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

FIRST SESSION

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CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

	Page
Knowles, John, M.D., general director, Massachusetts General Hospital, accompanied by Miss Eleanor Clark, chief of social service	599
Tobias, Saul, manager, Corporate Operations, Inc., Brookline, Mass	619
Levey, Samuel, administrator, nursing homes and related facilities, Department of Public Health, Commonwealth of Massachusetts	637
Connelly, Edward F., Esq., counsel, Massachusetts Federation of Nursing Homes, Boston, Mass	654
Bakst, Henry J., M.D., assistant dean, School of Medicine, Boston University	672
Robinson, Allan, former counsel, Special Commission To Study Convalescent or Nursing Homes (Massachusetts)	698
Lally, William F., director, Department of Welfare, City of Boston, and William H. Bonney, head social work supervisor	708
Gibson, Count D., M.D., chairman, Department of Preventive Medicine, Tufts University	714
Murphy, Campbell G., director, special services, United Community Services, Metropolitan Boston, accompanied by Mrs. Deborah Cohen, associate director, aging project	720

STATEMENTS

Bakst, Henry J., M.D., assistant dean, School of Medicine, Boston University	672
Connelly, Edward F., counsel, Massachusetts Federation of Nursing Homes, Inc	655
Knowles, John H., M.D., general director, Massachusetts General Hospital	604
Levey, Samuel, Ph. D., administrator, nursing homes and related facilities	641
Murphy, Campbell G., director, special programs department, and Mrs. Deborah B. Cohen, associate director, aging project, United Community Services, Metropolitan Boston	723
O'Donnell, Charles C., National and State president, Senior Citizens & Associates of America, Lynn, Mass	736
Quincy-South Shore Chamber of Commerce, Inc., William A. O'Connell, executive vice chairman	734
Robinson, Allan, former counsel, Special Commission To Study Convalescent or Nursing Homes (Massachusetts)	683

ADDITIONAL INFORMATION

Blonder-Freedman Co., certified public accountants, letter from, to Mr. Kosow	729
Bump, Virginia A., letter from, dated August 5, 1965, to Senator Moss	735
"Hospital Responsibility to Nursing Homes," Herald, Boston, Mass., August 3, 1965	606
"Hospitals Shouldn't Operate Their Own Nursing Homes," Herald, Boston, Mass., July 30, 1965	606
Kosow, Joseph, letter from, dated September 7, 1965, to Senator Kennedy	727
Price Waterhouse & Co., letters from, dated September 1, 1965, to Mr. Kosow	728
Saltonstall, Hon. Leverett, U.S. Senator from the State of Massachusetts, letter from, dated August 7, 1965, to Senator Moss	597
Special Commission to Study Convalescent or Nursing Homes, information and correspondence dealing with such a study	730

CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

MONDAY, AUGUST 9, 1965

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

The subcommittee met at 10:10 a.m., pursuant to notice, in the auditorium, New England Life hall, Claredon and Boyleston Streets, Boston, Mass., Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Neuberger, Muskie, and Edward M. Kennedy.

Staff members present: Jay B. Constantine, research director of Special Committee on Aging; Frank C. Frantz, staff director of the Subcommittee on Long-Term Care; and John Guy Miller, minority staff director of the Special Committee on Aging.

Senator MOSS. The subcommittee will come to order.

It is a pleasure to open this public hearing, in Boston, of the Subcommittee on Long-Term Care of the Special Committee on Aging, and particularly a pleasure to me to have with me on the panel several members of the subcommittee who have been working with me and exploring the subject of proper care of our aged and infirm citizens.

When the Special Committee on Aging was first formed in 1961, it embarked upon a series of field hearings which took us to all parts of the country. The purpose of those hearings was to make a broad survey of the problems of older Americans, to assemble the information which was available from the many hundreds of people working with these problems, and to define the subject areas into which the committee could profitably delve in depth.

Many of you here this morning will remember that one of these hearings was held in Boston under the chairmanship of former Senator Ben Smith of Massachusetts who, during his term of office, was one of the most effective and diligent members of this committee.

Following this phase of the committee's work, we organized several permanent subcommittees to examine in more depth and develop recommendations on the problem areas the committee had identified. One of these areas is that of nursing home and other long-term health care services.

I might say at this point that Massachusetts has been good to the Committee on Aging. Senator Smith was succeeded on the committee by your Senator Edward M. Kennedy. Senator Kennedy is chairman of our Subcommittee on Federal, State, and Community Services and he also serves as a very active member of this subcommittee.

The Subcommittee on Long-Term Care is charged with making a thorough study of conditions in nursing homes and similar facilities throughout the country. We need to learn how adequate these facilities are today as well as how adequate they are likely to be for the needs of the future.

We must measure the shortcomings as well as the achievements, and become aware of bad practices and neglect as well as the good work which is being done.

The picture is not all black or white. There are some of each of these conditions—the very good as well as the very bad. But the fact that we can point to good institutions and good nursing care must not be used as an excuse to be complacent or tolerate the existence of improperly operated homes and poor care.

As Federal programs become increasingly involved in the development of new facilities and the purchase of services, the Federal taxpayer has an increasing stake in the encouragement of modern and high quality care and the elimination or correction of inadequacies and substandard conditions.

Modifications and additions to our Federal programs affecting the long-term care field probably are needed to encourage the further development of services geared to modern methods of caring for the long-term patient, and to strengthen the hands of State and local agencies in carrying out their responsibility for assuring the quality of such services.

The witnesses who have participated in our hearings in other cities, and those who will speak today, are among the principal sources of information which will guide our efforts.

I want to point out that this hearing in Boston follows the hearing that was held last week in New York City. Prior to that time, we have held hearings of this subcommittee in Cleveland, Indianapolis, Denver, and Los Angeles and we have programed beyond this point a hearing in Portland, Maine, and undoubtedly there will be others that will be set later in this year as we are trying to make a nationwide survey.

This inquiry is therefore, not limited to Massachusetts or to New England but it is a nationwide inquiry and one in which we hope to develop a record for study and possible action, if action seems to be required by the facts developed.

I am pleased to have all of my colleagues here today. The first member of the subcommittee that I wish to recognize is your own Senator from Massachusetts, Senator Edward M. Kennedy.

Senator Kennedy. [Applause.]

OPENING REMARKS OF HON. EDWARD M. KENNEDY, U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman.

Senator Moss, and my distinguished colleagues on the subcommittee, I am delighted to welcome you to my State and to Boston. I have followed the work of this subcommittee very closely and I am gratified that this hearing has been scheduled today.

All of us who serve on this subcommittee receive letters from time to time telling of conditions, both good and bad, that the writers have experienced in nursing homes. However, since the newspapers reported that this hearing was to take place, I have received literally

hundreds of such letters, a sampling of which I have with me this morning.

Some of these have been quite heartening, telling of the cheerful atmosphere of the home and the kindness of the personnel. Many others have given appalling accounts of experiences of patients and family members in nursing homes in this State.

Several letters reported homes in which patients are routinely tied to their chairs and left for the entire day. In another case, a patient who had fallen was unattended for hours unable to get up from the floor. A cook employed in a nursing home was told by the operator to "give the patients anything because they don't know what they are eating."

I would like to know how such extremes of good and bad can exist in similar institutions in the same State functioning under the same laws and regulations. I am sure that our subcommittee's work will shed some light on this question.

In the meantime, I am writing to each of the people who have reported these situations in their letters to me asking permission to turn their letters over to the State health authorities. Many of the situations described demand attention now and will not wait for this committee to finish its work. I shall ask for an investigation and report from the State health department on all of these charges that have been brought to my attention.

I am sure that further action by this subcommittee will be found to be necessary, and I look forward to participating in making legislative proposals for longrun solutions to these problems all over the country.

Senator Moss. Thank you, Senator Kennedy. We appreciate your words of welcome and your comments on some of the conditions that do, indeed, call out for our investigation.

I have here a telegram that was delivered to me this morning from the senior Senator from Massachusetts, Senator Saltonstall, expressing his appreciation for being invited to join the subcommittee here today. Because of his commitments on the Appropriations Committee of the Senate, Senator Saltonstall was not able to join us. He says in his telegram that he has been interested since his legislative days in Massachusetts and has both sponsored and supported legislation to help our senior citizens.

The recent passage of the Social Security Amendments establishing a national health care for the aged program places heavier demands and responsibilities on our Nation's nursing homes to provide adequate facilities for needy aged persons. Certainly we want them to receive the care they require.

He has asked to be kept informed of developments of the hearing and pledges himself to help in working out a solution to any of these problems.

We are pleased to have this telegram from Senator Saltonstall and it will be made part of the record at this point.

WASHINGTON, D.C., *August 7, 1965.*

Hon. FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care of Senate Special Committee on Aging, Meeting in New England Mutual Life Hall, Boston.

MY DEAR MR. CHAIRMAN: I appreciate your inviting me to join you in the hearings that you are holding today in Boston on the long-term care of our elder citizens. As a member of the Appropriations Committee, I must be here in Washington as you know.

As one who has been interested ever since my legislative days in Massachusetts and have both sponsored and supported constructive legislation to help our Nation's senior citizens, I believe your hearings are most important.

The recent passage of the Social Security Amendments Act of 1965, establishing a national health care for the aged program, places heavier demands and responsibilities on our Nation's nursing homes to provide adequate facilities for needy aged persons. Certainly we want them to receive the care they require.

Massachusetts I know has made significant improvements in upgrading its nursing home standards in recent years, especially in the licensing and enforcement areas. I trust you will find this program is continuing.

Please keep me informed on any developments that your hearings will bring to light on our existing problems in order that we may all work in helping to solve them.

LEVERETT SALTONSTALL,
U.S. Senator.

Senator MOSS. Senator Maurine Neuberger of Oregon, a member of this subcommittee, is with us.

Do you have any remarks to make at this time, Senator Neuberger?

Senator NEUBERGER. I will make my remarks to the witnesses.

Senator MOSS. Thank you.

Senator Ed Muskie, your neighbor, the Senator from Maine.

Senator Muskie.

Senator MUSKIE. I will say this, Mr. Chairman: First of all, I want to compliment the chairman on the concern that has moved him to hold these hearings throughout the country in this subject area.

Secondly, I would like to express my appreciation for the fact that these hearings are scheduled in New England, this one in Boston, and one later this week in the northern half of Massachusetts in Portland, Maine.

Thirdly, I want to share the feeling of the chairman, Senator Kennedy, and Senator Neuberger, that under the new health care or medicare program increasing reliance is going to be placed upon these institutions across the country for taking care of our elder citizens.

We must make sure in every reasonable way that this care will be adequate and proper and help these people in their declining years.

I am again grateful, Mr. Chairman, that you are holding the hearings not only here but across the country.

Senator MOSS. Thank you very much, Senator Muskie.

We have a very distinguished list of witnesses to appear before us today and we will try to proceed and keep the hearing moving on time. As is always the case, we try to do a great deal in a limited period of time but in so doing, we don't wish to overlook any area of inquiry.

We will make every effort to get for our record anything that will be helpful to the committee in studying this problem.

I might point out that the record will be available to have inserted in it statements of citizens who are not listed on the list of witnesses if those statements are pertinent to the inquiry, have something to do with the facts surrounding the operation of nursing homes or the regulation of them, or the licensing or inspection here in Massachusetts.

I announce that in advance so that everyone may feel that he has an opportunity to contribute to the record information that may be helpful to the committee.

Our first witness is a very distinguished doctor, John Knowles, M.D., who is director of the Massachusetts General Hospital.

I believe that Miss Eleanor Clark, chief of the social service of the hospital, will accompany Dr. Knowles. If these two people would

come forward, this will be the witness table over here with a microphone on it and we ask them to come there to make their statements.

We have placed this up on the stage because we knew you were all very interested in what these witnesses have to say. I am very pleased to see that there is a large turnout here of interested citizens. This indicates that you are concerned with the problem that we are examining today and have the interest to come here and sit with us.

Dr. Knowles and Miss Clark, we are very happy to have you. You may proceed.

STATEMENT OF JOHN KNOWLES, M.D., GENERAL DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL, ACCOMPANIED BY MISS ELEANOR CLARK, CHIEF OF SOCIAL SERVICE, MASSACHUSETTS GENERAL HOSPITAL

Dr. Knowles. Thank you.

I am here in my capacity as general director of the Massachusetts General Hospital, a 1,050 bed, voluntary teaching hospital, the third oldest of its kind in this country.

I also speak as a physician who continues to care for the sick and to teach their best care to medical students and house staff and indeed, to visit the patients I send to nursing homes.

At the turn of this century, the statement was made by Alan Gregg that the occasional patient in meeting the occasional doctor stood only a 50–50 chance of benefiting from the encounter. Some today would say that the same thing applies to the patient encountering the nursing home.

Is it because of a change in our cultural values that says that our older patients are no longer our responsibilities but somebody else's? Is it because of the traditional tyranny of the ceiling of welfare reimbursement of $7.71 in this State which rewards the profitmaker and penalizes the person who tries to give the maximal number of services?

Is it because the medical profession and the medical schools and teaching hospitals have traditionally taken what was acute, curative and interesting and left what was chronic and difficult to the communities?

Perhaps it is all of these things, and again, as that great social philosopher Pogo said, "We have met the enemy and they are us"—all of us, to a certain extent.

In the 1930's and 1940's, there were only a handful of nursing homes in this country. Many people have said the proprietary motive has interfered with the giving of best care to these patients, but I daresay if the profit motive had not held sway we would have very few nursing homes in this country today.

Today, there are over 700 nursing homes in the State of Massachusetts, of which the great proportion are centered around the Greater Boston area. The average age of these patients is well over 65 and closer to 80, three-quarters of them qualify for welfare support, largely medical assistance to the aged.

The Massachusetts General Hospital sends some 300 patients per month to these nursing homes, a great number of which are concentrated, as I have said, in the Greater Boston area.

The Massachusetts General Hospital, at the turn of this century, recognizing that the social and economic problems of the diseased and

injured were as important as the disease itself, initiated the first medical social service department in this country and indeed, the world.

By the ensuing 20 or 30 years, no hospital worthy of its name was without such a department. This department was structured to come to grips with the social and economic problems, particularly of the chronically ill and their aftercare.

Over the past several years we have expanded the function of this social service department while other hospitals, trying to contain the inexorably rising costs of medical care have restricted the growth of these departments or closed them: false economy to say the least.

With the passage of the medicare bill, our legislators have obviously made an attempt to intervene at the area between disease and the social and economic problems surrounding the disease.

By fostering aftercare and the payment of benefits for nursing homes and aftercare facilities and home visits, the Federal Government has now attempted to rationalize—and by that word, I mean to make reasonable or understandable—to rationalize the behavior of hospitals and the medical profession, both of whom have traditionally displayed very little interest in chronic care facilities unless they were proprietary owners of these homes themselves.

Our own plans at the Massachusetts General Hospital have been criticized even as recently as last week, on the basis that our interest might increase the cost of the care of these patients. I have submitted as testimony the letter that was written to the Boston Herald and my reply to it the following week.[1]

We have, over the past several years, even before the medicare bill was passed, involved ourselves in four general areas as related to after-caring facilities for the aged. Let me say first of all, we have expanded our social service department.

The first area concerns visits by the ward medical team. The entire medical ward team which consists of medical people, house officers, dietary students, nursing students, nurses, all of us have made a visit each month to one of the nursing homes to which we have sent our patients.

When we go to that home, we very quickly look at the exterior of the home, we look at the recreational facilities, we go in and we try to evaluate how much nursing there is and how much home there is.

The quality of the American home has changed since the Second World War, quite obviously. A home can be defined as a place which has certain creature comforts such as a roof and heating and lighting and plumbing, and equally and perhaps more important it has somebody who continuously cares 24 hours a day about the people in the home, the dogs, the cats, the furniture, the plumbing, everything.

Now the American home has changed and very frequently in our great American middle class, both parents are working and there is not somebody who can care. This plus the cultural change which has said our fathers and mothers are to be the responsibility for somebody else, has thrown the care of our aged sick and infirm into the hands of the nursing homes.

Now we have made these visits to these homes and gone into the house, reviewed the staffing, reviewed medical records, found out

[1] Reprinted beginning at p. 606.

whether the homes are carrying out our medical orders, trying to find out whether any doctor has displayed any interest in the home and whether or not in addition to nursing care there is professional medical care available and how much of a home is there.

Almost inevitably we find, first of all, that very rarely do the children of these oldsters visit them. Second, there is no effort made for these people to tell them who they are, where they are, where they have been; no pictures of family home, no calendar on the wall, no clock to tell them who, where, what time, and so on.

Sometimes the problem has been that in our eagerness to do good we have taken people who lived in the city all their life and transported them to the country. They have been used to the sights, smells, and noises of the city, and when they get to the country they are totally out of it, they become apathetic, fully institutionalized, and have a blank, vacant stare on their face.

We have seen all these things.

Again, we have seen good nursing homes and we have seen poor ones, too. I certainly agree with you, Senator, that we are not here to destructively criticize the bad, but to constructively provide for improvement which is precisely your intention and the intention of the medicare bill.

So we have made this monthly visit, and we visit some 4 to 8 homes a month with our team of 10 to 20 people.

I honestly believe we are one of the few, if not the only, teaching, university hospital in this country that is doing this.

The nursing home proprietors meet us with open arms, they don't look upon us as policemen, they are grateful for our interest and our help.

Secondly, last year, we expanded our traditional activities of the social service department and formed a new transfer office. Interestingly enough, the medicare bill has the word "transfer" in it. It now says that the aged are going to go to nursing homes and qualify for the benefits only if they come to the hospital and the hospital must evaluate them and have a decent and rational arrangement for their aftercare in these nursing homes.

This is something that has been off the main beat of practically every one of the 7,000 hospitals in this country since this country began.

I applaud the attempts to force the medical profession and medical students and the universities into putting this on the mainstream of their activities. We are now evaluating more fully the nursing homes that we send our patients to and Miss Clark will describe this new office more fully.

Our capacity to obtain the best care for the different needs of our patients has always struck me as paradoxical when one day a patient 75 years old is being treated for multiple diseases in a hospital for $50 a day and the next day he is sent to the nursing home where he may not have one-tenth of the care we provide and cannot be provided because of the ceiling in welfare payments to these homes.

Thirdly, a year and a half ago, a proprietary group of nursing home interests came to us and asked us to advise them on the best structure of a nursing home in terms of staffing, dietary facilities, recreational facilities, anything to do with the nursing home.

We invited these people in with open arms believing that the proprietary motive does not necessarily have to interfere with the giving of best care. After all, the medical profession has worked to a certain extent on the proprietary motive and some people think that it must be so to recruit people to the profession.

We have invited these people in and have worked with them. We are assured of their high motivation and minimal profit return to structure the best possible care for our sick patient. Three hundred patients a month discharged to nursing homes gives us considerable leverage to help improve standards. If they don't improve standards, we will not send them and the ones that do, will be rewarded by having these patients.

We were criticized loudly for this and the major gripes last week were that the Massachusetts General Hospital was trying to increase its territory and by its interest was going to increase the cost of caring for the sick.

I say "yes," that is entirely true, because with rising costs you can't feed the sick sawdust or the people who take care of them and expect them to win the race.

Yes, it is going to cost more money and it should; it is a birthright, it is an inalienable birthright now and it costs money to achieve high quality.

Finally, several years ago, Governor Peabody appointed me to the public health council of the State, one of six members appointed for 6-year terms. In this capacity, my major interest has been in the State's new program for licensing nursing homes; in reviewing the three interim reports of the legislative committee of which Senator John E. Powers was the first chairman, which brought about much-needed improvement, provided for annual review of nursing homes, improved the safety measures, and so on.

In my capacity with the public health council, I have worked very closely with Dr. Frechette and Dr. Levey, who is head of the nursing home division of the State's department of public health and helped to implement their plan of accrediting and licensing nursing homes, which I am sure Dr. Levey will discuss. Very briefly, when you say "nursing home," half of the function is nursing and the other half concerns the qualities and character of the home. The evaluation of these two areas is on a point system (500 for nursing service and 500 for the home attributes) which will now give a higher reimbursement to those who get a thousand points, 500 for each, and they will not give the same reimbursement for those who do not have adequate staffing or adequate home facilities, a most important change. The degree of service and facility will be matched by the level of reimbursement.

Now, what finally are the problems as I personally see them today? First of all, the proprietary nature of the nursing home. Eighty percent of our nursing homes in this State, as well as this country, are proprietary in origin. It is a fact of life that we must live and work with them.

Now, some of the people in medical schools and universities today have pointed to an analogy, citing that the fact that at the turn of this century the medical schools were largely proprietary and the proprietors had to be driven out of business before the new era of medical education which started with the Flexner report in 1910 could begin.

I think you are comparing apples and onions if you try to make this comparison, myself, and I think we have demonstrated in nonprofit institutions like ours working with proprietary homes, that the profit motive does not have to be incompatible with the giving of adequate service.

Second, the problem of personnel which the medicare bill is going to highlight. Obviously, we have a tremendous shortage of nursing and technical help as well as doctor help to a certain extent in this country today. Hopefully, if the reimbursement is adequate and we can improve the lot of people who work in hospitals and nursing homes in this country, we are going to recruit more people to work in them.

