

Due to circumstances beyond my control, it is necessary to have my mother in a local nursing home. Visiting her every other day for a period of 14 months I observe things the casual visitor does not note. The comments I am about to make are directed to private nursing homes. Those with county or church affiliations are vastly better managed nursing homes.

Just what is a first-class nursing home? Are they places designed to rehabilitate and/or to help the aged to retain active interest in themselves and their surroundings or are they places where there is nothing left but to resign oneself and vegetate?

Many of the elderly are not yet ready to sit and stare at four walls or sit and nap much of the time. A sweet and very articulate little old lady made this remark: "When you know there is nothing you can do about the situation you are in you must resign yourself to accepting the conditions that exist or lose your mind." How right she is.

In the home in which my mother is staying there is no person to give occupational therapy or to direct simple recreational activities. Three walls of the lounge are lined with comfortable chairs and a TV in one corner which must be viewed from a distance too great for most to be able to see the screen with clarity.

There is no person to give even the most rudimentary physical therapy. At the time mother was admitted, members of the family provided simple manipulative toys recommended by a hospital therapist. We went to the home and personally helped her go through the exercises. Some months back, when the manager feared an investigation because he had no therapist, he hired a

woman who is not a registered therapist but who has had illness in her family which necessitated learning to give simple therapy. Mother showed much response and was regaining the use of an arm and leg paralyzed from a stroke. She has a great deal of fight and we were all so pleased that she was winning her battle. What did the manager do? At what seemed a crucial point in Mom's recovery he told the woman he no longer needed a therapist. Unless I walk my mother she does not get walked. At the present time there is much leg swelling and she must wear elastic bandages. Our doctor says this is the direct result of not being walked. Another person in town, who has no means of transportation, hires a taxi to take her well beyond the city limits each day so that she may walk her father and shave him. Without her love and devotion the old gentleman would simply vegetate. Just what are we, or the State, paying for in the way of care?

There is a staff shortage but the place is very poorly managed. How can a manager know the needs of his institution when he keeps himself closeted in his office, with his graphs and copies of the Wall Street Journal, day in and day out? As I see it, he deliberately keeps the place understaffed. It is cheaper that way. He constantly laments that he cannot make it on the amount he receives from the patients.

I have few complaints to make about the nurses aids. They work long hours and are underpaid. These women must have much compassion for the elderly infirm or they could not stand it. They have time only for routine things. Their hands are tied by the facilities available and the management.

It is true that stealing is a common practice. I assume the temptation is great. However, they know the management has one sign, a release, from responsibility in case of fire, theft, or accidents. This, I feel, contributes to a laxity on the part of both management and the help. Incidentally, there is proof of padding of bills for medication in a Denver nursing home. We have no way of knowing how much such bills should be. Some doctors feel that prescriptions are renewed too often. It is understandable that there is a feeling of distrust of both personnel and management of nursing homes in general.

Food is often so very poor. Being a graduate home economist I can verify that the particular home of which I speak serves food poor beyond belief—yet occasionally serves very good meals. A Sunday evening meal served to my mother 2 weeks ago consisted of a small serving of stale peach slices, a portion of canned tomatoes, mostly juice, a half a grapefruit cut in such a way that the segments were hard to separate, a back from a fried chicken which was left from a previous meal and a small handful of potato chips. Many persons have suffered strokes and it is most difficult to eat such foods with one hand. The combination of foods was nauseating.

I quarrel with the management over the food and the manner in which it is served as my mother is a diabetic. The manager asked if I would prepare menus for him as he admitted having trouble with the diabetics. I complied and prepared menus for a period of 2 weeks. I knew in my heart they would never be used. Many of the cooks are women from the neighborhood who know nothing of therapeutic diets. Often the manager's wife prepares the menus. They are designed to be as cheap as possible regardless of the patient's needs.

I have no quarrel with the Kerr-Mills law. It provides for broad benefits. Somewhere along the line there is not enough enforcement of standards, both physical and mental. All too many homes are being operated to fatten the pocketbooks of the managers to the detriment of the elderly. I dislike too much Government control but there is a need for pressure being brought to bear on these homes. Inspections need to be made without any previous warning of any kind. Otherwise, for a brief time, conditions are improved just as they are on Mondays when the doctors are due to call.