It was not until 5 or 10 years ago that the hospitals even met the minimum wage. Here in the great State of Massachusetts today, we are fighting with the State department of public welfare to try to get them to pay our costs. Now historically, that has been a great source of concern to me, that for some reason or other in our State, local, and Federal reimbursement levels have always been less than we said it costs us. They figured if they paid us 80-percent money and 20-percent sawdust that we would become more efficient, and better managed—a peculiar form of logic.

We are giving the State of Massachusetts presently a 30-percent discount on what it costs for us to take care of the indigent sick. The same situation has held historically in other parts of the country. If the medicare bill in the wisdom of the Federal Government, tries to give us 80 percent of what it costs us, then you are going to see a downward spiral and you are not going to see reflected the best elements of caring which the political profession, the medical and the nursing homes, want to see, for you will lack adequate numbers of health workers and adequate facilities.

Today, we live under the tyranny of a ceiling of welfare reimbursement of $7.71 for nursing home care which as I said, rewards the poor home and penalizes the good home. I would make a special plea that you have a moving average of welfare reimbursement with a spread of plus or minus at least 30 percent on each side of this moving average so that you can reward the good homes and penalize the bad homes on point systems.

I think this will improve standards remarkably.

I would plead with you in your committee to try to help us get the medical profession and the islands of excellence, the teaching hospitals, and the medical schools of this country to weave the social and economic problems of medicine into the fabric of medical education and the caring professions.

Time and time again, we are beset with the medical profession who by the time they become loyal members of the AMA, have closed their intellectual shutters and they have no knowledge of the social and economic problems surrounding medical care as they have never had the chance to learn anything about them.

We meet constantly with our staff at the Massachusetts General Hospital day in and day out and discuss the problem. One said, "Will you stop telling us so much about it because once we understand it, we will have to do something about it." It is true. If you don't understand it, you can put your head in the sand and ignore the problem.

Finally, the standards of medical schools, teaching hospitals, and the excellent community hospitals must be extended to these facilities. If these people don't have our interest, then they are no better and no worse and it is our responsibility as much as it is that of our political representatives.

I appreciate the opportunity to appear before you and I applaud your activities. I can assure you that speaking for one hospital, one teaching hospital, and the major teaching hospital of the Harvard Medical School, the third oldest in this country, we have already taken steps to set the best possible standards for our chronically ill citizens.

Thank you very much. [Applause.]

Senator MOSS. Thank you, Dr. Knowles, for one of the most articulate and perceptive statements that we have had before this subcommittee.

You have, indeed, touched on many areas that we may want to ask you a few questions about. I think as a matter of procedure that we will hear Miss Clark and then perhaps have questions that may alternate between you, if that is all right.

Dr. KNOWLES. Thank you.

Senator MOSS. Your written statement will be made part of the record.

(Statement referred to follows:)

PREPARED STATEMENT OF JOHN H. KNOWLES, M.D., GENERAL DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL

I am here in my capacity as general director of the Massachusetts General Hospital, a 1,050-bed, voluntary teaching hospital, the third oldest of its kind in this country. I also speak as a physician who continues to care for the sick and to teach their best care to medical students and house staff. I am grateful for the opportunity to appear before you.

The MGH initiated medical social service in this country at the turn of the century, recognizing that there were serious social and economic problems surrounding the care of the sick—their families and their communities. By 1930, no hospital worthy of its name was without such a department and the concepts generated in this department spread throughout the world. Subsequently, psychiatric social service was developed to deal with the enormous problems surrounding those deprived of reason.

Over the last several decades as the costs of medical care have continued their inexorable rise, many hospitals have closed these departments and the continuing aftercare of our patients has been neglected. Indeed many of our hospital-medical centers have isolated themselves from the expanding socioeconomic problems of chronic and continuing care, paradoxically, at a time when these problems loom large in our efforts to care for the sick and injured of our communities. Meanwhile the MGH has increased the support and activities of its medical social service department in ways which I will describe.

The Federal Government, the public, and our political representatives have grown restless and impatient with our irrational behavior as regards chronic and continuing aftercare and have attempted to rationalize and improve our services with the new medicare bill, which encourages continuing care, home care and nursing home care.

The nursing home situation in this country is very definitely an area where some of the worst social and worst medical problems meet. True to its tradition of attacking these problems through the early establishment of medical social service, the MGH is anxious to assist in any way it can, in the firm belief that the teaching hospital must extend its influence (and influence is the effluence of affluence), its resources, its standards and its help to the community and its other caring institutions. It is too easy to attack the present state of nursing homes, but we are as much to blame as they. As Pogo said, "We have met the enemy, and they are us"—or as Lincoln said, "He has a right to criticize who has the heart to help."

The medicare law is an attempt to solve the problems of our aged sick in nursing homes by the raising of standards and the provision of money.

There are today roughly 730 nursing homes in the Commonwealth of Massachusetts with a total of 26,000 beds. Roughly 80 percent of the homes are under proprietary ownership and therefore operated for a profit. Greater than two-thirds of the patients are over the age of 65 and roughly three-quarters of them are medically indigent and the cost of their care assumed by the State department of welfare. Of the 730 nursing homes, 99 are in the central Boston area and more than 400 are in the Greater Boston area. The ceiling today for reimbursement to nursing homes for the care of the aged and chronically sick is $7.71 a day. The source of payment for the nursing home care of these patients is overwhelmingly from public assistance programs, predominantly medical assistance to the aged. The median age of the patients surveyed in the Boston College study of nursing homes was 80 years. A study and careful analysis of the types of people employed showed 50 percent of all nursing personnel were unlicensed nurses aids, 26 percent were practical nurses, licensed by waiver, 12 percent were registered nurses, 10 percent were graduate licensed practical nurses, and less than 2 percent were unlicensed graduate nurses.

The problems can be broadly stated as three in nature:

1. Proprietary nature of the home. There have been many who said the profit motive is incompatible with the best service to our chronically ill, but all of us must realize that this is a fact of local and national life today and if the profit motive were not operating, there is much evidence for the statement that we would have almost no nursing homes in the country if it were left to the voluntary hospitals and public agencies. I do think we should look at the positive aspects of the profit motive and realize that the profit incentive in this case may indeed be necessary in order to provide facilities for our chronically ill. I am reminded of the fact that the medical profession itself is operating very well on the basis of the profit motive. I would like to call your attention to an experiment that the Massachusetts General Hospital is carrying on in this regard. Over the past year and a half we have worked very closely with a proprietary group in advising them how to staff, operate, and give the best possible care to the chronically ill. We intend to work closely with this home without having any legal or financial obligation. We believe that we can demonstrate that a voluntary teaching hospital can cooperate very effectively with a proprietary nursing home to provide the best possible care to the community of patients.

2. The problem of welfare reimbursement and lack of standardization. The ceiling of reimbursement of $7.71 per day serves only to reward the poor homes by not providing the necessary services can turn a handsome profit while the good homes which do supply the services are penalized. It is only logical and rational that an operating average of reimbursement with a range of plus or minus 30 percent coupled with the new point system of accreditation and licensing which is being implemented at this time in the Commonwealth of Massachusetts by the department of public health will encourage better service, while simultaneously rewarding the good homes and penalizing the inadequate ones. In this connection it has been my honor to participate actively as a member of the public health council of the Commonwealth in this new point system which can serve only to improve the standards of our nursing homes.

3. The third problem is an equally serious one and one which must be met if over the long range our nursing homes are to be brought into the mainstream of medical care which to my mind must be accomplished. This problem concerns the tremendous lack of interest by the medical profession, teaching hospitals, and medical schools, which have always taken what was most interesting, manageable, and acute and left what was chronic and difficult to the community at large. The lack of interest by medical schools, hospitals, and the medical profession (except when proprietary) in chronic care and the homes where this care is provided has worked to the disadvantage of the community and their natural interest in continuing and comprehensive care. In this regard, we at the MGH and I as a physician and medical educator have proceeded in the teaching of medical students and house staff and encouraged their interest in the problems of chronic care. We have for the past 2 years visited on a monthly basis our patients discharged to nursing homes. It has been shown time and time again when real interest is displayed by medical staff and teaching hospitals that nursing home standards improve, the recruitment of personnel is enhanced, and they are sincerely grateful for our help and interest to say nothing of the patients' feelings in this regard.

I have not described the new transfer office in the department of social service which Miss Clark, chief of social service, Dr. Neumann, administrator of the MGH

and myself have been involved in for the past year—and this is the most important project of relevance to today's hearing. Miss Clark will describe its functions and the ways in which we feel we can contribute, uniquely at the moment, to the solution of the problem of placing our 300 patients we discharge monthly to the best nursing homes. In this regard I submit with my statement an exchange of correspondence on the editorial pages of the Boston Herald last week.

I applaud the activities of this most important committee and urge you to encourage through Federal legislation improvement in the standards of nursing home care and a more rational system of reimbursement for care given commensurate with the service provided and to help us to exhort the medical profession, our medical schools, and teaching hospitals to weave chronic care and nursing homes into the fabric of their interests and intellectual commitment.

[Herald, Boston, Mass., July 30, 1965]

Hospitals Shouldn't Operate Their Own Nursing Homes

To the Editor of the Herald:

I was surprised to read in the July 14 Herald that the Massachusetts General Hospital may build its own nursing home. From all reports, hospitals have enough problems taking care of their own affairs without going into the nursing home business.

The daily hospital rates are continually going up and part of the reason is that we, as patients, must pay for the extra activities now carried on by the hospital. A hospital-run nursing home probably means higher rates for the hospital patient.

It is perfectly reasonable and beneficial for all concerned to have the medical profession serve as advisers and consultants during the planning stages for a new nursing home, as was the case with the new 600-bed facility planned for Boston. This same cooperative effort should prevail in all existing nursing homes on a 12-month basis.

But the statements by Dr. John Knowles, director of the Massachusetts General Hospital, leaves the impression that his ambition is to establish a hospital-based empire that would control all aspects of medical care. He states that the Massachusetts General Hospital must extend its influence into the communities.

Most people have come to realize that the high cost of medical care is due primarily to the high cost of hospitalization; and it goes up every year.

Now for hospitals to take on the job of building and running nursing homes is a burden they can ill afford or, more to the point, the patients can't afford it.

Blaise F. Alfano, M.D.,
Melrose.

[The Boston Herald, Aug. 3, 1965]

Hospital Responsibility to Nursing Homes

To the Editor of the Herald:

The incredible statements contained in Dr. Alfano's letter of July 30 cannot be left unanswered, although they barely deserve the dignification of a response.

First of all, Dr. Alfano should realize that the care of the patient does not start and stop with the hospital or the doctor and both have a larger responsibility today for insuring the highest quality of continuing, chronic care, much of which is carried out in nursing homes. Study after study has demonstrated the low quality of care in inadequate chronic care facilities due to several factors: (1) the profit motive, which interferes with the necessary expenditure of money to provide necessary services and facilities; (2) inadequate rates of reimbursement from State welfare departments; and (3) the lack of interest by medical schools, hospitals, and the medical profession (except when proprietary owners) in chronic care and the homes in which it is carried on.

The good doctor should also update his knowledge of the medicare legislation which states that the aged sick must be referred to nursing homes after evaluation in the hospital in order to qualify for nursing home benefits. To this end, the hospital has the larger responsibility of assuring the appropriate and highest quality of care to its patients by their proper placement in only those nursing homes which can and are willing to maintain the highest standards. High

standards of care require money and here Dr. Alfano is correct, but I am sure that neither he nor I want cutrate medical and nursing home care for ourselves, our families, or our patients.

The MGH is attempting to meet these problems and extend its influence in the public interest to the upgrading of care in the nursing homes of the State, so that our patients and their families will be confident of our continuing interest in their best care and will be reasonably assured that they can get it when they leave our hospital and enter the nursing home. To this end we have done the following:

1. Established a transfer office within the social service department, staffed by social workers, nurses, and doctors, which will evaluate the homes to which our patients are referred (some 300 per month) and help the homes to provide the best possible care.
2. Structured a relationship with a nursing home to be built near the Massachusetts General Hospital in order to demonstrate that a voluntary, nonprofit hospital can cooperate with a proprietary home and maintain high standards. Dr. Alfano should have read the reports of this venture more carefully—the Massachusetts General Hospital is not building this home and has no financial or legal obligations to this home. Its abiding and enduring interest in this facility is to cooperate in the establishment of the best chronic aftercare of our patients.
3. Aided the State department of public health in the new point system of accreditation and licensing of the over 700 nursing homes of this State, a highly desirable innovation. In this regard, I have the honor of serving as a member of the public health council, having been appointed by Governor Peabody to a 6-year term.
4. Participated in the teaching of medical students and house staff and encouraged their interest in the problems of chronic care In this regard, as a physician and teacher of medicine we have for the past 3 years visited on a monthly basis the patients we have discharged to nursing homes.

Dr. Alfano is unnecessarily afraid of the rise in standards which our national legislators wish to be accomplished under medicare. The public demands the best medical care and there are those who will assist in seeing that their wishes are fulfilled.

It dismays me that anyone in the medical profession will attempt to speak for the public in declaring the public unable and unwilling to support their inalienable birthright to the best possible care. Perhaps as Pogo said, "We have met the enemy, and they are us."

JOHN H. KNOWLES, M.D.,
General Director and Physician,
Massachusetts General Hospital, Boston.

Senator MOSS. Miss Clark.

Miss CLARK. Thank you, Senator Moss.

Dr. Knowles has made clear many of both the needs and responsibilities of the nursing homes, and indeed, they are carrying major responsibility for the chronically ill and particularly the aged in our country.

For far too long these homes have been excluded from the mainstream of the medical profession and have been isolated from the acute hospitals.

As Dr. Knowles mentioned, this past winter the Massachusetts General instituted what we call a transfer office and I would like particularly to speak to the work of this office and what we have been learning about the problems of both our patients and the nursing homes to which we are sending them.

This office is staffed, incidentally, with trained social workers and a registered nurse who is also trained in rehabilitation.

Our goals are essentially to select nursing homes that we send our patients to which have the potential for offering both the quality and quantity of both nursing care and of home care that is needed:

To develop closer cooperation between the Massachusetts General Hospital and the nursing homes to which our patients are transferred;

To improve communication between the hospital and the home so that patient care is in fact more continuous and more comprehensive;

And to institute means and methods of consultation and educational exchange in order to upgrade the care of the chronically ill.

We all know many of the facts of today in regard to the need for programs such as this as life expectancy approaches 70 years of age, medical care improves, the standard of living becomes higher, the number of older people increases.

Current studies indicate that three-quarters of the population over 65 has some chronic condition. As age increases, the impact becomes more severe in nursing homes and chronic hospitals for long-term medical facilities. They are also a major component of comprehensive medical care.

Yet, these facilities are usually quite isolated from the hospital. Cooperation, all too often, has consisted only of very informal arrangements for transferring patients with limited communication about the patient's needs or the plans for the continuing care of the patient, and the patient's care subsequently must suffer from his lack of coordination.

In addition, hospital staffs, as Dr. Knowles has said, frequently know far too little about the facility's resources and services available in the nursing home.

As a result, the needs of the patients are often poorly matched with the nursing home's capacity to meet them. Perhaps this is our biggest job, the adequate and careful matching of the patient's intricate needs with the capacity of the facility to meet them.

Nursing homes are certainly, in turn, beset by many problems; the staffing, financing, inadequate diagnostic services and inability to provide up-to-date staff education.

Our first step toward meeting today's pressure is for more effective extended care to examine our own practices in selecting patients for nursing home care. We have carefully examined the patients from the month of March 1965. These patients numbered a total 226; another 45 were referred to chronic hospitals.

Certain striking characteristics of the patients who were transferred to nursing homes give us evidence of the type of care needed in the homes. Three-quarters of the patients were over 65 years of age. Almost three-quarters of the total group had help from an agency, public or private, in meeting the cost of nursing home care. Eighty percent of these patients had two or more diagnoses. One or more nursing procedures were ordered for three-quarters of the patients.

At least one medication was prescribed for 91 percent of them and almost half of the patients required special diets.

From the Massachusetts General Hospital then, we are sending from 200 to 300 patients a month to nursing homes and by the broad gages I have indicated they are for the most part elderly, dependent, and quite ill people requiring extensive nursing care.

Our next step was to follow up these patients in the nursing homes seeking to evaluate whether we had indeed placed the patient in a community facility adequately equipped to meet his needs.

We were interested to discover from the nursing home point of view what problems they encountered with the Massachusetts General Hospital, and indeed, we discovered a number, and are trying to do something about fixing them, to learn more of the problems of the nursing home and to add our help in finding solutions to these problems.

I, too, would second Senator Moss' comment that they are not all good and not all bad, and this is not what we are going to find.

We are in the midst of this step but can report some observations on 68 of the homes which we have visited and in which we have visited our patients. Some of the nursing homes are doing excellent work in care of the aged and others are not.

Most of the homes we have visited are making a real effort to serve sick people well. The majority of the homes offer attractive, safe facilities and are clean and odor free.

Nearly all of the homes face acute difficulties with staffing. The better homes have registered nurses. In homes that did not have registered nurses, the quality of patient care was clearly inadequate to meet the level of need that we are referring today to nursing homes. Virtually none of the nursing homes had adequate help from dietitians and therefore, special diets and good care for many patients could not be adequately provided.

Nearly all of the homes had major difficulties in providing adequate supervision by physicians. All of the homes struggled to provide adequate care for major illness with the reimbursement rate which is currently in effect for public welfare patients in this State. Social and emotional and economic needs of the patients tend to be overlooked as they try to deal with the absolute bare human needs of these patients.

All of us face the severe shortages of trained people. One answer may lie in the more efficient use of this scarce commodity of trained people. For this reason, the MGH has applied for help from the Public Health Service to provide closer communication, adequate consultation, and in-service educational programs to the homes helping to care for our patients.

This program will make available to certain homes dietary consultation, education in current nursing practices, closer medical liaison, consultation from social service, medical recordkeeping, accounting, and administration.

No nursing home can afford or needs a full-time dietitian, for example, but close consultation with highly trained dietitians from the acute hospital an hour or two a week should go a long way toward helping to upgrade care in this area.

Hospitals and nursing homes must share these concerns if the community is to fulfill its responsibility to the elderly who are ill, and I think I can say that all of the resources of the Massachusetts General Hospital are available toward this goal.

Thank you. [Applause.]

Senator Moss. Thank you, Miss Clark, for a very fine statement and report to us.

It would appear to me from what you and Dr. Knowles have both told us that in a sort of an informal way you have developed an affiliation technique with at least some of the nursing homes in Massachusetts.

Would that be a fair statement?

Dr. Knowles. Yes, sir.

Senator Moss. I particularly noted, Miss Clark, that you said "visited our patients in the nursing home" which is a very encouraging thing. So often our hospitals which treat acute illness of various

kinds come to the point of discharge and it is no longer "our patient"—the patient is gone and the hospital does not retain any interest.

If we can develop this continued concern and supervision in visiting with the patient in another institution such as the nursing home, then we have reached one of the gaps that I think exist.

Is there any requirement in Massachusetts for any kind of hospital affiliation with a nursing home as a condition of licensing?

Dr. KNOWLES. No, there is not, Senator.

Senator MOSS. So there would be, I take it, quite a number of nursing homes that would really have no connection or even communication with a hospital?

Dr. KNOWLES. That is very true.

Senator MOSS. Another thing that concerns me, Dr. Knowles; you talked about the fact that about 80 percent or more of our nursing homes are proprietary and, therefore, must, of course, realize some measure of profit in order to stay in business. Yet the maximum amount available from welfare which accounts for about three-fourths of all the patients is $7.71 a day.

What standard of care can a nursing home provide at a limited maximum amount of $7.71?

Dr. KNOWLES. This is a very good question, Senator, because one of the problems that exist here is that it depends on the number of beds in the home and the occupancy of those beds.

You and I could build a 200- or 300-bed nursing home which is 91 percent occupied and turn a 6-percent profit on our money and have it adequately staffed with nursing personnel, rehabilitation services, and so on, and do that for between $7 and $8 a day.

Now when you get down to a 30-bed home with adequate staffing, if there were only 20 patients in the home for a week or two, it is going to be much more expensive.

I think it is important as a principle in hospital costs as well as nursing home costs, to recognize that it is the number of beds but, more importantly, the average occupancy of those beds.

So if you have a very large home and it is fully occupied, say 92 percent occupied for an average over the year, we could provide very good care for most types of patients at between $7 and $8.

Again, we get into the problems of the proper identification of the patients' needs, if we had multiple system disease, for example. As I understand, in some States there is better reimbursement if the patient is in bed rather than walking around. Now there is an interesting idea because if you and I were running the home and we were not getting enough money from the State, we would keep grandma in bed, we don't want her to get up and walk around, because we would lose a dollar a day on her care.

That flies in the face of where the impetus should be. Then one gets into the area of what is convalescence versus chronic care and the nursing care that an individual needs.

I think a large home, fully occupied, can do it fairly well for $7, $8, $10 a day.

Senator MOSS. The point system you described for determining the amount of reimbursement would require close enough inspection that you would not fall into this trap you have just mentioned, that of getting extra points for bed patients and therefore motivation to keep them in bed.

Dr. KNOWLES. That is very true.

Senator MOSS. Actually, the points ought to be given the other way for keeping the patient ambulatory rather than in bed?

Dr. KNOWLES. Precisely.