The public needs to be educated as to what services and care one should be getting from homes of various classifications. Those of us who have loved ones in these homes need this information. Perhaps we could put a little pressure on these places ourselves and help to see that standards are upheld.

Sincerely,

Miss HARRIET E. ERDBRUEGGER.

GOLDEN AGE MANORS,
February 26, 1965.

HON. FRANK E. MOSS,
U.S. Senator, Subcommittee on Long-Term Care of the Special Committee on Aging, U.S. Senate Building, Washington, D.C.

MY DEAR SENATOR: I want to thank you for the opportunity you afford me to send you a written statement since you did not have time to hear me on Tuesday. It will be a distinct pleasure to submit the attached factual information and to voice my opinions.

I listened with a great deal of interest to the scholarly and statistical reports submitted and concluded one can gore a lot of oxen when none of your own hard work and money is at stake. With the exception of Mr. Virgil Davis and the testimony of the doctors, there was little disagreement with anything you fostered in your own statement. All felt with rare exceptions that home nursing care might be a panacea for most nursing problems and cost less; that nursing homes needed more regulation, as they were not doing as good a job as was expected of them, and only Dr. Vest sensibly suggested, "Maybe nursing homes are not getting enough money?"

To boil my own observations down, based on years of experience, there is very little wrong with nursing home care and operations that economics won't cure. Why hospital procedures should be expected of them on the starvation diet they are held to somehow doesn't make very much sense to me. Just why Blue Cross-Blue Shield should have found it possible over the years to OK an average 9-percent increase in hospital costs and, at the same time, steadfastly refuse to pick up nursing home tabs for convalescents at one-third the cost raises the question in my mind whether it wouldn't be wiser to take pricing out of the hands of Blue Cross and welfare because a definite conflict of interest exists and to put it in the hands of a public body having powers similar to those of the public utility commissions throughout the land whose obligations by law would be to protect the public interest and at the same time assure the governed that the service they are required to give is compensatory.

With an associate, I own and operate eight nursing homes in the Denver and Houston, Tex., areas. What happens in the nursing home field is, therefore, a matter of great concern to me. My family and I have a substantial amount of money invested in these enterprises which we entered into on our own in good faith, without any Government loans or assistance. It is needless for me to say that anything that would would be done unwisely and adversely affect the industry could prove to be calamitous to us and others throughout the land.

I very definitely am not in accord with many philosophies that were expounded by the various persons who appeared at your hearing. I am sure they are all high-principled persons and that they have no intent to do anyone any harm. However, I did observe one thing, and that is of all that appeared, only two Mr. Davis and Dr. Vest, ever visited any of our five homes. Had they done so, they could have included us out of their criticisms as four of our homes have been accredited and are considered to be among the better run in the Denver area.

Since we own 10 percent of the nursing home beds in the Denver area, I presume it behooves me to indicate my qualifications, if any to speak. We are not "Johnnies-Come-Lately" in this field. Mr. Glen S. Douthit, my associate, is a trained nurse and has been continuously operating and owning nursing homes in the Denver area for the past 15 years and is married to a working registered nursing home nurse. I joined Mr. Douthit 9 years ago, and between us we built the first new built-for-the-purpose nursing home in Denver (77 beds), the first one in Colorado Springs (72 beds), and the first three new homes in Houston, Tex. (451 beds), all with private funds.

With Maryland associates, I built the first two new nursing homes in Baltimore, Md. (269 beds), and had much to do with the 120-bedder built last year in Towson, a suburb of Baltimore. All are first-class homes and are providing high-quality nursing care and observing the highest standards. I sold out my Baltimore interests prior to moving to Denver 3 years ago.

One of the faults I find with nursing home criticism is that it comes from persons who have had no experience in operating them. This is not good, because there's a big discrepancy between theory and practice. As an example: Dr. Cleere, whom I have never met personally, stated that home nursing care would cost less and fill a need. I have no quarrel with this statement except that from my own personal observation where home nursing care is an institution it left much to be desired, perhaps less in dollars but not necessarily in human

misery and tragedy as a very large percentage of people in nursing homes are there because they can't take care of themselves. They're either practically paralyzed, suffering from a heart debility, or mildly senile.