Senator MOSS. I am very interested in the development that has come here in sort of a spontaneous and voluntary way. I am sure that later on when Dr. Levey testifies we will be able to go into more detail as to just what the statutory requirements are for licensing of nursing homes and their inspection here.

There are a number of areas that I could ask you about, but I think I will defer to my colleagues. I am sure that some of them may have questions.

Senator Neuberger.

Senator NEUBERGER. Dr. Knowles, I would say that Massachusetts General Hospital probably is recognized as the epitome of fine teaching hospitals; it is a model. Therefore, I am very much interested in your attitude toward the proprietary nursing homes. We really have not had such a forthright statement as this before.

The whole discussion of costs interests me. Massachusetts is somewhat notorious, if I may use the word, for having made use of Kerr-Mills. Now under Kerr-Mills where the Federal Government paid part of the cost, was it still rated at $7 per day for a nursing home?

Dr. KNOWLES. Yes.

Senator NEUBERGER. I said "notorious" because you did a smart thing in Massachusetts, and which I urge my own State of Oregon to do. That is to take advantage of the Federal Government's willingness to pay and get welfare patients going under Kerr-Mills.

I wondered if that gave you any better income for Kerr-Mills patients?

Dr. KNOWLES. It has not. If I were running a business, and I could get a buck back for every buck I put in myself, I would tend to expand that. We are arguing right now about our welfare rates; we have been taking them to the courts, and sometimes I worry about doing everything in court. It just seems to me that is as much a failure of the democratic process as it is a safeguard of democracy. We tell them time and time again that if they are going to get 50 percent of their expenditure back from the Federal Government, let's all pull together and make it better. We are still worrying about the taxes locally and in the cities and towns and they don't want to spend a dollar to get another dollar back.

Right now the hospitals of this State are giving roughly a 30-percent discount to welfare patients and I mean 30 percent.

Senator NEUBERGER. You do not need to.

Dr. KNOWLES. Not at all. The courts have agreed with us but the political representatives are not moving that fast.

Senator NEUBERGER. You also indicated that you approve of the provision of the new health care bill which requires 3 days in a hospital before being admitted to a nursing home.

Dr. KNOWLES. I do. This is going to bring us all problems in terms of utilization of health services. In the State of Massachusetts, most of our hospitals right now have waiting lists quite frankly, and it is going to be longer because I think roughly 50 percent of the people lying in our 26,000 nursing home beds in this State have gone there directly from the doctor's office or from their own home. These people now are qualified for the benefits but they must come to the

hospital first. It is going to overburden our facilities and our people but we have to rise to it and do it because in the long run that is going to be a plus for the best care. It is going to mean that they have to be evaluated fully medically to know what their real needs are. It is hard to do that by going into the home all the time on a house call and go directly to the nursing home. So that is very important.

Secondly, it is going to force us in the medical world whether we like it or not—and as I have said, we have always taken what was acute, curative, and interesting for ourselves and left what was chronic, dirty, and difficult for our political representatives and the community—it is going to force us now to put that on our main beat and one of these days I hope I can report to you that our medical students and our house officers are going out to nursing homes to learn about the care of their responsibilities.

So I think these two things overweigh any negative aspects. Sure, it is going to throw another load on us. I don't know but what on July 1, 1966, there will be a line stretching from the Massachusetts General Hospital halfway across the bridge to Chelsea of people hobbling, on crutches, crawling, I don't know, but I think it is going to net out at about the same amount of utilization. That was the experience in Britain, for example, on these two facets.

Furthermore, politically in a good sense of the word, we are going to have to join forces with the nursing homes to get proper reimbursement from State and Federal Governments and we will get right into bed with them to help the good ones to succeed. We will throw every inch of our force behind it as long as they fulfill maximal standards. Everything today is set on the basis of minimal standards. Why don't we get into the idea of setting maximal standards? I think we can through our transfer office, form the best affiliation agreement and get right into bed with them and help them.

Senator NEUBERGER. Concerning your question as to why don't we have maximal standards, the American public has been told for so many years that we are the healthiest Nation in the world and that we have the best medical care. Yet one of the doctors at Harvard Medical School has proved otherwise, that we don't, we have a very high rate of infant mortality and so on. The sooner we face realism, the better.

Dr. KNOWLES. Precisely.

Senator NEUBERGER. Along that line, I am interested in what you say about medical education because as you know, the Congress has supported medical education. Yet, in this country there are very few medical educators. I know one in California but I don't know very many. I have spoken to the third-year students at Harvard Medical School for a good many years and they are indoctrinated with an entirely different approach than the one you presented here today.

Dr. KNOWLES. There is no question about that. The people that talk as physicians the way a handful of us do, are as scarce as hen's teeth or they have been segregated and isolated from the medical schools in schools of Public Health where the public health man sits in a nice, tranquil upland pasture and studies the mass movement of people and money and things.

We have been trying to get the public health people to come on down to the teaching hospital and be subjected to our bunch of tigers who have to be shown not pontificated to by those safely removed from the

the firing line. About 1850, John Simon was appointed health commissioner in the city of London and thereon public health interests were separated from medical education and medical school. We now have schools of public health that know all these things we are talking about but have precious little influence on what the people are doing in the hospitals.

Still and all, each generation has a set of heroes and a set of conventional wisdom and our medical students are flying now up in the cloud of cuckoo land, biological research and moon shots and the Lord knows what.

Down on the ground, there are a handful of people who in the next generation are going to be the medical administrators, who are going to make it their business to articulate the advances of medicine with what the people need and want and if there is anybody in the crowd that is interested in this, I will offer him a job tomorrow.

We have been looking for 4 years. I can't find many M.D.'s who want to do this but it is a very promising area of inquiry and contribution.

Senator NEUBERGER. We have made a start in the Federal Government to aid nursing education. Miss Clark, I was interested in something you said just as a matter of course that these nursing homes have, I presume, registered nurses so many per capita. Isn't there a lot of work that can be done in both hospitals and nursing homes that can be done by a practical nurse to save the registered nurse?

Why do they have to have so many registered nurses?

Miss CLARK. Well, in nursing homes, in general, Senator we are not talking about numbers of registered nurses. Of the nursing homes that we visited, the 70 that I mentioned, approximately half of them have a registered nurse. The remaining half had no registered nurse and were staffed by aids.

There is no question but that aids can do a tremendous amount to help the registered nurse, but when the aid is left without a registered nurse to help to make major decisions, this is when major troubles of our patient care begin to arise.

As we have correlated some of our material from our visits, the single highest and most important issue is the fact that the nursing home has on their staff at least one well-trained registered nurse. It is a rare nursing home that has a registered nurse on all three shifts, for example.

Senator NEUBERGER. One more question, if I may, Mr. Chairman, and that concerns the portion of the health care bill which I supported but which was left out in final passage.

In most hospitals the physician services of anesthesiologists, radiologists, and pathologists have little selection by the patient.

Isn't there a great change in what is going to happen in hospitals now that it has been taken out and they must subscribe to it under the $3 a month?

Dr. KNOWLES. Absolutely.

Senator NEUBERGER. How is this going to affect hospital care?

Dr. KNOWLES. Needless to say, speaking as someone who knows the history of the evolution of hospitals as a coordinated social instrument to provide care regardless of the abilities of the patients to pay we have recognized that there has to be some semblance of orga-

nization in the hospital albeit the medical profession has always been the avowed enemy of bureaucracy and always will be.

Now we have taken out these three or four people and all I can say is if I am going to be a patient and I get a bill from somebody called a pathologist or an anesthesiologist, I hope at least I will have seen the person.

Now in many instances, you, as the patient, will not see these people, don't know who they are. We are going to get into hassles about who takes the $50 deductible. You and I don't know how many people are going to buy this voluntary health insurance.

What you have done is to segment and fragment and make a very chaotic situation out of what had finally almost evolved to the point where you had coordinated medical and social services, and that is what medicine is.

Now you flip the coin over on the other side and maybe here the profit motive or the proprietary motive or the piecework motive will triumph and we may get more service and more hard work or what-have you. I don't know, but I certainly was unalterably opposed to the removal of the Douglas amendment.

I get into a number of fights locally about this and I think it is bad in the long run. However, in our own hospital we are having meetings to try to find out how we are going to meet this thing. The patient comes first above all, and our decision will be based on this feeling. Yes, we are a teaching hospital but the first function of that hospital is to take care of the sick.

The second and third functions are what we do in terms of teaching or research, but the first function is the care of the sick. We feel that we can rise to this and make the best of it. Over all, the 7,000 hospitals in this country, radiologists, pathologists, anesthetists, the cost of medical care is going to rise; it is a fragmented, chaotic situation.

I assure you that the public is tiring of the irrational behavior of the medical profession and hospitals. We are either going to rationalize our services on a voluntary basis or we are going to be nationalized. Whether it comes 10 years or 30 years from now, and if it becomes more chaotic, I might even vote to hand the whole thing over to the Federal Government.

I am a firm believer in voluntarism. When local hospitals are fully supported by their local communities, they will reflect what the local community wants and needs much better than a central Federal Government can do. [Applause.]

One of the things that made this country great was voluntary, local community activity and the medicare bill to a certain extent is a monument to our own inability to solve what was an increasing problem. The problem was there and it was not until 3 or 4 months ago that the AMA allowed there even was a problem and it was too late.

If I had been a Senator, I would not have been listening to them, either.

Senator NEUBERGER. That is where the Senators listened because they put on a snow job, the likes of which you never heard. You have to say to them, "I don't believe we should change it, the way it has been done is good."

Dr. KNOWLES. I believe the AMA and Association of American Medical Colleges, which is as conservative and backward as the AMA is, the two major political forces of American medicine, are equally conservative and have stuck their heads in sand and put their backside to the socioeconomic problem of medicine.

If they don't come to grips with it, then I say let's work as best we can with the Federal Government to make this as good as possible.

I would also make a special plea to try to recognize the problem, solve it on a local basis, because the doctors are right to a certain extent, too. A committee of the Federal or State Government never took care of a patient at 3 o'clock in the morning—it is your doctor. We must not lose sight of the fact that the doctor and the patient form the very primary element of medical care, so let's try to keep the doctors happy, they function best without a lot of bureaucratic fetters.

I don't expect our staff to say, "I better not be abrupt with that employee even though the patient is vomiting blood; I won't get the X-ray because that will cost $4.50 in the morning." If I am vomiting blood, I think it is important. I think one has to walk the tightrope of bureaucratic fetters and cost versus the individual who remains the most important element to us all.

Senator NEUBERGER. Thank you.

Senator MOSS. Thank you, Doctor. [Applause.]

As I said before, you are a very articulate and perceptive witness, Dr. Knowles.

Senator Muskie has a question or two.

Senator MUSKIE. Dr. Knowles, you have indicated, and I think properly so, that performance of these nursing homes is both very good and very bad.

I would like to look at the very bad for just a moment. I take it that you have run into nursing homes to which you would not refer your patients.

Dr. KNOWLES. Yes, sir.

Senator MUSKIE. Have you found in your experience, nursing homes which, in your judgment, ought not to be operated?

Dr. KNOWLES. Ought not to be operated? Yes, I think so. But here again, I think it is up to the State department of public health.

Senator MUSKIE. I recognize we are measuring performance of all kinds of people.

Dr. KNOWLES. Yes, sir.

Senator MUSKIE. It is your belief that there are nursing homes which you think ought not to be operated?

Dr. KNOWLES. Yes.

Senator MUSKIE. Are there a great number of such homes?

Dr. KNOWLES. I would hesitate to say. There was a very good study by the Boston College of Nursing and we have our own initial experience of some 70 to 80 homes. In both of these studies a certain percentage should not be operated.

Also, each month the department of public health and its council, of which I am a member, reviews homes that have been given temporary licenses or extensions of time and we always give them a fair hearing.

If they can't meet the standards, then they have to be closed, they won't be licensed. That is the State's responsibility and it has been fulfilled in a much better way. Here again, that department needs more money to get more people to help the State review these nursing homes. They are inadequately staffed at the present time.

Unfortunately, the costs of education, local and Federal Government, and hospital costs, have all gone up together and each one of them suffers at the tyranny of the subdivided tax dollar at times.

There are homes that have been put out of business by the State licensing legal sanction.

Senator MUSKIE. What is the principal reason for the poor performance of these low-grade nursing homes? Is it economics?

Dr. KNOWLES. Inadequate staffing is the usual problem, nobody there who understands the needs of the patients and who, therefore, cannot give it.

Senator MUSKIE. Is that tied to economics?

Dr. KNOWLES. Not always, but most of the time. Well, not only economics but the adequacy of health personnel in terms of nurses. If every one of the 700 homes today was adequately staffed and every one of the 176 hospitals in this State were adequately staffed—our own hospital does not have adequate nursing staff nor does any other hospital in this State, as far as I know.

If we were all adequately staffed we would need another half a million people.

Senator MUSKIE. On the other hand, you have good nursing homes and bad nursing homes. I am interested in knowing why the bad ones are not able to perform as well as the good ones. Is it economics?

Dr. KNOWLES. I would say if you want a blanket answer, yes.

Senator MUSKIE. Let me ask you this: In proprietary homes, the incentive is profit. Presumably, the nursing homes are established by people in the profit business who evaluate the possiblities and decide they can make a profit.

Now, why has their judgment gone wrong in the case of these poor nursing homes?

Dr. KNOWLES. Well, it has gone wrong because several of them have picked up second and third mortgages on homes that have 10 and 15 patients; if they go for 2 weeks with 8 patients, they go broke.

Senator MUSKIE. In other words, the people should not be in business?

Dr. KNOWLES. Precisely.

Senator MUSKIE. How do you keep those people out of business because we are not dealing now simply with the failure to sell goods? We are talking about failure to deal with the health problems of people.

Dr. KNOWLES. I think that here the State department of public health's responsibility for granting permission to build homes and so forth, should be tightened up, and it is being tightened up.

Senator MUSKIE. Let me ask you this: In your statement this morning you said that you thought the profit motive is consistent with a good nursing home program.

In your letter to the Boston Herald of August 3, you said this:

> Study after study has demonstrated the low quality of care in inadequate chronic care facilities due to several factors; one, the profit motive which interferes with the necessary expenditure of money to provide necessary service and facilities.

That would appear on the face of it to be inconsistent with what you said this morning. I thought you would clarify that apparent inconsistency.

Dr. KNOWLES. I was not inconsistent. I said it may indeed interfere in the case of people who want to make a big profit and not give service. I have also said that instead of being a statesman I am trying to be a politician now and recognize the structure within which we are working and make it better. To that purpose we have joined forces with the proprietary home to get the best care for our sick. Certainly I think the proprietary motive may interfere with getting the best care, no question.

Senator MUSKIE. I think you have made an excellent witness and an excellent statement. Nevertheless, I am wondering whether it it is possible to feed a profit motive in this business and still get good care without resorting to the kind of rigid standards and supervision which defeat the whole thing anyway?

Dr. KNOWLES. That is a very good question, Senator, and I would hesitate to answer that with a blanket statement. In some instances, yes, what we are looking for are those instances. With our leverage of 300 patients a month we cannot help but weed out the best and support them and know they add good cost accounting in terms of decent profit but still give the services, and those are the ones that we want to help.

This is something I didn't say this morning. On top of that, we have a responsibility in nonprofit institutions to build our own nursing home to demonstrate the best care and the best structure of a nursing home so that that knowledge gained there just as our knowledge of how to do it is diffused to our communities locally and nationally.

That knowledge should be available to those people who are setting up nursing homes. I suppose we get almost to a state where we might look upon nursing homes as a public utility, and whether or not ultimately rates and profit margins would be set, I don't know.

Senator MUSKIE. At least they ought to be exposed to the experience which dictates the economics of one of these operations?

Dr. KNOWLES. Absolutely. Here again, what about absentee ownership? It is a very vicious business and it is not good.

Senator MUSKIE. Thank you very much.

Dr. KNOWLES. Thank you, Senator.

Senator MOSS. I am glad you volunteered that comment on absentee ownership. I was going to ask about that because that has come up in some of our previous hearings and some have expressed the opinion that absentee ownership was the worst enemy of proper standards in a nursing home.

Would you subscribe to a general statement of that sort?

Dr. KNOWLES. I think generally that is true, or unknown ownership and fronts for the people who really own it. It is not right. You have got to be able to talk to who is in charge and spot him publicly in order to provide certain standards; you can't do it by remote control. It never has been possible. Absentee ownership has always been vicious. If you are talking about housing, it is equally bad in our cities. Absentee owners are interested in mainly what the books show each month rather than what the people are getting in those areas.

Senator MOSS. Very good.

Senator Kennedy, do you have a question?

Senator KENNEDY. Dr. Knowles, I just have one or two very brief questions. I want to join my colleagues in commending you for the very fine presentation that you have given this morning.

As I understand, the MGH has conducted a study into the nursing homes in which it will assign its patients. You mentioned, when you referred to that this morning, that you have studied some 70 nursing homes in order to properly assign the patients that will leave MGH.

I was wondering how your standards differed from either the State standards which apply here in Massachusetts or elsewhere in determining whether you will or will not send a patient to one of these nursing homes?

Dr. KNOWLES. That is a very good question, Senator Kennedy. I think it is a little too early to answer that because as soon as we have made our own evaluation, which is very similar on a constructed basis to the State's more extensive review, we will certainly compare notes with the State and come to certain conclusions.

I think that we have a problem with the Massachusetts General because we are largely a referral hospital for patients with complicated disease conditions.

This is the main determinant of whether our very complicated sick people can get the best care, and our standards will be quite different from a local community hospital where the problems may not be as complicated.

Senator KENNEDY. Dr. Knowles, there must be an overlapping of some of the standards of care. Whether they are going to have requirements with regard to absentee owners, with regard to the physical environment, with regard to sanitation and the kind of furnishings and all these other factors which are important and certainly do reflect the adequacy of a nursing home.

Certainly it would seem to me to be similar, whether a patient has a particular chronic disease or another that might not be so seriously ill. I am wondering in these particular areas what your standards are and how they are distinctive from those which are currently applied in the State.

Dr. KNOWLES. Well, ours may be the ideal situation, and I think we also recognize with the State we simply can't close down the low standard and inadequate homes tomorrow.

Now the new point system has just come into being. Two years ago, the State decreed that a nursing home would be visited annually. Up to that time, it had not been for 2 or 3 years. Now we are just gearing ourselves along with the medical legislation to constructive improvement in these facilities.

The homes that we don't send our patients to, I would doubt in some instances they would be fit for licensing but I think here I would defer to Dr. Levey as the head of that division which licenses the home.

Your point is a good one.

Senator MOSS. Thank you, Dr. Knowles and Miss Clark. You certainly have been excellent witnesses. You have given us much information for our record, good insight into the operations of the Massachusetts General as related to nursing homes. We do appreciate your appearance and your answering our questions. Thank you very much.

Dr. KNOWLES. Thank you very much, Senator. [Applause.]

Senator MOSS. Our next witnesses are Mr. Saul Tobias, manager, Corporate Operations, Inc., Brookline; and Mr. Howard Lawn, president, Corporate Operations, Inc., Brookline.

These gentlemen operate a number of nursing homes. We are glad to have them come forward now.

STATEMENT OF SAUL TOBIAS, MANAGER, CORPORATE OPERATIONS, INC., BROOKLINE

Mr. TOBIAS. I am sorry, Senators, Mr. Lawn could not change his commitments around. We were originally notified for him to be here Thursday.

Senator MOSS. So you are Mr. Tobias.

Mr. TOBIAS. I am Saul Tobias.

Senator MOSS. Fine. We will go ahead with you, Mr. Tobias. You may proceed and then we may have some questions.

Mr. TOBIAS. Thank you.

Honorable Senators, ladies, and gentlemen, the beginning of any thinking, of any discussion, on the problems of nursing homes, should begin from the point of view of a patient in a nursing home bed.

Here is someone's father, mother, or relative, once a vigorous and useful member of society, like anyone else in the room, and now old and helpless, broke, not sick enough to be in a hospital, and not well enough to be without 24 hours of continuous trained care.

The great question—the great concern—is whether this person is getting proper care.

And the sad answer is that too often that person is not.

Now the greater question, and the reason we are here today, is why?

Why is it that too often that person does not have sufficient highly competent, continuous care?

In order to answer that question—if we sincerely mean to and want to answer that question—we must avoid falling into an error that so many of us do. We must not, as we stand at the bedside of that patient say that because he is in a particular nursing home the cause of his not having an even higher standard of care is the fault of that nursing home.

This is not analysis; this is emotion. This is not thinking; this is reaction. And this is not the cause.

It is, however, a natural reaction, because the nursing home is the place where the crowds and the critics see the patient. It is the only thing the critics see and they react emotionally. And so they blame—they blame the visible entity, the nursing home.

But it is these highly charged emotions that blind reason and obscure the true forces that caused, and continue to cause, the end result, the less-than-best care for the patient.

The evil, the focal point of the evil, is within the system that has been established for nursing care.

The nursing home is only one component of the system. The system, however, is made up of four components: the legislature, a nursing home licensing agency, a public welfare department, and the nursing home. And it is only when this system of these four components work well together that the desired standard of care is rendered.

Now, let us look at this system and see where the fault really lies.

How does the system work?

One agency of the government, the licensing department, has been raising the costs of nursing home care; but, mind you, has quite properly been raising the costs of nursing home care by raising the

standards of operation. But, and here is the point where the spotlight begins to show the true source of the problem, the other government agency, the other component in the system, the welfare department, has not been able to pay for these added costs.

One arm of the government body has been raising the costs while the other arm has not been able to raise the funds.

In this life, if you put a nickel into a vending machine, you get back a 5-cent candy bar; put a dime in, and you get back a 10-cent candy bar. Ten cents in costs give you 10 cents worth of product. But in the nursing home business, the government wants 10 cents in value for its nickel. And this, no business of any kind, in any place, can do.

So, we come down to the hard fact of life that the basic cause of the nursing home problem is the failure of the Welfare Department to provide sufficient funds for decent care of the welfare patient.

The nursing home is the vending machine; the welfare department is the customer. If the customer wants the 10-cent bar and puts in a nickel, don't bang the vending machine. It gave what it got.

The truth is that without money, public hand wringing, public blame on the nursing home operator, is misplaced, and cannot result in higher care.

Now, let us back away and look at why the welfare department resists paying the added costs of the higher standards imposed by the licensing department. Mind you, I never said they would not pay; I said they could not pay. They just have not been given the funds.

And this brings us back along the system to the source from which the funds originate: the legislature.

No one can, anywhere in the system, receive any money unless the legislature provides it.

And let's not kid anyone: The legislature has been tight.

I'll come back to the proof of the point that the legislature has been restrictive in funds in just a moment.

But just I would like to say, in partial extenuation of the policy of keeping the budget under part, that a legislature works within a climate of a tax-sensitive public attitude. It is said, but true, that this legislative inadequacy expresses the attitude of the taxpayer.

Now, it is not for me to say how the taxpayers' attitude, the climate in which this whole fiscal problem moves, should be changed. It is not for me to undertake the public relations work to educate the public to realize that the patient in the nursing home bed is his father or mother and some day, may well be himself.

My job is to point out that the care and concern that is given to his father or mother, or later to him, is directly related to the funds the Government gives. And, by golly, when the Government gives the funds, then, and then only, is it entitled to the product, the value in terms of care standards for which it pays. And then if the Government does not get that value, it has the right and the power to stop that nursing home—to take its business elsewhere.

The great point is this: It gives a lot of emotional satisfaction to blame the nursing home operator, to cluster around him and develop a climate of evil, to dramatize him because he is visible and the patient's condition is visible, to give him the headlines. But when you do that, you just blow up an emotional smokescreen. You do not put your finger on the point of the pain, on the cause of the illness.

Therefore, you solve nothing. And because you solve nothing, the illness continues, and because it continues, it gets worse. The point of the pain, the cause of the illness, is flatly the lack of the funds to pay the costs of the care.

For a moment, let us reflect on the subject of costs. I have no intention of repeating what Mr. Connelly will say. Very simply, let's look at it from the point of view, not of a detailed analysis, but of ordinary common sense. $7.71. Recently, as early as February of this year, it was $6.85. But $7.71.

How far does it really go? I have not taken the time to telephone hotels in Massachusetts to find out what a day and night lodging would cost. I have not taken the time to find out what a hotel would charge for a room with one meal; a room with two meals; or a room with three meals.

But do you really think that we could get any kind of sanitary accommodations and three meals a day at any hotel for $7.71? And now add highly professional, skilled, high-priced, 24-hour nursing care. Does anybody have to be a mathematical genius to argue that $7.71 is not realistic?

Now let me give you a flat assertion on the question of costs. We lose money, every day, 7 days a week, at $7.71. And on that point, the system about which I talked earlier when, in February last, it gave us the $7.71, told us that this was an interim amount, that by July 1 all homes would be rated and classified, and that those giving the maximum of nursing care to patients would receive an increase.

Because it is our concern to give a high standard of care, because it is only good business for a businessman in competition with other businessmen to give value, we raised our highly skilled labor force in anticipation of that increased rate. What did we get in July? Nothing.

What did we get in August? A letter. A letter from the system, which I have here if anyone cares to see it, saying that they were very sorry they did not have the funds. They have not, they said, even the funds to properly staff themselves in order to work out the classifications, let alone have the funds to pay for the increased standard of care.

What do the facts of life compel us to do? Either lower our labor costs to a lesser standard, or daily lose a greater amount of money.

And so I say, gentlemen, if the commonsense of the situation is not persuasive that $7.71 cannot buy a room, three meals a day, and highly professional nursing care 24 hours per day, I say that, as a matter of practical fact, our homes operate at a loss at $7.71 per day.

If the system about which I spoke wants an economy service, it can buy it an economy price. If the system wants a quality service, it must pay a comparable price.

As it exists today, August 9, 1965, the system is asking for a quality of performance the rates cannot produce. This is the inescapable fact from the point of view of a hard-headed, hard-working, dedicated business source, the nursing home operators.

Let us not forget that not only is the quality of service for the aged rising, but also that the standard of living of those providing these services is rising steadily. And it is business—the private enterprise system—that provides the incentive and the financing necessary to build and staff and operate the homes for these ever-increasing needs of the aged.

We shall have a solution only when the four components within the system develop a single standard of care and payment. The result will then be quality service available to all of us who are destined to become aged.

Thank you. [Applause.]

Senator MOSS. Thank you, Mr. Tobias, we appreciate your testimony. You have pointed to one of the difficulties we have, that of determining proper reimbursement.

How many nursing homes do you operate?

Mr. TOBIAS. Twenty-one.

Senator MOSS. Are they all in Massachusetts?

Mr. TOBIAS. Yes; in Massachusetts.

Senator MOSS. All in Massachusetts. And you are the——

Mr. TOBIAS. General manager.

Senator MOSS. For all of the 21.

Mr. TOBIAS. Centrally operated 21 homes.

Senator MOSS. Now, do you have welfare patients in all of the 21?

Mr. TOBIAS. Yes, sir; we have them in every home.

Senator MOSS. And your testimony is that you are losing money on them every day?

Mr. TOBIAS. Yes; but we have some privates.

Senator MOSS. You have some private patients and they pay a higher rate and that is the way you are able to stay in business; is that right?

Mr. TOBIAS. Yes, sir.

Senator MOSS. Could you give me an estimate of what the average payment should be in order for you to stay in business and make a reasonable return on your investment?

Mr. TOBIAS. Well, we have some nearby States that are paying $9.

Senator MOSS. $9.

Mr. TOBIAS. Connecticut is $9; New York is $9. We should be in the $9 to $10 bracket, some place in there.

Senator MOSS. This would enable you, then, to make a reasonable return on your investment?

Mr. TOBIAS. Yes.

Senator MOSS. And give adequate service?

Mr. TOBIAS. And give the best and highest standard of nursing care.

Senator MOSS. To what extent do you have registered nurses on duty in your 21 homes?

Mr. TOBIAS. In some homes we have them 24 hours around the clock.

Senator MOSS. Some of them have 24-hour registered-nurse service.

Mr. TOBIAS. Around the clock. And the smaller homes that do not require registered nurses, they require a licensed practical nurse and in those homes we have a licensed practical nurse around the clock.

In every home that we operate there is a licensed nurse around the clock. Now in some of the larger homes, we have two and three RN's on a shift. We will have three on the day shift, two on the second shift, and perhaps one on the last shift. This is 7 days a week.

Senator MOSS. How many RN's do you have on your payroll?

Mr. TOBIAS. I could not give you a figure right at this moment, I didn't break it down, but Dr. Levey should have it because his inspectors come into our homes and check our payrolls.

Senator MOSS. Now I believe you advertise that you have continuous inspection by RN's. Does this mean that RN's go to these homes that have practical nurses and inspect them?

Mr. TOBIAS. I have three RN's that I have engaged to go around as supervisors and I have one girl who is the director of nursing that goes around and checks these homes before the State inspectors come in.

We try to find our own problems without the State bringing them to our attention. We like to find them before they do.

Senator MOSS. How many patients do you have, in all, of your 21 homes? What is your total figure?

Mr. TOBIAS. Roughly 1,300.

Senator MOSS. About 1,300. Now in addition to nursing services, do you give occupational therapy and that sort of thing?

Mr. TOBIAS. Yes, sir; we have occupational therapy. Most of the homes we have people come in and show movies that go around to different homes and put up a sheet with the coming attractions for the following week. Then we have therapists who will take perhaps three homes in an area for our homes in an area that she can handle and then we look in different areas to find a therapist there.

They do ceramics and they have bingos and they do embroidery and they make things. This is something that we pay for, they are not volunteers. I had one woman once who came in as a volunteer but I have engaged them and put these people on the payroll.

Senator MOSS. Do you have a connection, either an affiliation or relationship, of any sort, with a hospital or hospitals here for your homes?

Mr. TOBIAS. Just as Dr. Knowles said; as a matter of fact, it is his group which has been to visit three of my homes.

Senator MOSS. They have been to three of your homes?

Mr. TOBIAS. They have been to three of my homes. As a matter of fact, they seem to be pleased. In the last inspection, they made their followup there and they have sent me patients since their visit.

Senator MOSS. How did you come into the nursing home business? Is this your background and training?

Mr. TOBIAS. As an individual?

Senator MOSS. Yes.

Mr. TOBIAS. Well, I was a builder and I built a nursing home in Rhode Island with another fellow. The previous owners of this operation bought it and they asked me to come into Massachusetts and see if I could remodel some of their facilities, see if there could be better conditions for the patients.

So I came up here and when I came up here to do the remodeling and maintenance of these homes, at that time we didn't have quite that many and they were still acquiring homes. I happened to be in the office and I showed them that I had a little background in the food business and so forth, and I started showing them what I had known about it and where, if they would centrally buy instead of having homes individually buy what they wanted. They made me the purchasing agent and then when Mr. Lawn bought it out I became the general manager.

Well, at the time when I was doing the purchasing, I was administering seven homes and I showed to them that if they had good supervision they could get better results. There was a lot of money

wasted in homes that people don't see and I was trying to use it to the best of my ability.

When Mr. Lawn took over he made me the general manager and until a year ago last June, they seem to think I have been doing a good job.

I have been trying to comply with all the State's wishes and inspections in correcting these homes. My background was for about a little better than 5 years. I lived 7 days a week in the nursing home, 18 to 20 hours a day, and there is no one can tell you differently because they find me 2, 3, 4 o'clock in the morning checking these homes myself, personally, to see what is going on.

Senator Moss. And it was a little over a year ago when Mr. Lawn bought the interest that you became——

Mr. Tobias. I believe he bought it in July of 1963 and the previous owners were operating it then, but they have other interests and they could not stay with it and that is when they resigned and Mr. Lawn asked me if I would be available to become general manager.

Senator Moss. Does Mr. Lawn own this personally, or is this a corporation?

Mr. Tobias. It is a corporation. Mr. Lawn owns 100 percent of the stock and I imagine the main question everyone wants to hear, the archdiocese of Austin, Tex., Bishop Reicher owns the properties.

Senator Moss. The diocese of Texas, you say?

Mr. Tobias. Of Austin, Tex.

Senator Moss. There is a landlord owning the property?

Mr. Tobias. Yes.

Senator Moss. Well, does the diocese have anything to do with the supervision of the homes?

Mr. Tobias. Nothing whatsoever. I have 654 employees on the payroll. The only thing the diocese does is they send a representative of the church to check their properties maybe two or three times a year.

Other than that, they have nothing to do with the operation whatsoever.

Senator Moss. Now you don't have any M.D. or medical service connected with this chain of homes?

Mr. Tobias. Yes. The welfare department pays for the visits that the doctor makes to the patient but I have gone a step further. I engage six doctors in different areas and I pay them a fee that they come in as an extra service to check these homes out.

They come up with suggestions, they come up with ideas beneficial to the patients, and if they have a call that they have to make for a patient, why, they charge the city. They charge them, but I pay them personally every week; the company pays them for this added service.

Other than that, we just run a normal business.

Senator Moss. Do you keep patient records on the people in the homes that can be examined when a medical doctor comes in?

Mr. Tobias. Every patient has got a chart, all the records are in the chart, from the day the patient entered the home until the patient goes home as a convalescent patient, or until the patient passes on.

Then those records are filed and they can be checked back in for 3 years.

Senator Moss. Do your employees know about keeping charts and filing and so on?

Mr. TOBIAS. Every chart supervisor, whether it is RN or not, understands this and when a patient comes in with a referral form from a doctor or hospital they take the chart and follow it right through. The State comes in and checks to see if they are up to date. In the meantime, I have our own supervision seeing that these records are kept up to date so that when the State comes in they cannot find problems.

Senator MOSS. Has Massachusetts General referred any of its patients to your home? Dr. Knowles testified that they referred some of their patients to nursing homes.

Mr. TOBIAS. They have, sir. They have sent them prior to this but since they have gone out to investigate these homes and to check them and to have a followup series on them, I believe he called it, he has been sending me patients.

We never refuse a patient and some of them are really tough. I mean you have to get trapezes, you have to get all kinds of equipment for some of these patients and you still get only the $7.71.

Senator MOSS. Those referred by Massachusetts General are visited at later times by medical people?

Mr. TOBIAS. Social workers and medical people.

Senator MOSS. Dr. Knowles estimated that about 80 percent of all the nursing homes are proprietary. Is that your observation of that being about the right number percentage?

Mr. TOBIAS. I imagine it to be. I would say it is about correct.

Senator MOSS. Is it your opinion that the proprietary nursing home can provide adequate service to—I don't like to use the word "compete," but to remain in the field with the voluntary and charitable type of nursing home?

Mr. TOBIAS. No, I think the voluntary type of charitable home gets a lot more money than we do.

Senator MOSS. Well, then your answer would be that this is going to be progressively more difficult for the proprietor?

Mr. TOBIAS. Yes.

Senator MOSS. On that basis, has there been any retrenchment of your organization?

Mr. TOBIAS. No, the only thing that we have decided is that the smaller home will eventually go out of the picture and we have to start to build newer and larger facilities to make money.

Senator MOSS. In order to do it economically you need a larger facility?

Mr. TOBIAS. Yes. In other words, I would say about a 110-bed home is a nice size home to get the proper supervision. If it is too large a home there is a question about the supervision and the care. If you can keep it about 100 to 110 beds, you ought to be able to give good care and supervision and come out with a fair profit.

Senator MOSS. Your base of operation is Brookline; is that it?

Mr. TOBIAS. Well, I have a home in Brookline, and you are only allowed patients on two floors. This happens to be the old hospital so we took the third floor, and I have my general offices there. We handle the entire operation of all these homes from that office, and, in the meantime, we keep a closer supervision on the home below us instead of being in a strange place away from it.

Senator MOSS. Does Mr. Lawn actively engage in any of the administrative work, or does he leave that entirely to you?

Mr. TOBIAS. He leaves it all entirely to me, excepting we have a CPA firm that comes in out of New York that checks everything out and they sit with Mr. Lawn. I would say weekly or every second week, Mr. Lawn is in Boston. He comes in to see if there is any problem.

I am daily in touch with him on the phone every morning. Mr. Lawn and I have our discussions, any problems or just to say good morning and get going.

Senator MOSS. He lives in New York, I take it?

Mr. TOBIAS. I believe he lives in New Jersey, but he has an office in New York.

Senator MOSS. Senator Neuberger, do you want to ask any questions?

Senator NEUBERGER. I must say I am very sympathetic with your testimony about the costs. I, myself, don't see how you really can give adequate care with that small payment. [Applause.]

I have a 90-year-old mother and any nursing care home that I have been investigating for her was nearer $400 a month. She still does not have to go to one, but I am anticipating it is going to cost that much.

What I don't understand concerns the Kerr-Mills payment. Here the Federal Government matches the State of Massachusetts in its payment. Do you have patients who are beneficiaries of the Kerr-Mills program?

Mr. TOBIAS. I imagine as far as the welfare department is concerned, I could not answer you. We get paid from the welfare directly, and Social Security people.

Senator NEUBERGER. So the Welfare Department of the State of Massachusetts has saved money for the State by cutting down and keeping this low rate of payment even though the Federal Government is willing to pay more.

Mr. TOBIAS. Yes, from what I understand.

Senator NEUBERGER. If the Federal Government were not in the program, then they would have to pay twice as much?

Mr. TOBIAS. They would have to pay the whole thing.

Senator NEUBERGER. When Dr. Knowles was testifying there was a murmur and a clapping in the audience when he said something about getting along without the Federal Government. Evidently, there is the segment of this audience that feels that the State of Massachusetts can run its own welfare and nursing homes without any aid from the Federal Government.

Do you think that is possible?

Mr. TOBIAS. No.

Senator NEUBERGER. That is what I wondered. [Laughter.]

Let's ask you first about the occupancy. What percentage of occupancy do you have in your home?

Mr. TOBIAS. I would say 95 percent.

Senator NEUBERGER. With the implementation of the health care bill you probably are not going to have any want of occupancy or vacant beds because they will all be filled, don't you think?

Mr. TOBIAS. Well, you see, the reason we are having an occupancy problem is that the State is demanding certain higher standards and in their standards they want you to change the facility.

So when you change the facilities you are not enlarging the home, you have to eliminate so many beds. So this is where you have a little problem.

Senator NEUBERGER. What is the average length of stay of a patient in one of your nursing homes?

Mr. TOBIAS. You say average. I would say in a short term and a long term, I would say 2 years.

Senator NEUBERGER. Two years.

Mr. TOBIAS. I would say about 2 years.

Senator NEUBERGER. Under the social security provision they are not going to be paid that long because they don't get the benefits for that long a period. What do you do then to assure that you are going to get your money? Don't you have a problem when you get a patient in your home, then how do you get him out?

Mr. TOBIAS. Well, getting them out is another problem, but getting them in is a problem, too. When a patient comes into the home what we try to do, we find the kind of resources they have, whether they have a social security check. We get from the welfare $239, roughly, a month. Now when the patient comes into that home, the social worker will tell you we will have to find out ourselves that we get a social security check, we will say, of $75. The welfare pays the difference and then they give $15 spending money to that patient.

So when the patient gets a social security check they either turn it over to us and we issue them back a $15 spending money check or they will cash their social security check and give the $60 to us and the city pays the rest.

If it is a private patient, why, we go about it a little differently. It is up to the social worker that sends the patient to alert us of the fact of what type of care. Now, sometimes they have pending cases, they don't know whether they are going to pay or not. This is something that can be hurting at times.

Senator NEUBERGER. Well, if you have a patient who comes in voluntarily, not a welfare patient, how do you assure yourself that you are going to get the payment?

Mr. TOBIAS. We check with the family or the doctor who recommends, and so forth. We check the family—what kind of resources they have.

Senator NEUBERGER. What happens if they get in arrears?

Mr. TOBIAS. Well, we just have to have a good collection agency to see what we can do about getting it. Most people, if they have so much money, as it dwindles down, the social worker that visits the home lets us know before time and they put them on old-age assistance or medical assistance for the aged, and then we arrange it that way so we know what we are getting.

Senator NEUBERGER. After the patient has used up his stay under the new legislation, approximately, 100 days, and he still can't take care of himself, and if he has no family to provide for him, then is he automatically switched over to welfare?

Mr. TOBIAS. Automatically, if he is in there for 100 days, what I would instruct my help to do is to check it out with the social service department to find out where we are going to get these resources when the time is up.

Senator NEUBERGER. I will have just one more question and that concerns your operation as a corporation.

Now, the Catholic Church operates many voluntary homes. They provide a good and wonderful service. We had, I think, a monsignor testify before us in New York about their interests. Now does your corporation rent or lease land from the Catholic Church?

Mr. TOBIAS. No; the real property and fixtures from the church, they buy all these homes and we incorporate operations and lease it from them.

Senator NEUBERGER. In some places the church operates, you might say, a proprietory home and sometimes a voluntary home.

Mr. TOBIAS. I could not say what the church does. All I know, we pay rent to the Texas Diocese. About the voluntary homes, I don't know.

Senator NEUBERGER. Well, maybe they make money off of your operation to run a voluntary home.

Mr. TOBIAS. It could be, I would not know.

Senator NEUBERGER. That is all.

Senator MOSS. Do you have any present connection with the Geriatric Services, Inc.?

Mr. TOBIAS. This is the old company, Geriatric Services. It was a public company that sold the real property and fixtures to the Texas Diocese. This is something that would have to be answered by Mr. Lawn. We have prepared statements. We would be glad to see that you Senators got them, if you wished them.

Senator MOSS. I think we would like to inquire about that. Your understanding is that the Geriatric Services, Inc., sold the real property to the Texas Diocese and that the diocese then made an operating contract to Mr. Lawn?

Mr. TOBIAS. I would not even answer that because I work for the old companies; see, I come up through the ranks from the old companies. As far as this here, I believe that Mr. Lawn or their attorneys could answer this. If you want statements, I would be glad to get them to you. I will have them delivered to you.

Senator MOSS. Senator Muskie, do you have questions?

Senator MUSKIE. Yes.

You have 21 homes?

Mr. TOBIAS. Yes, sir.

Senator MUSKIE. What is the range of size?

Mr. TOBIAS. They run, well, I would say the average from 44 to 125 but the 125 now is below the 100 because we attempt to keep it around 110 when we complete renovations.

Senator MUSKIE. What is the mix of welfare patients and private patients?

Mr. TOBIAS. I would say that we run about 85 percent welfare; 15 percent private.

Senator MUSKIE. What rates do your private patients pay?