Several years ago the clerk (acting mayor) of Sydney, Australia, arranged for me to visit some of the homes to observe their meals-on-wheels program in action. I visited several homes and was amazed at what I saw. I heartily approve of their meals-on-wheels program. But I couldn't say much for the total of the home nursing care these people were receiving.

For example: At one home we visited, it was piled high with filth and litter. The elderly couple lived on the second flood of the home so we proceeded to bring the meals upstairs. On the upper landing we found the unkempt husband lying on the floor, his wife in a filthy bed talking incoherently. I helped the nurse pick the man up and set him down in a chair. I was told because of his diabetic condition he blacked out quite frequently and was not drunk.

I am sure home nursing care was doing very little for this couple and that they would have been better off in the poorest of nursing homes where they would at least be living in relatively clean surroundings and have the benefits of on-the-spot-when-needed nursing care around the clock. Very frequently our on-the-spot nursing care has pulled many a person through that would have expired under a home nursing care program, because of the lack of immediate attention.

This type of care could cost less and would perhaps work with those requiring only basic care, but would hardly be satisfactory for the bedridden or those having very poor health.

There was considerable testimony that there is a lack of coordination between hospitals and nursing homes. With one-third of the hospitals in Colorado having sections where they provide long-term care, only two-thirds of them could go into programs with outside nursing homes. This number would be whittled down by the boards of directors who looked with covetous eyes on the Hill-Burton funds that were available to revamp the older sections of their hospitals, convert and operate their own nursing homes in conjunction with their hospitals.

In the Metropolitan Denver area, there are approximately 15 hospitals and 65 nursing homes. Five hospitals operate nursing homes of their own. Would the 10 remaining hospitals affiliate with the 60 nursing homes? Most likely no. If they did with 10, it would leave the other 50 in a sad plight—obviously H.R. 1 ought to be revised to avoid this situation.

As a general proposition, I fear hospital affiliation; principally from the viewpoint that there would be a constant attempt to fasten hospital rules and regulations and practices on the nursing homes as to the extent that their costs would rise and they would no longer be nursing homes, per se. The great value of nursing homes in the overall health picture is that they should continue to be able to provide satisfactory care at costs for one-half to one-third of hospital costs. Costs to a nursing home operator, since the majority are private enterprises, is far more important than to hospitals as nursing homes pay taxes, receive little if any free labor, and are not able to go into fundraising campaigns.

We regret the reluctance on the part of some nursing home operators in Colorado to submit costs. One of our homes was 1 of the 20 that supplied figures to the welfare department for study. We have no objection whatsoever to conforming in principle with their new requirements. However, we do object to some of their approaches. For example: Our Aurora home has 142 beds. By their formula, they will not allow as a cost more than $12,000 in salaries for administration, and will allow nothing for the owner regardless of how much time he finds it necessary to put in, in addition to the time put in by a paid administrator.

In my opinion, no job should have a fixed ceiling. Men should be paid in conformity with their worth, and the sky should be the limit. No business can expect to be profitably operated unless the administration is suitably rewarded for their services. This is a principle of American business that has proven its worth in every industry that I know of. Why should nursing homes be an exception to this rule? I sought an opinion on the welfare costing program from our auditors. I respectfully submit their reply and opinion.

Letter from Glenn R. Combellick, CPA, of Combellick, Whittemore & Co., follows:

"You and I have discussed briefly the various problems confronting the nursing home business as a whole with regard to welfare patients and also those which might qualify under any Federal medicare bill which might be approved by Congress in the near future.

"Many inadequacies and inconsistencies are appearing on the nursing home horizon, especially in determination of benefit payments with respect to the cost-plus approach. I would like to list these points for your review.

"1. There are many classes of nursing homes, some very costly and some very cheaply constructed. Some were built many years ago under an entirely different cost climate than at present. Of course, the newer and costlier homes offer better care as a result of more adequate facilities but at a greatly increased cost. It follows, then, that any benefit will not be proper unless it is graded into nursing home classes, not as only to service but classes of facilities.