Mr. TOBIAS. Well, some private patients pay the same as the welfare and then they vary. In some of the newer facilities we have got they have private rooms and then they pay as much as $100, $125 a week for a private room.

Senator MUSKIE. How do you decide what a patient is going to pay? You say some of them pay what the welfare patients pay, $7.71.

Mr. TOBIAS. They would go into a little place like a wardroom.

Senator MUSKIE. It is the kind of facility that they get?

Mr. TOBIAS. That is right.

Senator MUSKIE. How many, if any, of your homes make a sure profit?

Mr. TOBIAS. I would say roughly—well, I could not answer that unless I gave you a statement and it will show you exactly on the statement. If you like it, I will have a statement delivered to you.

Senator MUSKIE. Our information was that 19 of your homes showed a profit. Would that be accurate?

Mr. TOBIAS. No, sir; because I filed appeals with the court to show that they are not.

Senator MUSKIE. So that your impression is that most of your homes are not showing a profit?

Mr. TOBIAS. I would say at least half of them are not showing a profit.

Senator MUSKIE. Why is there a difference?

Mr. TOBIAS. Because they don't have the facilities to accommodate private patients.

Senator MUSKIE. The private patients make the difference?

Mr. TOBIAS. And the standards of care that they have increased us on.

Senator MUSKIE. You said earlier in your testimony that you thought that an economic unit ought to be about 110 patients.

Mr. TOBIAS. Yes, sir.

Senator MUSKIE. You would propose to enlarge those of your nursing homes that are below that standard to come up to that standard?

Mr. TOBIAS. No. We intend to close some of the smaller homes, 44-, 50-, 60-bed homes, and build new ones.

Senator MUSKIE. Now on this $7.71, that is the payment made by the welfare department; is it?

Mr. TOBIAS. Yes, sir.

Senator MUSKIE. Does the patient make any contribution in addition to that?

Mr. TOBIAS. No, sir. I believe the old companies did have those kind of deals set up but when we took over it was all stopped.

Senator MUSKIE. Are some of these welfare patients receiving social security, for example?

Mr. TOBIAS. Oh, yes.

Senator MUSKIE. But they make no contribution to their care?

Mr. TOBIAS. When they get social security they have to turn that over to us. That is part of what the welfare will pay.

Senator MUSKIE. That is part of the $7.71?

Mr. TOBIAS. Yes.

Senator MUSKIE. What percentage of your welfare patients make some contribution of that kind to the $7.71?

Mr. TOBIAS. What percentage? They would have to turn in their social security and their pension checks and so forth. A lot of them are on private pensions that they have to turn to. I would say around 40 percent.

Senator MUSKIE. So in effect, what the welfare department does is set the price to be paid either by the State or in a combination of State payments and these contributions from the patients?

Mr. TOBIAS. Right, but this is resources as they call it. This is part of the money that has got to be paid.

Senator MUSKIE. I understand. I was just interested in where it came from. Some of it comes from the patient, some of it from the State.

Mr. TOBIAS. Right. Some of it comes from their retirement plans and everything else, and the welfare department pays the balance.

Senator MUSKIE. Let me ask you this: You emphasize on the first two pages of your testimony that the hard fact of life is that the basic cause of nursing home problems is the failure of the welfare department to provide sufficient funds for decent care for welfare patients.

Now, why is it that some of these homes are doing a good job and some of them a very bad job, if that is the case?

Mr. TOBIAS. Well, a lot of these homes—the standards have to be raised considerably and the welfare is not raising the funds at the same time.

Senator MUSKIE. No, this payment of $7.71 is made to patients of all nursing homes; is that right?

Mr. TOBIAS. Yes.

Senator MUSKIE. So if all nursing homes are getting the same rate——

Mr. TOBIAS. $7.71.

Senator MUSKIE. Why are some performing so well and some of them so badly? In Dr. Knowles' opinion, they should not be operated at all.

Mr. TOBIAS. It is because they have private patients that are offsetting the $7.71. That means they have an added income that absorbs it.

Senator MUSKIE. Based on your experience then, in order to make a profit or maintain decent standards with the present welfare rate should nursing homes have 15 percent of their patients who are private paying?

Mr. TOBIAS. I would not say 50.

Senator MUSKIE. Fifteen.

Mr. TOBIAS. They would have to have just a little more than that. If they had 15 or better.

Senator MUSKIE. What should the percentage be?

Mr. TOBIAS. I think the percentage should be about 25 percent private.

Senator MUSKIE. So if a nursing home had 15 to 25 percent private patients, what rates would those patients have to be paying in order to give the proprietors a profit?

Mr. TOBIAS. Well, see, a lot of them pay $12 a day, $11 a day, $10 a day.

Senator MUSKIE. So that 15 to 25 percent of your patients were paying $11 or $12 a day, then the nursing homes would make a profit on the present $7.71 daily rate?

Mr. TOBIAS. I would say on our operation. I would not speak for the rest of the operation.

Senator MUSKIE. I understand.

Mr. TOBIAS. I believe Mr. Connelly has the figures for the Federation of Nursing Homes.

Senator MUSKIE. I understand.

Thank you, Mr. TOBIAS.

Senator MOSS. Senator Kennedy.

Senator KENNEDY. Mr. Tobias, you are in effect the administrator for the company, is that correct?

Mr. TOBIAS. Yes, sir.

Senator KENNEDY. How many patients are under your administration?

Mr. TOBIAS. 1,300.

Senator KENNEDY. 1,300. How many registered nurses would you say would be under your administration?

Mr. TOBIAS. Roughly, I would say about 78-odd.

Senator KENNEDY. Seventy-odd.

Mr. TOBIAS. Registered.

Senator KENNEDY. Seventy-odd registered nurses.

Mr. TOBIAS. Yes.

Senator KENNEDY. How many licensed practical nurses?

Mr. TOBIAS. I would say over 100.

Senator KENNEDY. Over a hundred.

Mr. TOBIAS. Over a hundred. These are not sure statistics but if you want the exact payroll records I will be glad to break it down and give it to you, Senator.

Senator KENNEDY. Then you have a number of maintenance people and you make that help take care of the various patients?

Mr. TOBIAS. Yes.

Senator KENNEDY. Besides the licensed practical nurses and the nurses, how many other skilled technical people do you employ and what is their nature?

Mr. TOBIAS. Well, we have the practical nurses or the nurses' aids that make up the balance of the employees, plus we have maintenance people in every home, plus we have cooks in every home, plus we have the dishwashers.

Senator KENNEDY. Now do you have any nutritionists?

Mr. TOBIAS. The State usually sets up the diets, they come around.

Senator KENNEDY. Wait a minute now. The State comes around. How often has the State visited your homes? How many times?

Mr. TOBIAS. Twenty-one.

Senator KENNEDY. Pardon?

Mr. TOBIAS. Twenty-one.

Senator KENNEDY. Now, how many visits have you had by the State in each of those homes over the past 2 years?

Mr. TOBIAS. I would say, oh, two dozen.

Senator KENNEDY. Now you have had 24 visits per home?

Mr. TOBIAS. Not a home; no, sir.

Senator KENNEDY. Now what is two dozen?

Mr. TOBIAS. When I say this is around the whole operation they might come in for 3 months, maybe monthly.

Senator KENNEDY. Specifically, you have 21 homes. How many times has each one of those homes been visited this past year?

Mr. TOBIAS. On nutrition?

Senator KENNEDY. I am talking of inspections.

Mr. TOBIAS. Inspections?

Senator KENNEDY. Yes.

Mr. TOBIAS. At least every 30 days or less from the department of public health I have had visits from the inspectors.

Senator KENNEDY. Am I to assume from your response that every 30 days there is an official of the State of Massachusetts who has visited each one of those homes?

Mr. TOBIAS. Either that, or more.

Senator KENNEDY. And during this period of time, do any of these State officials have responsibility to decide what the patients in those homes are going to eat?

Mr. TOBIAS. When the State official comes, usually they bring the nutritionist and dietitian with them.

Senator KENNEDY. Do you provide the service for the people that are in your home or do you depend on the State to do that?

Mr. TOBIAS. No; we do it. They give us a menu setup and we try to follow it through.

Senator KENNEDY. Now, then, who goes over the State recommendations in order to establish the various meal schedules in your organization?

Mr. TOBIAS. The registered nurses.

Senator KENNEDY. That is, specifically, you don't have anyone? Am I to assume that you don't have anyone?

Mr. TOBIAS. I don't have a dietitian.

Senator KENNEDY. You do not have a dietitian?

Mr. TOBIAS. No, sir.

Senator KENNEDY. In any of your homes or in your organization?

Mr. TOBIAS. No, sir; I do not.

Senator KENNEDY. You depend completely upon the State for that service; is that correct?

Mr. TOBIAS. Right.

Senator KENNEDY. Do you have terminal facilities for any of your patients in the form of rooms in these various homes?

Mr. TOBIAS. Some homes don't have them.

Senator KENNEDY. Now let's go over this. What homes do have them of your 21?

Mr. TOBIAS. Of the larger homes——

Senator KENNEDY. Specifically now, Mr. Tobias, how many homes? I understand you are the administrator and have had this experience. Maybe we ought to go back to that.

What is your educational background in the field of administration, your formal educational background, which you think would be helpful in giving you a background in nursing home administration?

Mr. TOBIAS. I just graduated high school and went to an institute to study electricity and I went to the building trades and I started building. I come into the picture from Rhode Island.

Senator KENNEDY. Now wait. In what capacity were you employed in Rhode Island?

Mr. TOBIAS. I worked for the fellow named Al Auburn and we built the nursing home.

Senator KENNEDY. In what capacity did you work with him?

Mr. TOBIAS. I was a partner and we were building it together.

Senator KENNEDY. I mean what was your responsibility as administrator?

Mr. TOBIAS. I was the general manager of the construction company and then when these people from Boston bought the nursing home, I opened it for them as the administrator and I ran it until they asked me to come back to Boston here to see if I could get some of the other homes squared away.

Senator KENNEDY. In what capacity were you hired by Geriatric Services?

Mr. TOBIAS. I was hired by them to supervise the maintenance and the remodeling of all their homes.

Senator KENNEDY. You were supervisor then, primarily, as a maintenance employee, is that correct?

Mr. TOBIAS. No, I would not say as a maintenance employee, maintenance director. That is the title they gave me.

Senator KENNEDY. You were hired in the capacity of maintenance supervisor?

Mr. TOBIAS. Right; yes, sir.

Senator KENNEDY. Now as a maintenance supervisor, have you had any background in the field of nursing or nursing care, or professional nursing, or public health, or nutrition?

Mr. TOBIAS. Not at that time.

Senator KENNEDY. When did you get this?

Mr. TOBIAS. When I came into the picture——

Senator KENNEDY. Now let's be somewhat more specific.

Mr. TOBIAS. In 1960, when I came into the picture——

Senator KENNEDY. In 1960, you came into the nursing homes picture?

Mr. TOBIAS. Yes.

Senator KENNEDY. Prior to 1960, you did not have any, either formal training or other background, or experience dealing with the care of senior citizens; is that correct?

Mr. TOBIAS. That is right, sir.

Senator KENNEDY. So whatever experience you gathered has been since 1960, and today in the State of Massachusetts you have, as I understand it, the prime administrative responsibility for 1,300 patients, 21 nursing homes; is that correct?

Mr. TOBIAS. Yes, sir.

Senator KENNEDY. Now were you at any time required to put down in any statement or file a form here in the State of Massachusetts on your background in administration?

Mr. TOBIAS. No, sir.

Senator KENNEDY. You have achieved this position, therefore, without any kind of passing on, so to speak, or any kind of approval or licensing by the State of Massachusetts?

Mr. TOBIAS. Except that I have been with Dr. Levey and Dr. Rubenstein.

Senator KENNEDY. What do you mean "have been with Dr. Levey"?

Mr. TOBIAS. They know I have been running the homes and I have been satisfactory to them in the operation of these homes.

Senator KENNEDY. You, by your own statement, said you did not have to fill out any form as to your background.

Mr. TOBIAS. I never did, sir.

Senator KENNEDY. I would imagine that the prime consideration to you has been your own background and experience and credibility as an individual since it does not appear to me that you have a great deal of standing as far as an administrator in the nursing care of senior citizens.

Mr. TOBIAS. It is not what I am thinking; it is what everybody else thinks that I am capable of doing.

Senator KENNEDY. Who is everybody else? Would that be Mr. Lawn?

Mr. TOBIAS. No. The department of public health, Dr. Levey, all the inspectors.

Senator KENNEDY. Have you ever been convicted of a crime, Mr. Tobias?

Mr. TOBIAS. I had domestic problems. I think this should be discussed in——

Senator KENNEDY. Have you ever been convicted of larceny?

Mr. TOBIAS. Not that I know of.

Senator KENNEDY. Well, in 1949, June 23 of 1949, were you tried and convicted of three counts of larceny?

Mr. TOBIAS. Not that I know of. Not that I remember.

Senator KENNEDY. On August 2, 1949, were you tried and convicted of two counts of larceny?

Mr. TOBIAS. Not that I know of.

Senator KENNEDY. Were you ever convicted in the South Boston court of larceny by means of false pretenses claimed by a Thomas T. Henry?

Mr. TOBIAS. I don't recall. I don't recall.

Senator KENNEDY. Did you ever use another name?

Mr. TOBIAS. Saul Tobias.

Senator KENNEDY. Have you ever used another name, an alias?

Mr. TOBIAS. No, sir. They used to call me Mac McCarty because of being Jewish.

Senator KENNEDY. Have you ever been arrested or otherwise detained by the police authorities at any time within the past 12 months?

Mr. TOBIAS. Yes, about domestic problems, and it was cleared up.

Senator KENNEDY. What was the disposition?

Mr. TOBIAS. The case was dismissed.

Senator KENNEDY. Why was it dismissed?

Mr. TOBIAS. Because it was a domestic problem, it was straightened out.

Senator KENNEDY. Have you ever had any trouble with the welfare department?

Mr. TOBIAS. That was who I straightened it out with.

Senator KENNEDY. Well, could you elaborate to a greater extent? What was the problem and how was it straightened out?

Mr. TOBIAS. It was a domestic problem, my first wife.

Senator KENNEDY. Did Mr. Lawn help on that particular case?

Mr. TOBIAS. No, sir; nobody helped me. I went to the welfare department myself and squared it away.

Senator KENNEDY. Could you tell me how often Mr. Lawn visits these 22 homes?

Mr. TOBIAS. Mr. Lawn visits them weekly or every second week, and we speak every morning.

Senator KENNEDY. In your 22 homes, have you had any complaints as to treatment or health or overcrowding or lack of good facilities?

Mr. TOBIAS. Lack of good facilities, I would say "Yes."

Senator KENNEDY. Have you ever had any complaints about the food itself?

Mr. TOBIAS. No, sir; because I supply the best.

Senator KENNEDY. Have you ever had any complaints about poor nursing care in any of your 22 facilities?

Mr. TOBIAS. Not from the State.

Senator KENNEDY. From any individuals?

Mr. TOBIAS. Individuals, you always get complaints.

Senator KENNEDY. Not always. Well, what was the nature of these complaints?

Mr. TOBIAS. Well, a lot of these people like to come in and take the $15 spending money and they don't want to buy clothes. The nurses will call me and tell me that they don't feel this person should get it, so I tell them to call the social worker and the social worker will tell them to give it or not to give it.

Senator KENNEDY. As far as the $15 payments are concerned, you have some say as to whether an individual will get it or not?

Mr. TOBIAS. I don't mix in with it, I leave that up to the registered nurses and the administrator or supervisor of every home. When the patient's family comes in and gives them a real problem they might call me and I will advise them to the best of my ability not to have them contact the social worker.

Senator KENNEDY. Then you have overall control as to whether these people are going to get the $15 or not, don't you, Mr. Tobias?

Mr. TOBIAS. I don't have the overall say.

Senator KENNEDY. You have the authority.

Mr. TOBIAS. What they do in the home.

Senator KENNEDY. You issue the check, don't you?

Mr. TOBIAS. The company does.

Senator KENNEDY. Well, the company does it, but you, as the prime administrator, issue that check for $15 and decide whether they are going to get it.

Mr. TOBIAS. Right.

Senator KENNEDY. So you really do have prime responsibility for that, don't you?

Mr. TOBIAS. Yes, sir.

Senator KENNEDY. And ultimately, it is going to be up to you whether those $15 checks are going to be paid and who they are going to be paid to?

Mr. TOBIAS. No. These social security checks come in, the girl records them, sends them out to the home the way they are supposed to be, and the social workers check it out to see that they all get them.

Senator KENNEDY. Now have you ever had a complaint that these $15 checks had not been issued and had been withheld?

Mr. TOBIAS. Not that we have. We don't get any complaints of that. That is why we issue the check, is to keep our record so that we can show that we have given them. When it gets to a home, if a problem arises there and they acquaint you with it, we try to help straighten it out.

Senator KENNEDY. Have you ever had a complaint raised in a home about the failure to pay that money?

Mr. TOBIAS. No, sir; never a complaint.

Senator KENNEDY. Then why did you mention that if there is a complaint that you investigate it? Have you had such complaints?

Mr. TOBIAS. Not that we didn't refuse to give it to them, that we refused to give it to somebody in the family that is drunk or drinks and comes in once a month and wants to take that $15.

Senator KENNEDY. And you have never had any complaint as to those that appear to have a bona fide claim for that $15?

Mr. TOBIAS. I had one particular case here a few months ago.

Senator KENNEDY. What was the nature of that case?

Mr. TOBIAS. The secretary in that home told the gentleman that came in that his mother needed some clothing and that she didn't think he should take it because he is not bringing her in any underclothing.

The man came up to me and said, "Tell her to give me the check." I just told the woman to contact Miss Goldberg, the social worker, and "let her tell you what to do, don't put me in the middle of this."

Senator KENNEDY. What was the final disposition of that case?

Mr. TOBIAS. The man took his mother out of the home and took her elsewhere. When she left, all the spending moneys went with her.

Senator KENNEDY. Do you have any material here today that would indicate that when registered nurses or licensed practical nurses or maintenance people come and work for your company, Corporate Operations gives them job descriptions of what they are supposed to do?

Mr. TOBIAS. I don't have it with me but we have job descriptions. We have them printed for all, even the nurses aids. We just had them all printed up here about a month ago.

Senator MOSS. Thank you, Mr. Tobias.

Do you have a regular hiring system, a way of selecting your people?

Mr. TOBIAS. We had connections with the Peter Bent Brigham Hospital training program, the nurses aids, and we have contracted Boston College, BU, to hire these RN's, and we pay them the highest dollar for registered or licensed nurses in the State. We pay top dollar.

Senator MOSS. Have you ever been involved in an accusation of giving a bribe to any of the welfare people for assigning of patients?

Mr. TOBIAS. No, sir.

Senator MOSS. Well, thank you, Mr. Tobias. You have answered our questions.

Mr. Constantine has a question.

Mr. CONSTANTINE. We just want to clarify two things here. You say you have never paid any money to a public employee to refer a patient to your home?

Mr. TOBIAS. That is right.

Mr. CONSTANTINE. Have you ever paid any money to insurance adjusters who were examining losses in your homes?

Mr. TOBIAS. No, sir.

Mr. CONSTANTINE. Does Corporate Operations borrow money on its receivables?

Mr. TOBIAS. I don't know. I don't think that I should have to discuss this in front of my competition or competitors but I will give you the statement.

As I said to you, I will be glad to give you a statement for the audits prepared and everything is on it.

Mr. CONSTANTINE. Let's do it this way so that you are not revealing anything to your competition.

In connection with the securing of a loan on your receivables, do you at any time during the past year know of any falsification of records in connection with borrowing on receivables from the Armstrong Co. in New York?

Mr. TOBIAS. No, sir; nothing whatsoever as far as our records are open to anybody's examination.

Senator Moss. Thank you, Mr. Tobias.

Now I call Dr. Samuel Levey, Department of Public Health, State of Massachusetts, administrator of the nursing homes and related facilities branch.

We are pleased to have you, Dr. Levey.

STATEMENT OF SAMUEL LEVEY, ADMINISTRATOR, NURSING HOMES AND RELATED FACILITIES, DEPARTMENT OF PUBLIC HEALTH, COMMONWEALTH OF MASSACHUSETTS

Dr. Levey. Thank you.

Senator Moss, members of the committee, I am privileged to be here today as a representative of the department of public health where my capacity is administrator of nursing homes and related facilities. I would like to point out that a large number of the problems that we are confronted with are due to lack of definitions. Another category of problems is due to the lack of understanding by professionals of differences between classes of medical care facilities. There are numerous other problems that we are confronted with in the licensing unit but initially I would like to get into the history of nursing homes in Massachusetts and then go on to some of the problems that we have encountered during the past 2 years.

In 1948, the Massachusetts hospital licensing law was amended to include nursing homes and rest homes or boarding homes for the aged. Licensure of city and town infirmaries was added in 1953. Originally, responsibility for the licensing and regulation of nursing homes rested with the department of public welfare. In 1948 it was recognized that public welfare departments were not organized to take care of public health facilities and accordingly a transfer was initiated to the department of public health.

During 1962 and 1963 there was an investigation of the nursing homes with several reports by the Senate commission which was referred to earlier. Senator John Powers served as chairman of that commission. On October 9, 1963, responsibility for the nursing home program was transferred to the division of adult health then the division of chronic disease. I assumed responsibility for the nursing home section at that time. The staff of the unit consisted of myself, seven inspectors, and three clerical persons. One or two secretaries were added to that complement.