"2. Someone has mentioned that 4.5-percent of the total patient cost would be adequate profit to be included in the welfare benefit payment. In my opinion, investors would not be interested in operating nursing homes if this is all that could be derived from their operation. Especially since many actual costs are eliminated from the base cost computation. At this rate, a 100-bed nursing home which would cost $400,000 to $1 million as per some FHA approvals to equip and build could net $1,012.50 per month or $12,150 per year if it were completely full of welfare patients paying $225 per month each. Does net income of approximately 3 percent of the investiment seem worth the trouble?

"3. The method which the Colorado Department of Welfare is using to determine costs is somewhat regressive. The reporting year for homes will end between June 30, 1965, and June 30, 1966. Administrators of all the newer facilities are well aware that the present welfare benefit for technical care patients will not cover present patient costs. These administrators will be doing all they can to reduce current costs to be able to keep from going broke before June 30, 1966, arrives. Such cost reductions will be reported to welfare as required and thereby reduce the ultimate benefit amount to be determined.

"4. We are retained as accountants for a dozen nursing homes, all of which have been constructed within the last 7 years. In most cases, the costs of operations are very close on a patient-day basis. However, not one of those homes with a predominant welfare census is doing any more than breaking even if the administrator does not charge the family an amount in addition to welfare allowance.

"5. Why is it so difficult for the welfare agencies to realize that you are performing a public service, alleviating an ever-increasing problem, and that the income derived from this service should not be much less than serving those who are not State supported.

"Well, Bob, I guess that is all that's on my chest at present. Maybe you can impact some of these ideas to the powers that be."

Two years ago I prognosticated there would be a serious surplus of nursing home beds in the Denver area. Mr. Samak confirmed it as a fact of life (perhaps death to underfinanced operators). Out of 4,210 beds, 960 or 23 percent were empty at the turn of the year. No mere bagatelle this, and of those filled the fact that 74 percent of the beds are occupied by welfare recipients makes it quite apparent that the nursing home situation here is in a very chaotic state, and unless the situation is corrected very soon it will have a serious and adverse effect on the quality of care rendered to welfare recipients and private paying alike. On this point, I disagree with Mr. Davis's opinion. Self-preservation is the first law of nature and if an operator can save his own hid by cutting care, prolonged starvation could force him to do it.

Already several operators are having financial problems. One new home operator with 113 out of 120 occupied principally by welfare patients was unable to meet his payroll on the 1st of January. Further, they do not put pillow slips on their pillows. The welfare department stepped in and ordered them, I am told, to segregate their funds and make no payments to anyone until wages had been paid. It's quite obvious to me that this operator will be tempted to cut nursing care somewhere along the line.

Some operators, I am told, now clean up their bedrooms but once a week in order to cut down their costs. Another was reliably reported to have had no toliet paper in its public rooms for at least several days. Since from 50 to 60 percent of true nursing home costs consists of wages, it is practically the only place where an operator can cut his costs in order to save his hide and stay alive and this, of necessity, must cut the quality of care, not to mention possibilities of saving money in the use of poor quality foods.

We have 4 new nursing homes (593 beds) that have been completed and opened within the past 12 months. We have been losing in excess of $10,000 per month due to low census or empty beds. This is not hay in anybody's language for a small business operator.

I was glad to note that you indicated a keen interest in the overbuilding problem since you were interested to know what it was caused by. Of the 960 empty beds reported, 100 were ours. A substantial portion of the other 860 came about because everybody wanted to get into the act.

Frustrated apartment builders decided that nursing homes were a new and promising field, so they build nursing homes. Some nonprofit organizations felt that needs were not being met, so they built nursing homes. (Nine years ago when we started building new nursing homes, and there was a real shortage of beds, it seems that the nonprofits were unaware of the need for decent nursing home facilities because none saw fit to get into the act.) Plenty of FHA money, Hill-Burton money, and easy mortgage money all played an important part in creating this surplus. I also think that the expected need for nursing home beds did not materialize as indicated by Government prognosticators. Competition is the life of trade, but operating nursing homes is not trade. It's a service to the public that must be performed exactingly or human lives are involved. Under these circumstances predatory competition will prove to be the death of trade and that can hardly be in the public welfare or the best interests of public health. The combined effect of empty beds and low welfare rates cannot help but be detrimental to the quality of nursing care and inimical to the best interests of the public. The quality of care should never be impaired by lack of funds.