Since that time we have made some progress in augmenting our staff. We now have 14 inspectors. We have an educational coordinator whose position is financed by the Public Health Service. We have a survey administrator who is largely devoted to classification of facilities and various clerical and supportive personnel. In addition, we secured the services of a consulting architect to assist us in reviewing plans for construction and in appraising the types ond quality of construction plans that are submitted to us for necessary approval.

We have approximately 727 facilities—this is the number as of June 8 of this year—with about 29,000 beds.

At this time we have pending a supplementary budget request for 17 additional staff, the majority of whom will be inspectors. The reason for this addition is that it will not be possible to meet all the requirements of the statutes under existing conditions. If the nursing

home section is to operate at a level at which statutory requirements can be realistically met and the public interest safeguarded added support must be secured.

A primary catalyst for this request for new positions was the 1964 amendment to the general laws which requires annual rather than biennial renewal of nursing homes licenses, demanding more frequent inspection of facilities. Very recently the department of public health assumed the responsibility for outlining the criteria for a classification system. Classification as a refinement of accreditation can be used both for better placement of patients and to relate nursing home rates or charges to the type of facility and kinds of patients that the nursing home can accommodate.

Nursing care is the primary criterion in the classification system, with quantity and quality of nursing care comprising about one-half the maximum points. Other criteria include administration, diet therapy, recreation therapy, physical therapy, physical facility, functional design, and safety.

To a significant degree classification can be termed the evaluation of the quality and quantity of nursing care provided in the facility. The nursing home quality of care in the nursing home depends to a large degree on the direction of services by trained personnel wno must be present in the facility if the job is going to be accomplished adequately. It also depends on the range of services provided which are in turn dependent upon the physical plant. The lack of trained supervisors in many facilities and the dearth of manpower in this area creates a difficult objective in the upgrading of the quality of patient care across the board.

One of the problem areas which the department fully recognizes is that it will continue to be confronted with facilities which do not meet minimum standards and which will require constant surveillance and considerable expenditures of effort until their licenses are revoked or their problems resolved.

In fiscal year 1965, 21 nursing homes and 37 rest homes were closed for a variety of reasons. Three of the nursing homes were closed by direct action of the department which implies the commission and the public health council, and Dr. Knowles earlier referred to the public health council of which he is a member. Of those facilities closed by direct action of the department, the majority lacked acceptable standards of patient care or physical plant and, in most cases, were having special financial difficulties of some kind or another.

A good deal of our progress has been made because of the recommendations of the special commission, and in my report I cited many of the suggestions of the commission which we have complied with to some degree or another. I don't feel that we have the time to get into all of these progress notes but it is true that the patient has been the most important focus of the past year.

An important piece of recent legislation requires that all proposed nursing homes in Massachusetts must be built specifically for this purpose and must be of at least type 1 or type 2 construction. This is a fireproofing requirement, and I believe it indicates significant progress in an area that most States are so far behind in.

I have been working on a questionnaire which was sent out to each State in the Union in preparation for a conference which is forthcoming. I would like to point out at this stage that in comparison

with other States even in the personnel area full of regulation and inspection that we are ahead of a large number of the other States. I would say that in terms of control and standards we are, too, above average.

I have some information which is at the present time being compiled with that will show that in some States regulation and inspection of facilities occurs only once per year and in some States it goes as high as six times a year. I fully believe that at the present time in order to keep standards enforced, four to six visits per year are necessary.

As I have indicated, in spite of many advances in terms of construction and in terms of the classification system we have achieved some progress but numerous problems remain to be solved. As in 1948, manpower needs continue to be of vital concern to us and to the owners and administrators of nursing homes. We found in a recent survey that recruitment of adequate professional and nonprofessional personnel was one of the primary problem areas which is recognized by the industry itself. The difficulties of attracting and retaining superior personnel due to the inability to meet wage demands were frequently indicated by owners.

Another problem still exists in the construction of new facilities. This is in the area where many of us only had a very limited or restricted awareness. Just because the facility is new does not mean that the facility is geared to high levels of care. There is marked inconsistency in the quality of plans submitted to the department for new construction and additions. A number of the architects performing in this area seem primarily interested in conserving capital outlays for their clients, and demonstrate little or no knowledge of the psychosocial and physical needs of the nursing home patient.

To a large degree the criticism of institutionalization in the large modern facility is warranted. Many of our patients, I am sure, react to this institutionalization by withdrawal and sometimes exhibit destructive tendencies. This is the only way in which they can get rid of some of their hostilities in the environment in which they frequently find themselves. Bricks and mortar, beds, and personnel certainly do not make a nursing home a home in the usual sense of the word, and it may well be that a home environment is not suitable for the provision of skilled nursing services.

I have indicated the basic problem of construction and the fact that many new facilities that are seen today exhibit to me and to some of our consultants a limited degree of patient orientation. We need studies in the area of zoning, in the area of site analysis, in the area of control, and in the area of psychological sequences of space.

We need to know what qualities in a specific community make it livable for the elderly person. We do not know very much about that. We should find out whether elderly persons should be dispersed or concentrated, and if so, should they be homogeneously concentrated or not. What kind of facilities actually are needed to care for the diverse backgrounds and needs of all these patients and in what ways are elderly persons different from each other? The sociologists have to a considerable extent agreed that the fact that the elderly person withdraws from society is an inevitable process. This is one of the areas where we must be concerned.

47-467—65—pt. 6——4

The quantity of nursing home beds and the utilization of existing beds is of vital concern to us. Perhaps you have seen the recent article in the Wall Street Journal that there is at the present time an oversupply of beds in this country. Nobody is really too knowledgeable in this area, and I don't think that anyone can state with certainty that there is an oversupply of beds. During the past year we have conducted a statewide study to determine patient origin, utilization of facilities by residents and nonresidents and so forth. The objective is to develop scheduled concentrations of beds and facilities in order to meet the needs of our forthcoming increase in elderly population.

Planning for the future of nursing homes and related facilities consumes a very significant proportion of our resources. One of the areas which we feel should be the primary watchword is that of education. Our ultimate objective, of course, is to raise standards in these facilities, and we are doing everything that we can to promote educational programs in order to train nurses aids and to remedy the manpower situation.

A good deal has been said about joining the nursing home to the mainstream of medical care. The only way to accomplish this is to assist in the upgrading of an industry where industry must be the prime mover. Sometimes too much is expected of the department of public health as the regulatory agency and sometimes too much is expected by the health agency of the industry. What we need is cooperation, and I would like to continue to emphasize that education is the primary watchword.

Dr. Knowles alluded to some problem areas that we have. In fact, my own problem is the regulatory agency, which is mostly an administrative problem. If we had enough resources and did not operate with limited resources, I am sure that many of our problems could be solved. Unfortunately, we are operating with very limited resources, and this can be said for the industry as a whole.

If you look into the backgrounds of nursing home administrators—and we have just been working on a study in this area—you will find that a large number of them have not graduated from high school and a fair segment has not stepped inside the doors of a college. This is an area where the industry needs to do something about itself. If they are going to upgrade the quality of care provided, they must upgrade the quality of administration.

One way in which to upgrade nursing home administration is to provide university training across the country such as was undertaken in the hospital area, when the graduate programs in hospital administration were established, of which I am a product. This kind of education is vitally necessary in universities across the country in order to train persons who will meet the needs of new medical care facilities.

In contrast to the hospital which has a centuries' long history it would seem that the nursing home in the United States is relatively new and it dates back only to the depression years. Nursing homes grew out of boarding homes as the patients grew older. Growth of the industry itself has been exceptionally rapid. To a large extent the growth of the entrepreneur operation in this country and also much of the expansion is due to the increased publicity in the speculative aspects of the nursing homes which was prevalent in our media during the last several years.

A good deal of the material that has been written about the industry is quite erroneous although I am sure that in this State, as in others,

there are people that are realizing reasonable profits out of their facilities. One of the reasons for the larger facility of today is that the smaller facility is uneconomical.

The facility that Dr. Knowles mentioned earlier will have a transfer agreement with the Massachusetts General and will be 300 beds with a potential 600 beds.

We have seen that through the evolution of society there has been a greater proliferation of external control in all forms of organizations. What is going to happen is that the nursing home, through the concepts and philosophy of social responsibility and the public interest, will have a more expanded series of controls placed upon them. Again we need to look at the nursing home as a quasi-public utility with reasonable rates of return promulgated and perhaps a Federal or State commission in order to regulate the rates that are promulgated.

In a large measure the problems that we are faced with in terms of poor facilities is that the situation that developed in nursing homes was due to a lack of external controls and not due to the personal errors of individuals, organizations, governmental agencies, or legislative bodies. The problem is one that was brought about because society to a large degree has neglected the elderly and continues to do so. The quality of nursing homes reflects an attitude of society toward the aged and infirm. However, recognition of problems in the health care of the aged and the inauguration of new programs indicates that an altered environment which will hopefully lead to substantial progress has already manifested itself.

With the current emphasis on nursing home care, the alternatives to such care are often forgotten or relegated to secondary status, but these alternatives are being carefully studied by the department; for example, foster-home placements, homemaker and visiting nurse services, day-care services, and others. Much pioneering is yet to be accomplished in this area expecially in the reconciliation of administrative and medical alternatives.

It is frequently remarked that the hospital is a multifaceted enterprise. The modern nursing home is much the same type of organization, and the day in which it could function almost in isolation is rapidly disappearing. As indicated earlier, one of the difficulties in appraising the status of today's nursing home is that its role in the medical care system is not clearly defined. In order to remedy this condition, knowledge in related fields must be heavily drawn upon.

I will conclude at this point and leave it to the Senators to ask questions.

Senator Moss. Thank you, Dr. Levey, for a very excellent statement, a good paper that you have prepared.

There are some parts I think which you have skipped over in the interest of time; so the full statement will appear in the record, together with the comments that you have made.

(Statement referred to follows:)

Prepared Statement by Samuel Levey, Ph. D., Administrator, Nursing Homes and Related Facilities

In 1948 the Massachusetts hospital licensing law was amended to include nursing homes and rest homes or boarding homes for the aged. Licensure of city and town infirmaries was added in 1953. Originally, responsibility for the licensing and regulation of nursing homes rested with the department of public

welfare, but in 1948 this responsibility was transferred to the Division of Hospital Facilities of the Massachusetts Department of Public Health. At that time it was evident that although there were a number of good facilities, many were substandard, and among the more obvious problems were shortages of personnel, poor sanitation and physical plant, inadequate medical supervision, nursing care, nutrition, and equipment.

On October 9, 1963, responsibility for the nursing homes program was transferred to the division of adult health. The staff of the nursing home section consisted of only an administrator, seven inspectors, and three clerical persons, responsible for the regulation of approximately 1,200 facilities throughout the State. Today the nursing home section is staffed by the administrator, 14 inspectors, an educational coordinator whose position is financed by the U.S. Public Health Service, a survey administrator, and various clerical and supportive personnel. In addition, the section has secured the services of an architect on a consulting basis, and has available a number of professional advisers within the division of adult health. In spite of this augmented staff, however, the nursing home section is unable to fulfill its responsibilities at an optimum level because of the size and complexities of the nursing home industry in Massachusetts. The following tables indicate the scope of the responsibility of the nursing home section:

TABLE I.—*Facilities and bed capacities as of June 8, 1965*

Type of facility	Total number facilities	Total number beds
Nursing homes	727	28,617
Rest homes	410	7,189
Public medical institutions	2	782
City or town infirmaries	6	173
Infirmaries with PMI beds	16	1,177

TABLE II.—*Summary of nursing and rest home facilities by county as of June 8, 1965*

County	Nursing homes			Rest homes			Percent population 65 years [1]
	Total number of homes	Total number of beds	Beds per 1,000 population [1]	Total number of homes	Total number of beds	Beds per 1,000 population [1]	
Barnstable	11	468	6.6	13	155	2.2	12.7
Berkshire	24	830	5.8	12	214	1.5	11.3
Bristol	49	2,368	5.9	31	385	1.0	11.6
Dukes	1	28	0.5	1	13	0.2	17.4
Essex	83	3,065	5.4	77	1,055	1.8	12.1
Franklin	10	322	5.9	10	137	2.5	13.3
Hampden	30	1,460	3.4	30	668	1.6	10.5
Hampshire	12	342	3.3	7	116	1.1	10.6
Middlesex	180	5,924	4.8	71	1,312	1.0	10.1
Nantucket	0	0		1	8	2.2	14.8
Norfolk	82	2,911	5.7	20	338	0.7	9.8
Plymouth	49	1,814	7.3	37	561	2.2	11.3
Suffolk	106	5,650	7.1	34	1,027	1.3	12.1
Worcester	90	3,435	5.9	66	1,200	2.0	11.6
Grand total	727	28,617		410	7,189		11.1

[1] Based on 1960 U.S. Census figures.

At the present time, the section has pending a supplementary budget request for 17 additional staff, the majority of whom will be inspectors if the request is approved by the legislature. Such support is imperative if the nursing home section is to operate at a level at which statutory requirements can be realistically met and the public interest safeguarded. A primary catalyst for this request for new positions was the 1964 amendment to the general laws which requires annual rather than biennial renewal of nursing homes licenses, demanding more frequent inspection of facilities. Another force is the pending implementation of a comprehensive classification system (see appendix) through which public assistance rates for nursing home patients can be directly correlated with the standards of care and physical plant provided by the nursing home.

During the past year, the board of rate setting for convalescent or nursing homes and rest homes delegated to the nursing home section the responsibility for classifying nursing homes in the Commonwealth. Classification as a refinement of accreditation can be used both for better placement of patients and to relate nursing home rates or charges to the type of facility and kinds of patients that the nursing home can accommodate.

The system being used is geared toward individual needs of patients and their care and comprises a number of criteria which are beyond minimum requirements for nursing home licensure.

Nursing care is the primary criterion in the classification system, with quantity and quality of nursing care comprising about one-half the maximum points. Other criteria include administration, diet therapy, recreation therapy, physical therapy, physical facility, functional design, and safety.

A pilot study to pretest the classification document was started late in April and the final draft of the document was mailed to all nursing homes on June 1. Classification by teams of nursing home inspectors began on June 11 and will progress as rapidly as possible until completed.

The department fully recognizes that it will continue to be confronted with facilities which do not meet minimum standards and which will require constant surveillance and considerable expenditures of effort until their licenses are revoked or problems resolved.

In fiscal year 1965, 21 nursing homes and 37 rest homes were closed for a variety of reasons. Three of the nursing homes were closed by direct action of the department, and the 37 rest homes include 3 which combined into 1 without any change in the number of beds. Of those facilities already closed by direct action of the department, the majority lacked acceptable standards of patient care or physical plant and, in most cases, were having special financial difficulties. The majority of facilities which closed voluntarily did so because of inability to meet minimum licensure requirements.

It should be emphasized that a substantial measure of the activities of the nursing home section are guided by the reports and recommendations of the special commission to study convalescent or nursing homes, created by chapter 138, Resolves of 1962 of the Massachusetts Legislature. It may be worth while to examine some of the recommendations of the commission. The following are excerpts [1] and include recommendations which have been partially or fully implemented since October 1963:

"The commission therefore recommends that the commissioner of public health establish in detail, and if necessary in such form that may be enacted as legislation, a classification and grading system for nursing or convalescent homes and to specify thereunder minimum standards for definition, classification, and grade" (p. 29).

"The commission favors and recommends the establishment by the commissioner of a grading system, according to the level of nursing care, with an increase in the public assistance rate to fit the category or grade of care" (p. 30).

"A merit and demerit system, or point system, related to grading, has been suggested. If it would help, we favor it" (p. 31).

"The commission therefore recommends that G.L. c. 111, ss. 71–73 be amended to provide for annual licenses of nursing homes" (p. 36).

"We recommend that the general court by appropriate legislative action prescribe such procedures as will require applicants for a license to operate a nursing or convalescent home, to furnish any agency properly entitled thereto with all the information necessary to enable the agency to make a clear finding as to ownership of the home and all the financial implications involved. The agency should be empowered to demand the most detailed financial statements and personal histories" (p. 38).

"All buildings used for nursing home purposes shall be of type I, fireproof construction and shall be of incombustible materials in all structural parts" (p. 43).

"All presently existing nursing homes requiring major repairs, alterations, or additions thereto, shall make the same in accordance with the fireproof regulations recommended above dealing with new nursing homes and they shall not be performed without the prior approval of the qualified person referred to in paragraph three above" (p. 44).

"The commission therefore feels and recommends that it would be in the best interest of the patients if the following were made mandatory.

"1. Current regulations relating to posting of menus be strictly enforced.

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[1] Senate No. 970, the Commonwealth of Massachusetts, second interim report, special commission to study convalescent or nursing homes, July 31, 1963.

"3. A State master plan of food service management be published as a guide" (p. 51).

"The commission recommends that the commissioner weigh a requirement that present facilities which are subsequently allowed to add new, connecting, structures provide a dining room in either the original or new facility" (p. 52).

"There should be a registered professional nurse or a licensed practical nurse on duty at all times. The number and type of nursing personnel on duty should depend upon the number and condition of the patient population * * *. There should be a nursing-care plan established for each patient. In the development of the nursing-care plan, it is necessary to have a written statement by the physician, regarding the nature of the illness, the condition of the patient, and the treatment prescribed" (p. 59).

"There should be written nursing policy and procedure manuals which are kept in line with currently approved nursing practices * * *. There should be written personnel policies, job description, planned for orientation for new staff, and provisions for inservice education. Employment standards should be consistent with those recommended by the State nurses association * * *. The nursing staff should be provided opportunity to attend professional organization and other educational meetings * * *. That concerted efforts be taken to encourage community participation in nursing home programs, particularly in the areas of recreation, diversional therapy, and occupational therapy" (p. 60).

In spite of many advances, numerous problems remain to be solved if the nursing home is to gain widespread status as a health-care facility. As in 1948, manpower needs continue to be of vital concern to owners and administrators of nursing homes. In a recent survey conducted by the nursing home section, recruitment of adequate professional and nonprofessional personnel was found to be one of the most serious problem areas recognized by the industry. The difficulties of attracting and retaining superior personnel, due to the inability to meet wage demands, were frequently indicated by owners.

An area of departmental concern is the construction of new facilities. There is marked inconsistency in the quality of plans submitted to the department for new construction and additions. A number of the architects performing in this area seem primarily interested in conserving capital outlays for their clients, and demonstrate little or no knowledge of the psychosocial and physical needs of the nursing home patient. To a large degree the criticism of institutionalization in the large modern facility is warranted. Bricks and mortar, beds and personnel certainly do not make a nursing home a home in the usual sense of the word, and it may well be that a home environment is not suitable for the provision of skilled nursing services.

Quantity of nursing home beds and utilization of existing beds is of a vital concern, and the rapid growth of the industry in the last several years has prompted the initiation of studies and inquiries into these facets of nursing homes. During the past year, the nursing home section conducted an areawide planning study of nursing homes and related facilities to determine patient origin, utilization of facilities by residents and nonresidents of municipalities in specific population groupings, patient admission and occupancy rates of facilities in every city and town in which these facilities are located, comparison of occupancy rates and vacancies by type of facility, comparison of facilities by number of beds, beds per thousand total population and population 65 years of age and over, comparison of type of facilities by method of reimbursement (private or public assistance), comparison of public assistance and private patients utilizing these facilities by county, city, and town. The data collected will be employed in projecting future bed requirements. However, much is yet to be learned about the need for nursing home beds.

TABLE III.—*Summary of statewide nursing and rest home ratios as of June 8, 1965*

Nursing homes:	
Beds per 1,000 population [1]	5.6
Beds per 1,000 population, 65 years [1]	50.1
Rest homes:	
Beds per 1,000 population [1]	1.4
Beds per 1,000 population, 65 years [1]	12.6

[1] Based on 1960 U.S. Census figures.

Recently, arrangements were made with the area development center at Boston University to develop formulas for determining nursing home bed needs and to formulate specific procedures and plans for analysis. Existing source material

will be compiled and suggestions made on additional information that will be needed to make such determination.

Planning for the future of nursing homes and related facilities consumes a significant proportion of the resources of the division of adult health. The nursing home section is vitally interested in encouraging much needed educational programs for nursing homes personnel. During the past year, considerable effort was directed toward the exploration of resources available for educational opportunities in order to develop constructive plans for needed services. With the ultimate objective to raise standards in these facilities, a comprehensive questionnaire was designed and sent to the administrator of every nursing and rest home in the State. The questionnaire asked about the educational and professional background of the administrator, his responsibilities and remuneration, and his attitudes toward additional educational opportunities designed specifically for those in the industry. Opinions were solicited about major problems of the industry and probable trends in the next decade. Once the collected data is analyzed, it will be possible to develop specific plans.

The recently enacted Federal medical care legislation makes it imperative that nursing homes, hospitals, and other community health and social resources develop closer working relations, and one of the major objectives of the nursing home section is to help develop this liaison. In the last year, the section, together with other members of the division of adult health, have worked closely with personnel from the Waltham Hospital and nursing home administrators in the Waltham area to explore areas of potential exchange, in order to maintain consistently high levels of patient care and to mobilize resources to meet patient needs and develop administrative patterns to assure their delivery. A grant application was formulated and approved and funded by the Public Health Service, and it is hoped that this project will serve as a model to be adopted by other communities in the State.