There seemed to be great concern on the part of all who made statements that nursing homes' standards can be improved. No erudite operator would disagree with this. All he asks is that he be compensated properly so that he can provide the demanded or required higher standards.

Presently, Colorado welfare allows group IV homes up to $195 per month or $6.50 per diem for patients requiring technical care. The cost of providing just nursing service according to their requirements is $3.90 per patient. The relatively fixed cost of rent, taxes, furniture, and fixtures, administration, building maintenance, and heat, light, and water is at least in our case approximately $3 per bed making a total cost of $6.90, per patient, excluding the variables such as the cost of food and its preparation, the cost of an activity director, occupational and recreational therapist, and the many other costs necessary to maintain and operate a first-class institution for the benefit of the patients.

I verily suspect that welfare took advantage of the surplus bed situation in Denver and drove too hard a bargain with the committee with whom they negotiated who had their backs up against the wall. I feel that welfare by an attractive rate of payment for nursing care could make it inducing that nursing home operators would fall all over themselves to provide more and better care and service at all times in the interest of the patients. Failure to recognize this must, of necessity, be destructive to the upholding of standards required and the quality of care provided. I reiterate, there is very little wrong with nursing home operations and the quality of care that economics won't cure. Unlike voluntary or nonprofit organizations, private enterprise nursing home operators cannot employ fund raisers, put on the tear bags, send people out with tin cups to collect alms for them, nor can we claim or get tax exemptions. Federal food, or equipment handouts. They must meet all obligations and the costs of providing adequate care from income, and if that income is not sufficient and forthcoming, it would be unreasonable not to expect something to suffer somewhere.

Mrs. Lewis of the Visiting Nurses' Association said "qualified personnel would not accept jobs with nursing homes because they did not receive sick leave." This, again, is a matter of economics. Nursing home operators cannot give out any more than they get in. It would appear to me that the employment of more qualified personnel would make a nursing home operator's life much easier and the only thing that stops him from employing those with the highest qualifications is his ability to pay what they deserve to get. Unfortunately nursing home operators' costs don't loom very large with most agencies who made derogatory statements about nursing home operators.

Re rehabilitation programs in nursing homes: Aside from the economies involved in administering a rehabilitation program, we submit that too many nursing home residents are too far gone when they enter nursing homes to be able physically or mentally to take part in programs arranged for their benefit. Attached hereto are some statistics relating to the first 67 residents to enter our newest home in Denver. You will observe that only a very few are willing or able to take part in the various programs that are set up for them. I honestly feel that there should be a suitable extraordinary reward provided to nursing home operators who are able to interest their residents in therapy, and are able

to rehabilitate them to the point that hey can go home, instead of the present sysem which is self-defeating. I see no reason why we shouldn't have incentives, financial or otherwise, to encourage us to get better results. After 40 years of communism, they even see this light in the U.S.S.R.

Every time we cure someone and send him home, it makes for another empty bed. Last year, one of our homes had a 169-percent turnover, including expirations. Excessive turnover is an ever-increasing and a costly item, particularly when it's caused by a surplus of beds. Between Houston and Denver, we have spent approximately $35.000 to bring our facilities and services to the attention of those that would require them. And we still have 293 empty out of 925 beds. It is anticipated that by the 1st of July, there will be approximately 2,000 empty beds in the Houston area and perhaps more because they have not yet stopped building there.

In the Houston area, legitimate private enterprise nursing home operators have pseudo nonprofits to contend with. One nursing home there completed a year ago has not yet opened. The owner confided that he can lose less money keeping it closed than trying to open and run it. It took the owner of one speculatively built nursing home 9 months to find a tenant to open it up. Another has been tottering for 6 months. Still another nonprofit foundation nursing home-hospital owner took almost a year to decide to open. After 90 days, with a total bed capacity of 200, they had 27 patients last week.

As to accreditation: Four of our five homes in Denver have been accredited by the National Council for Accreditation of Nursing Homes. Our three in Houston were inspected last week by the American Hospital Association for accreditation and we feel reasonably sure that they will be fully accredited. We wholeheartedly approve of accreditation when done by disinterested third parties. Of a total of nine homes so far accredited in the Denver area, four are ours. I point this out merely to show that all nursing home operators are not hostile and that some are making every effort to do a good job and provide the very finest nursing care possible.