In contrast to the hospital which has a centuries-long history, the nursing home in the United States is a relatively new organization dating back only to the depression years. Growth of the industry has been exceptionally rapid due to the growing segment of our elderly population, the expanding incidence of chronic disease, and the rising demand for facilities by patients and relatives, health professionals and the public. In spite of the increased momentum in the construction of larger facilities, the average size of the nursing home remains fairly small in most areas, but across the country the typically modern structure is at least 50 beds and frequently larger than 100.

If one scans the evolution of society, the proliferation of external controls upon all forms of organization is obvious. The concepts and philosophy of "social responsibility" and "the public interest" have always been major forces in channeling the development of medical-care organizations and systems. This current evolution in nursing homes will have a positive effect on the already visible alteration of the nursing home image, its patients, its physical plants, and its organization.

In large measure the unfortunate situation that developed in some nursing homes was due to a large extent to a lack of external controls rather than to personal errors of individuals, organizations, governmental agencies, or legislative bodies. The quality of nursing homes reflected attitudes of society toward the aged and infirm. However, recognition of problems in the health care of the aged and the inauguration of new programs indicates that an altered environment which will hopefully lead to substantial progress has already manifested itself. In a recent article it was pointed out that:

"Within the area of medical care the nursing home now has the spotlight to a significant degree. The public interest in this institution will continue to grow. State licensing and regulatory agencies must reexamine their objectives relating to the maintenance and development of nursing homes. The new national concern in this area is regarded by the department as a welcome opportunity to institute necessary change leading to improved care.

"In Massachusetts, as in most other States, nursing home care has suddenly grown into an important and rapidly expanding segment of the total bed-care facilities. In comparison with other States, the Commonwealth today has one of the highest ratios of nursing home beds per 1,000 population 65 years of age and over. Like most other rapidly growing institutions, this development has its problems. At the same time it is perhaps correct to observe that Massachusetts nursing homes are qualitatively above average when compared with those in other areas. This, however, is not a reason for complacency or self-satisfaction. The department needs to continue its studies of nursing homes and the care that they provide to work closely with the medical profession and the nursing home

industry, to interest the general public and communities in this area and to develop practices and procedures for nursing homes that will continue to raise standards and insure that the patients receive the best possible care suited to their individual needs and problems." [2]

With the current emphasis on nursing home care, the alternatives to such care are often forgotten or relegated to secondary status, but these alternatives are being carefully studied by the department; for example, foster-home placements, homemaker and visiting nurse services, day-care services, and others. Much pioneering is yet to be accomplished in this area especially in the reconciliation of administrative and medical alternatives.

There is no question that numbers of patients placed in nursing homes do not belong there. But it is equally true that inappropriate placements are evident in all categories of medical care facility.

The attached appendix includes the department classification document and reprints which represent the most recent publications of department officials on the subject of nursing homes.

Senator Moss. I was particularly glad to have you emphasize that the problem of appropriate care for the elderly is not solved just by the nursing home, that so much needs to be done in providing for other types of care permitting elderly people to remain in their own homes as long as possible with visitation, or foster-home care and all of these other possibilities.

The nursing home is just part of this scope that must be developed if we are to give our elderly people an adequate opportunity to continue to function as members of our society with full expression in their later years.

I appreciate that very much.

Is the department of health the licensing agency in the first instance for nursing homes?

Dr. Levey. Yes, sir.

Senator Moss. To what extent is this coordinated with the fire department or building inspection?

Dr. Levey. For every license that is issued by us we must have approvals by the fire department, local health authorities, building inspector, wire inspector, and public safety.

We do obtain certificates of approval from each of these authorities before we are able to issue a license.

Senator Moss. That is, one of your functions is to get the approval of all of these other inspecting agencies, but the final license is issued by the department of health?

Dr. Levy. That is right.

Senator Moss. And on the same basis, you are the responsible department if any license is canceled or suspended; is that right?

Dr. Levey. That is correct.

Senator Moss. I think you mentioned the figure, and I did not catch it, of the number of nursing homes that have been closed in the last 12 months as a result of your inspections.

Can you tell me what that number was?

Dr. Levey. Well, we closed nine facilities through the past 18, 19 months, by direct action of the department. However, about 30 other facilities closed and in many of these facilities we exerted pressures in order to upgrade standards. They could not meet these increased standards and because of financial difficulties they closed their doors.

Many others went out of business because of the increased competition of the large new structure. Many of our smaller nursing homes

[2] Frechette, A. L., and Levey, S., "Massachusetts Nursing Homes Today," New England Journal of Medicine, 272: 1010–1012 (May 13), 1965.

are today confronted by reduced occupancies because of this, and they find it impossible to sustain their livelihood in the smaller facility.

Senator Moss. This process of classification that you are now engaged in, is its effect going to be to permit higher payment for public patients, welfare patients, to institutions that get the higher rating? Is that the incentive part of it?

Dr. LEVEY. Yes sir. The incentive is to upgrade and to, in turn, reimburse for providing this additional care. We are at the present time trying to correlate the standards in terms of expected care to be provided with the reimbursement formulas promulgated. At the present time it is my impression that not too many people know—in fact, I don't know anyone who knows—what it costs to provide a nursing home of good day care.

There is a lot of speculation but very little in terms of actual figures.

Senator Moss. Is a breakdown or an itemization of the cost of a day's care in the nursing home required either by the licensing department or under its classification system?

Dr. LEVEY. Yes, there is, Senator Moss. In Massachusetts, we have a rate setting board which is composed of the commissioner of administration and the commissioner of public health and the commissioner of welfare, and these three individuals and/or their designees, work on financial matters.

Each nursing home is asked to submit to the rate setting board on a regular basis a statement of operating income and operating expenses. Rates are promulgated in accordance with the information and the types and quality of the financial statements which are submitted to the rate setting board.

The lack of uniform accounting systems is one factor which contributes to the inability of State departments to correlate to a more intelligent degree the cost of care as contrasted with the quality of that care.

Senator Moss. As a result of these inspections, some of which have caused some of the homes to close, have you had any problem of the tendering of bribes to any of your inspectors or any difficulties of that sort?

Dr. LEVEY. I do not believe that our inspectors—at least during the past 18 or 19 months that I have been responsible for them—that any bribes have been offered to them.

Senator Moss. Have you had any problem of being tendered bribes or offered favor of any sort by a nursing home operator?

Dr. LEVEY. There have been attempts by the nursing home people to assist me in taking trips and acquiring various material things. Many of these proposals are indirect and do not develop into actual transfers of any kind of funds or material items.

Senator Moss. There are tenders that just come to nothing more than a broad offer, is that right?

Dr. LEVEY. That is right. When the response is evident, then I am sure this creates a withdrawal.

Senator Moss. Are any of these organizations still in business in Massachusetts or are these the ones that have gone out of business?

Dr. LEVEY. Well, to a degree, the kind of situation that develops here is the promoter rather than persons who are operating in the existing facility. I have encountered from time to time people who

are interested in building, say a large number of facilities in Massachusetts, and we have to act on the need in the department of public health when incorporations are organized for a new facility.

In this area I have been approached and have turned them down and these individuals then proceed on to other States.

Senator Moss. Have you had occasion to report any of these tenders to other State agencies, the attorney general?

Dr. Levey. The attorney general's office is aware of some of the problems.

Senator Moss. Now there are currently over 700 nursing homes operating here in Massachusetts?

Dr. Levey. That is right.

Senator Moss. Is the trend generally as has been said by the other witnesses, toward the larger sized homes and the smaller ones where we have attrition?

Dr. Levey. Yes. In fact, during the past 2 years, approximately 2 years, we have lost about 40 nursing homes and there were 40 replacements, approximately, of new facilities with a considerable increase in the number of beds. The number of nursing homes since 1961 remains fairly constant but the number of beds since 1961, has increased from about 21,000 to 29,000 today.

The break-even point is approximately 80 beds, so this is why they go up to approximately at least a hundred in the modern facility.

Senator Moss. Thank you, Dr. Levey.

Do you have any questions, Senator Neuberger?

Senator Neuberger. Yes.

I was wondering whether you consciously or subconsciously consider as a criterion for granting a license the fact that there are already a lot of nursing homes and if you granted more licenses then those existing ones would have trouble succeeding, or do you just feel if they meet the requirements, give them a license?

Dr. Levey. As I indicated, we are working on this which ties into your question, as I understand it. At the present time, we are working with the Area Development Center in Boston University involving a statewide plan.

In some States, people build at random. In Massachusetts, this is not very likely. One of the factors to be contended with is that there is a large amount of entrepreneur capital that is ready and available to go into nursing homes. Banks today are less concerned about the attitudes toward nursing homes than they have been in the past.

It is not a problem as it was in the past, and to a considerable degree, new nursing homes are developing and the smaller facilities become obsolescent because they have to compete with the facility that provides all kinds of plant.

Plant differences do exist, but many of our smaller facilities provide much better care than our brandnew facilities.

Senator Neuberger. Do you feel that you have a responsibility for controlling the number of nursing home beds in relation to their ability to staff?

Dr. Levey. Well, this is a problem we have to contend with every day really as part of routine inspections. In the areawide planning study, we are intending to evaluate manpower sources in the State.

Until this point, until Federal legislation and the progress that has been accomplished in the past few years, very little thought was given

to the manpower situation toward promoting new kinds of educational opportunities and related programs.

We have to be more concerned with this today because if facilties don't have the staff, then they are obviously not going to be able to function effectively.

Unfortunately, thus far we have meager, you might say, manpower sources and supplies but we do know that the hospitals are crying for nurses.

Many of their problems are just as bad as nursing care problems.

Senator NEUBERGER. Do you license a place before or after the fact?

Dr. LEVEY. For new facilities we license before they go into operation.

Senator NEUBERGER. So for that facility to be adequate and get a license, they must have to present to you a plan for staffing?

Dr. LEVEY. That is correct.

Senator NEUBERGER. So you have quite an important role to play?

Dr. LEVEY. Yes. In a new facility for 100 beds, when they are ready to open, our inspectors sit down with the new operators and work out a personnel schedule and then what we ordinarily do at the beginning is to give them a quota of 15 or 20, and then as their personnel are augmented we then increase the quota in the facility.

Senator NEUBERGER. Yes. You have a great responsibility if somebody having invested $100,000 or whatever it would be, and then after it was built, you would not issue a license because they did not have the right staff.

Would you confirm what Mr. Tobias said about the monthly visit to the nursing home; would you say that is quite general?

Dr. LEVEY. As I indicated, I think, in my report, one of our problems has been that we don't have enough personnel. In the beginning we concentrated on our poorer facilities. I asked our inspectors to rate all facilities. During the first year, we visited with more frequency and thoroughness, facilities that had not had recent inspections and were known to have questionable conditions.

At the present time, we find that even in our existing staff we are not able to concentrate across the board and provide the consultation we would like. Some of our facilities are operating on expired licenses, because they are still in the process of meeting basic standards.

Senator NEUBERGER. Two things that have not been mentioned so far during the hearings. What about mental patients in nursing homes?

Dr. LEVEY. I am glad you brought that up. We have been involved for some time. Until about a week ago, we were responsible for transfers from State mental hospitals to nursing homes and our inspectors were ordinarily involved in making sure that at least in their impression that the facility could meet the basic need of the patient that was transferred.

We ran into a number of problems, one of which was that the mental hospitals had a considerable backlog of patients that they wanted to transfer. I think that here there is a need for investigation of referrals both by mental health and public health.

I recently talked to a psychiatrist about patients in nursing homes, and he informs me that the fact that our inspectors were involved in

checking these facilities for placement he feels might have led to an upgrading of care. This is an area that is still short of information.

Senator NEUBERGER. There is provision, of course, in the new health care bill for psychiatric patients.

What about other discrimination for race or religion? Do you have any kind of requirement if you license the nursing home and it takes Federal money in Kerr-Mills about discrimination?

Dr. LEVEY. Recently, we received a letter from the Public Health Service, who are interested in this problem, and through their regional representative, asking whether we had any problems of this kind. At this point I have not encountered any problems in terms of discrimination of this sort.

Senator NEUBERGER. You have been administrator 18 months. Were you connected with the health department before that?

Dr. LEVEY. No, I was on the faculty of the Univerity of Iowa.

Senator NEUBERGER. The point I wanted to ask concerns this terribly small payment that the State of Massachusetts allows for a welfare patient. What in the world did they do before thay had Kerr-Mills? Do you have any idea how they took care of these people

Dr. LEVEY. We had a random sort of industry without any intelligent inquiry. We were fortunate in terms of the industry as a whole, this is only a personal opinion.

Senator NEUBERGER. Massachusetts, New York, and Pennsylvania use the greatest proportion of Federal money of all States under the Kerr-Mills program. It is a big expenditure. That is why I wondered, with this sort of contribution that the State makes, how they ever got along beforehand.

We hold these hearings and so many of our questions of you and your testimony have to do with State and local management. Do you wonder yourself why a Federal Senate committee is here? What is the role of the Federal Government in this? Should we leave each State to itself to do as it pleases more or less, or should we be concerned?

Dr. LEVEY. I am glad you brought up this question.

At the present time, the Nursing Home Branch of the Public Health Service is interested in determining such differences. As I indicated at the beginning of my presentation, there are substantial differences between the States in definition of the types of and quality of care provided and in terms of personnel assigned to regulating agencies.

Senator NEUBERGER. We know that to be true, of course, but should it not go on that way? Should not the Federal Government just keep its hands off this and leave each State do what it wants to? Why are we holding these hearings?

Dr. LEVEY. I am glad somebody is holding hearings. It is only very recently that we have been meeting in Washington in order to discuss these differences.

I think the Federal interest in this area is necessary because, as I indicated, we have sent questionnaires to the States, and some of the attitudes we get back are not as positive as others.

For that specific reason, I would think that the Federal Government, and you as legislators, do remain interested in these differences.

Senator NEUBERGER. Thank you.

Senator MOSS. Senator Muskie.

Senator MUSKIE. Did I understand you to say there are now 29,000 beds in nursing homes?

Dr. LEVEY. Approximately 29,000.

Senator MUSKIE. What percentage of capacity is used?

Dr. LEVEY. In our most recent survey, this was late last year, we had about 89.5 occupancy, and at the present time it is slightly less.

We feel that anywhere between 80 and 90 percent at the present time is reasonable occupancy.

Senator MUSKIE. What percent of the occupancy is for private paying patients?

Dr. LEVEY. Approximately 18 percent.

Senator MUSKIE. Welfare patients?

Dr. LEVEY. I am sorry, 72 percent on welfare and 28 percent, approximately, private.

Senator MUSKIE. Eighty percent of these homes are proprietary?

Dr. LEVEY. No, more than that. Ninety percent.

Senator MUSKIE. Does that mean 90 percent of the beds?

Dr. LEVEY. No, it is less than 90 percent of the beds because the nonproprietary facilities are large 200-bed facilities. I would say that about 25 percent of the beds are nonprofit.

Senator MUSKIE. What is the profit picture of the proprietary homes? Are they all making profit? Are they all viable economically? Are they getting along all right financially?

Dr. LEVEY. Until the most recent rate increase, which was very recent, this year sometime, I think they were operating under very marked difficulty. At the present time, the situation is altered considerably and the levels of care that are provided in these facilities are closer to what the patient needs.

There is no point in expending sums of money that go to the kind of care that is not needed. This is one of the areas that I am interested in. We know that there are a number of placements in nursing homes and in other kinds of medical care facilities that are not appropriate, that some people in nursing homes belong in rest homes and the reverse, and some are in hospitals that don't belong there.

If we are going to spend money for medical care facilities that are not needed, it is very uneconomic.

Senator MUSKIE. How did you arrive at $7.71 rate; what is your basis for that?

Dr. LEVEY. The rate setting board took all the figures that were provided by facilities across the State and then the Massachusetts Federation of Nursing homes submitted their information and at a public hearing all the data that was submitted was examined.

Subsequent to the hearing, a rate was promulgated which took into consideration the data provided by licenses, and the data provided by the Massachusetts Federation of Nursing Homes and other spokesmen.

Senator MUSKIE. Is it your conclusion that with the $7.71 rate the nursing home ought to be able to maintain a business in the black?

Dr. LEVEY. No. Speaking from a personal viewpoint, I think that it is not possible for each nursing home to operate in the black.

Senator MUSKIE. The $7.71 was not designed to make these businesses profitable?

Dr. LEVEY. It was designed as an average rate and I think as an average rate it does provide sufficient to allow the average facility, which in this State is 38 beds and has a specific allocation of personnel to operate.

I don't think it is possible to arrive at that figure for special kinds of patients.

Senator MUSKIE. So the $7.71 rate provides a lesser standard of care than you think should be provided?

Dr. LEVEY. I didn't say that. For some patients, there must be provision made for higher rates and that is what we are trying to do with the classification system. It may turn out after study that 50 percent of the patients in nursing homes don't need more than $7.50 care. We don't know.

Senator MUSKIE. Now would you describe the standards as minimal standards for nursing homes?

Dr. LEVEY. Our standards from a regulatory point of view that are provided in our written documents are, I think, minimal, but if you ask me as to what my appraisal is of standards in relation to other areas, I would say that they are above average.

Senator MUSKIE. In your judgment, in terms of the need of patients, should the standards be higher than they are now?

Dr. LEVEY. I would like to see standards higher, yes.

Senator MUSKIE. In what ways ought they to be improved?

Dr. LEVEY. Well, I would suggest that the biggest area of need is that of the registered and licensed practical nurse and physical plant. We do not have in our facilities sufficiently trained personnel that are able to adequately attend to needs and are able to keep up records——

Senator MUSKIE. One problem is there just are not enough of those people, but this would add substantially to the cost if there were.

Dr. LEVEY. Yes, I would think so.

Senator MUSKIE. Do all of your nursing homes now meet the standards which you now have?

Dr. LEVEY. No; not all of them.

Senator MUSKIE. In other words, many of them are something of a probationary status?

Dr. LEVEY. We have a number of facilities that our staff work with on a very continuing basis and who make repeated inspections.

If the standards are not complied with by a certain date after a certain reasonable period, when we cannot be considered arbitrary and capricious, then we revoke the license.

Senator MUSKIE. What percentage of the 760 in Massachusetts would this apply to?

Dr. LEVEY. I frequently thought about this question. I am glad you raised it, Senator Muskie. We do have in the industry an irreducible minimum of people who should not be in business. I think it is true throughout.

Now if I were to make an estimate, I would say probably around 10 percent. There are a certain number of people who whatever we do, do not help us or themselves and these are the people that we must get rid of.

Senator MUSKIE. It is true, is it not, that as Federal and State payments may be increased for these homes, that you are going to expect to raise the standards? Isn't this the evolution of the thing

Dr. LEVEY. Yes.

Senator MUSKIE. I assume so.

Dr. LEVEY. Yes.

Senator MUSKIE. Let me ask you this: Do you think that licensing standards should set basic qualification requirements for operators as well as for homes?

Dr. LEVEY. Yes, I do.

Senator MUSKIE. Do you think they ought to be licensed separately?

Dr. LEVEY. Well, a great deal of the activity that goes on in this area is uncoordinated, and if you are talking about an essential group in order to effect standards of all kinds, I would agree with you. There is too much overlapping of departments even though there are good communications.

Senator MUSKIE. Just one other question.

Is the performance of Corporate Operations adequate, in your judgment?

Dr. LEVEY. Well, when the transfer was effective, we felt that several of the facilities were not adequate. Our inspectors have spent considerable time with them in getting the standards to the point where we feel that they are at least minimum.

I, myself, have been out to some of the facilities. We have had hearings on regulations with them, so they are aware of our interest and constant supervision. We have expended a considerable amount of effort.

Senator MUSKIE. Is it your judgment that one of these homes ought to make a profit if it is not meeting adequate standards?

Dr. LEVEY. I am sorry, I didn't hear you.

Senator MUSKIE. Is it your judgment that one of these homes ought to make a profit if it is not meeting adequate standards?

Dr. LEVEY. No; I think that——

Senator MUSKIE. The first thing to go out, to be the profit? Is that your judgment?

Dr. LEVEY. As a regulatory agent and disregarding the economics of the situation, I feel that whatever the need, if they are not adequate to meet minimum standards, the home should be put out of business.

Senator MUSKIE. I do not want to be misunderstood in my question here, but I do think we have reached the point where we ought to find out what it is going to take to make them economically viable, and economically viable to the extent that they can provide decent standards of care.

Dr. LEVEY. Yes.

Senator MOSS. Thank you, Dr. Levey. You have been an excellent witness and have helped us greatly. We appreciate your testimony and your answers to our questions.

The committee will now be in recess and will resume promptly at 2 p.m. [Applause.]

(Whereupon, at 1:10 p.m. the subcommittee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m., Senator Frank E. Moss (chairman of the subcommittee) presiding.)

Senator MOSS. The hearing will come to order.

We will resume this afternoon. We have quite a number of witnesses to be heard. I think this morning we had exceptionally good testimony and have an excellent record which will help this subcommittee as we deal with this problem in various sections of the country.

This afternoon we have some very eminent people to testify.

I would like to announce at the beginning that it is possible and sometimes desirable, if a witness who has prepared his statement in considerable detail, to submit his statement for the record and it goes in the record and is printed in full and then he can highlight for the subcommittee points that he thinks should be emphasized and on which the committee members may well like to ask him questions.