I must concur with the remark made by Mr. McLeish, executive director of the Colorado Hospital Association, when he said: "Unfortunately, quality and need are equated with the dollar sign."

Private patients, knowing that welfare patients receive the highest quality of service for $195 per month, are less willing than ever to pay more than that for their services. Therefore, it is becoming increasingly difficult to get enough profit out of the private patient to enable us to carry welfare patients at a loss.

I know of no operators of large and new nursing home facilities who do not keep proper medical records on which all pertinent matter is put down. For years we have endeavored to maintain ours so they will compare favorably with those maintained by hospitals. We are fully in accord that adequate and proper medical records should be kept and the salient portions be sent along to the hospital with the patient for their guidance should it be necessary to hospitalize him.

Some speaker raised the question as to what would a proper return be for a nursing home to receive on their investment. The responsibilities of a nursing home operator are great, and he should be adequately compensated for the moral and financial risks he assumes. The total volume that a nursing home can generate in the course of a year is not too great. An average 100-bed nursing home will gross somewhere between $250,000 and $300,000 a year. In my opinion, if he can't net from $25,00 to $36,000 per year as a minimum, he ought to find some more remunerative field.

In these fast-moving days, obsolescence has become a very important factor in business longevity. Equipment and styles are changing overnight and unless an operator is able to keep up wtih the times, he will soon find himself unable to fill his beds because the public is no longer moribund.

With heavier taxes and few dollars left to spend, they want the "mostest for the leastest." Nursing home operators must be in a position to build up a surplus so they can improve their plant and install new equipment when necessary. As the setup is today, free enterprises must make enough to be able to pay enough taxes to exempt the nonprofits from taxation which, I believe, is a great injustice to free enterprise.

I would respectfully suggest that if nursing home operators are going to be required to carry welfare patients at rates lower than they will be compelled to get from private patients, they should be "exempt from all taxation" if and when their welfare load exceeds 51 percent of their gross take. I see nothing unfair about this. What's good for the "nonprofit" goose ought also to be good for the gander—the difference is only—money.

I see little difference between the Colorado cattle breeders and feeders objection to supermarket chains controlling the price they receive for beef and that of my philosophy that welfare should not determine the price of nursing home service, when the buyer of a commodity or service decides what he will pay for it and you have no alternative but to accept. It is my understanding that Congress is now investigating the relationship between supermarkets and beef production as it affects the public. Perhaps Congress shall also investigate the relationship between welfare and nursing home operators as it affects nursing care.

It is my understanding that Denver is not the only metropolitan area with a surplus of nursing home beds, that a similar acute situation exists in Chicago and most of the large cities of the United States today, with the possible exception of New York City, where I understand no new building has taken place.

Congress would, in the writer's opinion, do well to seriously look into this situation and take some steps of their own to remedy it, because a flock of nursing home failures and foreclosures throughout the land, and there will be some, could prove very detrimental to good nursing care besides leave many persons who seriously need good nursing care, high and dry.

As a casual observer, I should like to report that it seems that health conditions of the elderly entering nursing homes today seem to be much poorer than they were yesterday. If the Government through HEW wants to do something else worth while, may I respectfully suggest that they appropriate some funds for a research project to determine when it's the proper time for an elderly person to entrust their care to a nursing home. I am sure the health and the lives of many could be prolonged if they entered a nursing home earlier. Too many people are sent into nursing homes when their life expectancy is at a minimum and are at the point of death. This has a serious psychological effect on those who are still holding up. Too many expirations in nursing homes create a very poor image for them as too many people already reject nursing homes because they fear they'll never get out of them alive.

Furthermore, expirations mean more turnover and turnover is anathema. Nursing home operators would much prefer to have their patients live on and on, and enjoy better health. Not unimportant is that fact that it pays off. With all due respect to the administration's attempt through HRI to provide home care in the hope that it will keep the elderly afloat longer in their homes, it is my feeling that the disadvantages outweigh the advantages. More and more elderly persons have expressed their regrets in having refused entering a nursing home when it was first suggested.

In a nursing home they meet up with their contemporaries, and their life is no longer as dismal as a result of it. The patient is relieved of many worries since he is aware that instant nursing care is available should an emergency arise. To many, it provides a new outlook on life, freed from the worries of yesterday. They recognize and know they no longer interfere with the life and actions of their children and that their children can now live their own lives without being tied down to their homes babysitting them. The children are also less worried because, to the contrary notwithstanding, they know their parents are being taken better care of in a nursing home and when death does come the ordeal is less disturbing.

We'd like to go on record and state unequivocally that we have no fear of higher standards, will not resist them when suggested by proper authorities, and are even willing to act in the role of guinea pigs for and in behalf of further improvement of care and services; we will gladly equip our homes with whatever additional equipment thought necessary (short of cobalt, etc.) and add to our payroll every technician and service thought necessary, provided, the bureau, commission, or agency that requires its installation and inclusion also sees to it that we are compensated for these added services at the time they are effectuated rather than some time in the distant future.

General Motors, which has more cash on hand than all the nursing homes put together, to the best of my knowledge, has never been asked to add gadgets and improve their cars without charging more for them on delivery. Why do most public agencies expect it of us? Only in the nursing home field are standards upgraded, staffs expanded, better nursing care required, better buildings and facilities demanded, without thought of their being compensated additionally for it. To add injury to insult, through the device of a ceiling upon family supplementation, the children of welfare patients may not authorize physical therapy treatments, etc., for their parents, even if the doctor prescribes it. As

a result, some patients are unable to get full advantage of the facilities we provide for them, though it will benefit them under risk of having their welfare payment reduced by the amount of the excess supplementation.

Most nursing homes harbor some indigents who require little medication, yet require constant medical supervision; harbor some that are homeless and who no longer have any relatives alive. Periodic home nursing care can hardly take care of these persons adequately and certainly not at lower costs through visiting nurses than full care in nursing homes. I hope improved care through these newer conceptions and extensions will not bring back the good old-fashioned alms houses, nor encourage residence in obsolete firetrap hotels, or in slum area flophouses which abound in all metropolitan areas, including Denver, with their convenient soup kitchen and B-girl populated bars.

I believe there are too many commissions, agencies, and what have you trying to influence the direction which better nursing care should take and none looking into the economics of how the cost of their suggestions can be met. I believe that nursing homes should be under the control of one agency and that be a State nursing home commission, to operate similar to public utility commissions, for and in behalf of the public, with requirement that one of their obligations be that the service required and rendered in conformity with their rules be suitably compensatory and sufficient for the creation of sound surpluses from operations from which to make further improvements in standards as time goes on. Such a nursing home commission should also pass on the area need for additional facilities before they are built, eliminating for all time all possibilities of a recurrence of the situation that exists today. Under such conditions, it would not be necessary for any nursing home operator to enter into an agreement with welfare that puts them under their domination. With 74 percent of nursing home occupants receiving welfare payments, welfare would be assured that their payments to nursing home operators would be fair and just and would enable them to devote their time and energies to determining who is entitled to how much welfare, etc., etc. Congress and State legislatures would be more accurately able to determine the size of appropriations needed and be relieved of the costly problems they now have to cope with determining how much they should appropriate.

For ratemaking purposes, the break-even point for the operation of nursing homes should be around 75 percent. While, in the past it was possible to achieve a 95- to 98- and even a 100-percent census, the possibility of doing so from here on out is nil. Two, three, or four years ago patient turnover was practically nonexistent and accounted for no more than a 5-percent differential in occupancy. Another thing, in the past, ambulatory patients helped carry the load and cost of providing adequate care to the bedridden. With classifications as they are, it is increasingly difficult to take care of both in one nursing home. Out of 40 patients in one of our homes at one time, 10 of them required hand feeding, which in some instances takes as long as one-half hour of the nurse's time three times a day for each patient. This costs us money.

I sincerely trust that the information contained in this letter will prove helpful to you and your committee. It was an effort to place the whole picture before you from the practical businessman's viewpoint.

Again, I wish to thank you for the opportunity afforded me.

Respectfully yours,

ROBERT FREEDMAN.