This is a timesaving device and yet has the effect of making every bit of information available to the other members of the committee and to others in the Congress and the public who read the record.

The committee hearings will be printed and will be available when we have completed this whole series to anyone who would like to write in and have a copy of them.

If any of the witnesses who are called this afternoon would like to operate in that manner, I would invite them to do so, submit a statement for the record and then comment upon it. In that way we will be able to hear all of the people that have agreed to come and testify before this committee, all of whom have important information to contribute.

I have one other brief announcement. Senator Muskie and I will have to leave before the hearing is concluded this afternoon, Senator Neuberger will take over the chair and Senator Kennedy will be here during the whole afternoon.

So, the hearing will proceed without any interruption. If you see us leaving our places and walking out, you will know it is because the airplane schedule has come around and we must be on our way back to Washington tonight.

We are both happy that these distinguished members of the subcommittee will be able to carry on and there won't be any interruption of our work.

Our first witness this afternoon is Mr. Edward F. Connelly who is counsel for the Massachusetts Federation of Nursing Homes here in Boston.

Mr. Connelly has prepared a very excellent statement. I have had a chance to glance through it. We look forward to having his testimony before the committee now.

Mr. Connelly.

STATEMENT OF EDWARD F. CONNELLY, ESQ., COUNSEL, MASSACHUSETTS FEDERATION OF NURSING HOMES, BOSTON, MASS.

Mr. Connelly. Mr. Chairman, my name is Edward F. Connelly and I am counsel for the Massachusetts Federation of Nursing Homes. I have been counsel for about 12 years.

I want to say to the committee that I have no intention of reading the document that has been presented to you. I have given 20 copies to your committee. I have also left with the committee a number of copies of the study of the Boston College School of Nursing with respect to nursing affairs in Massachusetts.

I left with the committee a couple of copies of the brief of the Massachusetts Federation of Nursing Homes submitted to the Massachusetts Rate Setting Board in 1964. I have also left with the committee a copy of the rules and regulations of the department of public

health and the regulations of the department of public safety governing nursing homes.

Senator Moss. Thank you, Mr. Connelly. Your statement will be part of the record and we will ask you to proceed to highlight your statement and emphasize such parts as you think should be brought before us orally.

(Statement referred to follows:)

STATEMENT OF EDWARD F. CONNELLY, COUNSEL, MASSACHUSETTS FEDERATION OF NURSING HOMES, INC.

My name is Edward F. Connelly of Lynch, Connelly, Welch & Whitney, 1130 Park Square Building, Boston. For about 12 years I have been counsel for the Massachusetts Federation of Nursing Homes, Inc. In this time much has happened in matters related to nursing homes.

The Massachusetts Federation of Nursing Homes, Inc., was founded in 1949. Its membership numbers about 315 nursing homes. It has played a major role in developments in Massachusetts affecting nursing homes.

The department of public health separately licenses the following different facilities: acute hospitals, chronic hospitals, nursing or convalescent homes, and rest homes for the aged. A nursing or convalescent home is defined in law in the most general terms as an institution of three or more persons admitted for nursing care.

Nursing home licenses are renewable each year by the department of public health. Applications must be accompanied by:

(*a*) Local board of health certification that the home is suitable for its purpose;

(*b*) A certificate of inspection of the egresses, the means of preventing the spread of fire, and the apparatus for extinguishing fire, issued by the department of public safety;

(*c*) A certificate from the local wire inspector that the home complies with the local wiring code; and

(*d*) A certificate of inspection issued by the head of the local fire department certifying compliance with local ordinances.

By State law the State fire marshal or the local fire department must inspect each nursing or convalescent home four times a year. By law, also, the local fire departments must conduct fire drills with the personnel of each convalescent or nursing home.

Safety in nursing or convalescent homes is a concern of the department of public safety, and of local building departments under city and town ordinances and bylaws. By law the State department of public safety is charged with the responsibility of promulgating a comprehensive code of safety. Such a code was promulgated January 19, 1965, applying to all nursing or convalescent homes thereafter erected and to existing buildings "where practicable."

This code requires sprinkler systems in convalescent or nursing homes, and homes for the aged by January 1, 1966.

The law under which this code was promulgated specifically gave authority to the department to require sprinklers with the proviso that alternative methods of fire protection could be required where "a sprinkler system would be unnecessary or impractical either as to location, size, or construction of a home."

The Massachusetts Federation of Nursing Homes, Inc., does not question the general requirement of sprinklers of all nursing homes in the Commonwealth except existing structures of class 1 and class 2 construction. The latter types of construction are considered to be fire resistant and the federation has suggested that with respect to existing structures of such construction circumstances might well warrant alternative methods of fire prevention.

The federation supported and in fact suggested the law now on the books giving this authority to the department of public safety to promulgate this comprehensive code of safety for nursing homes with its provisions for sprinkler systems. The points of difference between the federation and others suggesting sprinkler legislation were that—

(1) Since it would apply to over 500 nursing and convalescent homes and about 400 rest homes it should not create a sellers' market by becoming effective 90 days after the law was passed;

(2) Some measure of flexibility should exist within the discretion of an informed State agency; and

(3) It should be part of a comprehensive code of safety for nursing and convalescent homes.

Just as the department of public safety has the primary responsibility for safety in nursing and convalescent homes, so also the department of public health has the primary responsibility over standards of care in such homes. For years comprehensive rules and regulations have been enforced by the department which now has some 14 inspectors covering nursing and convalescent homes and rest homes. Undoubtedly you have a copy of these regulations. Since 1961 these regulations have included a provision that no original license could be issued except with respect to a facility newly constructed to serve as a convalescent or nursing home. In 1964 a law was enacted requiring that such structures must be of class 1 or 2 construction. The federation favored this regulation and this law.

There are some 730 nursing and convalescent homes in the Commonwealth licensed to care for some 28,000 patients. Over 70 percent of these are public aided. Except for a minor percentage under State benefits for the blind and for veterans, the public-aided patients receive benefits under laws administered by the department of public welfare, and most of these come uuder the Commonwealth's medical aid to the aged law. This law was enacted in 1960 to implement the provisions of the Federal Kerr-Mills law under which 50 percent of such aid is picked up by the Federal Government.

Though the Commonwealth's department of public welfare administers and issues governing rules and regulations with respect to medical aid to the aged and other welfare laws, applications for benefits are initially processed by city and town welfare agents in some 300 welfare districts in the Commonwealth. Many, if not all of these welfare districts have social service workers to help those on public aid. Referrals to nursing or convalescent homes, where the selection isn't made by a member of the family, are generally made or recommended by welfare workers or social service employees of hospitals.

Thus, Massachusetts has extensive laws and rules and regulations governing nursing and convalescent homes. But this committee, we assume, is interested in how effectively nursing homes in Massachusetts generally fulfill their function and what are the prospects for the future.

The answers to these questions depends upon many things, but principally upon two things:

(1) What is the function of a nursing home, and

(2) Its degree of success in fulfilling that function in relation to its income.

What then is the function of a nursing home? The federation and the Massachusetts Department of Public Health sought the answer to this question in 1960 and requested the Boston College School of Nursing to seek a U.S. Public Health grant to conduct a study and collect data that would be useful in establishing criteria pertinent to the operation and accreditation of nursing homes.

This study was completed in May 1963. A report has been published. Its information is invaluable.

The study revealed that—

The average age of patients was 80;

There were three females to one male;

The median length of stay was 17 months;

Forty percent of patients had been in a nursing home between 18 months and 5 years;

Ten percent had been in the homes from 5 to 35 years;

The major medical problems of patients were due to arteriosclerotic heart disease, generalized arteriosclerosis, cerebral vascular accidents, fractures, and amputations (see app. B);

Almost all patients expected to remain in a nursing home for the rest of their lives;

Slightly over one-third of the patients appeared to be mentally confused in some degree;

More than one-half were ambulatory and required little or no assistance in walking;

About 45 percent required assistance in toileting and about 30 percent were incontinent (see app. C);

The majority of patients required assistance or supervision with personal hygiene;

Many of the patients had developed close relationships with one or more members of the personnel in the home and considered these people as personal friends;

Patients spoke repeatedly of the importance of being treated as individuals, of having some degree of privacy, and of desiring companionship with patients who were mentally alert; and

The average patient required 2 hours of direct nursing care per day.

This 2 hours of direct nursing care did not include—so the Boston College study said—the time required to meet the psychosocial needs of the patients, the time required for record and chart keeping, or the time of a recommended registered nurse in charge responsible for planning, directing, implementing, and evaluating nursing care.

This study shows the function of a nursing home. It clearly is to be a home for people who, besides being old and discouraged and frightened, are physically infirm and need 2 hours of skilled nursing care per day. Physical environment, staff attitudes, and the programs and policies of the home must be oriented toward the full personality of the individual and not isolated to the medical or nursing care needs. In this a nursing home is much different from a hospital and in many ways things that are important in hospital disciplines lose much of their weight in relation to the needs of the total personality of the nursing home patient. What is important is how completely a patient lives to the extent of his faculties.

This analysis suggests many things. One of them is the question of how desirable it is to license large facilities as nursing homes. Certainly a nursing home should never be an institution in the generally accepted sense of the word and the question is how large a facility can be before it becomes an institution.

We ought to have in our minds a distinction between a nursing home and a convalescent home though no such distinction exists in Massachusetts licensing law. A convalescent home might well be thought of as a nursing care facility for short-term patients in transit between hospital and home. Thus it could take on much of the impersonal attitudes and disciplines of a hospital. But in a nursing home a patient is not in transit. He is home.

The analysis of the function of a nursing home also suggests another thing. Some residents in nursing homes improve to the point where they could be in a rest home for the aged rather than a nursing home. The Boston College study showed 6 percent could be in this category. If they prefer to remain among the people and associations developed in the nursing home, then certainly they should be allowed to do so.

As we move from a consideration of the function of a nursing home to the question of whether its income permits it to adequately fulfill that function it seems appropriate to review some historical characteristics and facts about nursing homes in Massachusetts.

There are 727 licensed nursing homes in the Commonwealth now. Since 1961 about 87 original licenses have been issued to nursing homes covering 7,000 new beds. Since in 1961 there were 731 licensed nursing homes it follows that in 4 years over 90 Massachusetts nursing homes have discontinued operations.

Fifty percent of Massachusetts nursing homes have 32 or less beds. The trend today is toward nursing homes having 90 beds or more. Rising costs are forcing the search for economics through increased beds.

Smaller homes have been putting on additions to add to their licensed quota. Appendix A gives the size of Massachusetts nursing homes in 1961. Similar figures for today would show an increase in the number of homes with 50 or more beds and a decrease in the number of homes with less than 30 beds.

At least 85 percent of Massachusetts nursing homes are converted frame structures and most of these are proprietary operations. Most of the newly constructed homes are also proprietary operations.

The facts have demonstrated a great social need for true homes for the aged who are infirm and in need of constant nursing care attendance as well as programs and an environment to enable them to live to the fullest extent of their faculties.

The facts also show that it has been the proprietary nursing homes who have met this need. The facts indicate, too, that proprietary nursing homes will continue to be the main reliance to fill this need.

Our problem is how we can provide the care and environment society wants for the elderly infirm with fairness to the nursing home. The key to this is the rate paid for public aided patients. In Massachusetts over 70 percent of nursing home patients are public aided. The public aided rate is the main factor controlling standards of care and safety in four out of five Massachusetts homes.

The federation's philosophy has been a simple one. It says to the State:

Define the standards of care and safety you want;

Break down the categories of capital and operating costs involved in nursing home operation;

Allocate to each category the amount reasonably needed to achieve the standards of care and safety desired;

Pay this rate to nursing homes;

Establish a strong regulatory department with competent personnel of sound judgment;

Get rid of the nursing homes who do not give value for what they receive.

Ten years ago nursing homes in Massachusetts were receiving a top rate of $5 a day for public-aided patients. If we assume $1.50 per hour paid in wages for each of 2 hours of nursing care per day for the patient (which is only a little above minimum wages and does not include fringe benefit costs) we see that but $2 per day per patient remains for all other wages, food, supplies, utilities, depreciation, interest charges, taxes, repairs, and all other costs of a business operation. Obviously, it is somewhat futile to think of high standards in relation to such a payment.

At this time the department of public welfare was setting the public aided rate without public hearing. The federation proposed a law which was enacted in 1956 giving the director of the division of hospital costs and finance the authority to determine the rates for public-aided patients in nursing homes. At that time and now this director had the responsibility to recommend the public-aided rate to be paid hospitals.

In September of 1957 the public-aided rate for nursing home care was hiked to $5.75 per day and on January 1, 1959, to $6.50 per day.

From the beginning the federation felt that the making of the rate by this single director was not the answer to the question of a proper method of rate determination for the following reasons:

(1) Rates were based on averaged historical costs 18 months to 2 years behind current costs.

(2) The director had no responsibility for standards of care or safety and as he saw it, it was his responsibility to determine rates on what had been expended in the past, not on what was needed to achieve a standard of care and safety.

(3) Four out of five homes were dependent on public aided rates and since it is difficult to spend what you haven't got, progress could grind to a standstill.

Beginning in the late 1950's the federation worked toward a method of rate-setting by a three-man board whose members would be the heads of the departments having the responsibility for setting the standards of care and safety in nursing homes. Such a system gave promise of two things if properly administered: (1) rates fairly related to standards of care and safety desired, and (2) better informed governmental agencies to eliminate substandard nursing homes.

The federation thought of this three-man board as the commissioner of public health, the commissioner of public welfare and the commissioner of public safety. As this board was finally created in 1963 it was composed of the commissioner of administration and finance, the commissioner of public health, and the commissioner of public welfare.

The problems of nursing homes in the midst of rising clamor for better care and greater safety is graphically illustrated in appendix D which charts the major factors in the nursing home public aided rate found for the years 1962, 1963, and 1964. The same rate of $6.85 was promulgated for each year.

This chart shows that on the basis of the State's own findings expenses of operation in nursing homes had increased 79 cents per patient-day from 1962 to 1964. The rate promulgated in 1964 came out the same as that of 1962 by reducing the return on capital investment from 49 cents to 22 cents, by reducing the salary equivalent for officers and proprietors from 83 cents to 49 cents, and by reducing the allowance for other factors from 30 cents to 8 cents.

The result was a shock of substantial proportions to nursing homes. Elaborate information had been made available to the board including that listed herein in appendexes G and H. Since 1959 Federal grants to Massachusetts for public-aided programs had increased 47 percent as against an increase in nursing home rates of 5.4 percent. In the same period public-aided rates to acute hospitals in Massachusetts had increased 41.3 percent and to chronic hospitals, 36.6 percent.

The severity of the shock was not tempered by the fact that it always had been the policy of the federation to cooperate fully with all departments of government. In 1960 at the request of the then commissioner of public welfare the federation assumed the major responsibility of coordinating all groups and in revising and guiding the medical aid to the aged law through the legislature implementing the Federal Kerr-Mills law.

Massachusetts enacted this legislation effective October 1, 1960—one of the first States in the Nation to implement the Federal law. The shift of nursing-home patients from the old-age-assistance rolls to the medical-aid-to-the-aged rolls brought into Massachusetts about $8 million more a year in Federal grants, or a saving to the State and cities and towns of about $1.90 per patient-day. Yet in the 4 years that had elapsed since 1960 the increase in the public-aided rate for nursing-home care had increased combined State and city and town costs only 17½ cents per patient-day. Even today with the public-aided rate of $7.71 the net increased cost to the State and cities and towns is but 60½ cents per patient-day as compared with $1.90 per patient-day additional Federal funds coming into the State as a result of the Federal Kerr-Mills law.

These facts were given national circulation in the magazine Consumer Reports and came to the attention of Congress in other ways together with facts from other sections of the Nation. These facts were unquestionably the reason why the Health Insurance for the Aged Act, the so-called medicare law, contains provisions to guard against similar happenings to further Federal grants.

We are happy to record that the despair of 1964 has been replaced by cautious optimism in 1965. The board of rate setting increased the public-aided nursing-home rate from $6.85 a day to $7.71. Individual appeals from this rate are being adjudicated under fair opportunity to be heard. The board of rate setting, the department of public health, and the federation are cooperating in evolving a classification system for nursing homes.

As yet we have not reached our goal of coordinating standards required with rates paid. It is not right that nursing homes should be exposed to unjust condemnation because they cannot do better than the public-aided rate will permit them to do. It is not fair to patients and their families to mislead them to expect far better care and environment than the public-aided rate of $6.85 per day or $7.71 per day will permit.

This subcommittee is fresh from a hearing in New York City. We can say to you unquestionably that the overall performance of nursing homes in New York City is superior to the overall performance of nursing homes in Massachusetts. It is not because of the New York City code for nursing homes. It is not because the New York City regulatory authority is superior to our regulatory departments. It is simply that the public-aided rate in New York City is $11.80 per day as against the Massachusetts rate of $7.71 a day.

Last year the federation at last succeeded in obtaining from the State the breakdown of its public-aided rate. We include this breakdown for the 1964 rate of $6.85 as appendix E. We include the breakdown of the 1965 rate of $7.71 as appendix F.

With this data and with the information contained in this paper and other exhibits submitted, it is possible for this subcommittee and other interested people to judge for themselves what is needed in a rate to achieve the standard of care and safety they may think desirable.

Look to exhibit E and you will note $2.79 as the amount allocated in the rate for nursing care wages. In exhibit F this figure is $2.81. We refer to exhibit E because we know exactly the way the State reached this $2.79.

The State assumed 1.8 hours of nursing care per day per patient at an average rate to be paid an employee of $1.55 per hour. This was reached on the assumption that 30 percent of nursing personnel would be licensed, that is, either registered nurses or licensed practical nurses, and that 70 percent would be unlicensed personnel. Further assumptions made were an hourly rate of $2 per hour to the registered nurse, $1.70 per hour to licensed practical nurses, $1.50 per hour to practical nurses, and $1.35 per hour to nurses aids.

The $1.35 per hour is exactly the minimum wage which will be in effect in this State in September of this year.

The hourly rates paid similar personnel employed by the State are:

	Per hour
Registered nurses	$2.53 to $3.21
Licensed practical nurses	1.94 to 2.41
Nurses aids	1.68 to 2.09

Nothing is included in the 1964 rate for fringe benefits. The 1965 rate includes 10 cents. This would provide about 1 week's vacation. It must be common knowledge that fringe benefits to State employees include vacations, sick leave, holiday pay, and pensions.

Is a ratio of 30-percent licensed personnel adequate in relation to the standards demanded of nursing homes? Can they secure competent personnel at the wage levels assumed, with little or no allowance for fringe benefits? In addition to

these nursing care hours, how do they also employ personnel for restorative services for patients, or rehabilitation as it is sometimes called? The Boston College School of Nursing says each home should have a registered nurse in charge of personnel, planning, and evaluation. Nothing is included in the rate for this.

The purpose of this evaluation and these questions is not in the expectation that this subcommittee can directly help but simply to focus attention of all interested people on the realities of the problem with which we are concerned.

As a further guide to make these appendixes helpful and meaningful may we refer to appendix F and the allowance in the rate of 27 cents for return on capital investment and 23 cents for interest on debt capital.

We have referred to the importance of the environment and physical structure of a nursing home for the patients well-being. The allowance in the rate of a total of 50 cents for return on capital investment and interest on debt capital is figured at 6 percent interest on debt capital of about $2,000 and 12 percent return on equity capital of about $850 or a total capital investment of $2,850 per bed.

Massachusetts law now requires that original licenses for nursing homes can only be issued with respect to new structures of first or second class construction. A reasonable cost of land, building, and equipment of this nature would be $5,500 per bed.

If we take a fair ratio of 30 percent equity capital and 70 percent debt capital, then instead of 50 cents the figure would have to be $1.16.

If we decide that the structure should be of a nature warranting Federal Housing Administration approval, namely about $7,000 per bed, then the figure would have to be $1.50, or an increase to $8.71 rather than $7.71 for this item alone.

If we choose, as a matter of social policy, structures of new construction and of first or second class construction, then depreciation allowances in the rate must be at last doubled. Real estate tax allowances must be increased, too, beyond those now in the rate.

Look to the allowance in the rate for dietary wages in appendix F. Forty-four cents is included in the rate. Is $13.20 a day in a 30-bed nursing home sufficient to pay decent wages and obtain a competent cook and kitchen help to prepare and serve 3 meals a day to 30 patients plus employees?

Look to the allowance of 24 cents or $7.20 a day for a 30-bed nursing home for household employees. Is $7.20 a day sufficient to pay decent wages to provide the standard of cleanliness you would want in a 30-bed nursing home, recognizing that under Massachusetts regulations nursing personnel and kitchen personnel and household personnel must stick to their particular occupations.

Look to what is allowed for laundry in appendix F, which amounts to 15 cents per patient day. Hark back to the fact that 39 percent of nursing home patients are incontinent either all or some of the time. Does 15 cents a day approach what is needed to maintain the standard of cleanliness so needed for human dignity? In 1961 wages paid to laundry workers in Massachusetts hospitals having 51 to 100 patients averaged 91 cents per patient day.

Again may we make it clear that the Massachusetts Rate Setting Board for the last 10 months has been moving in a direction to solve these problems. Daily rates up to $7.75 were approved for individual homes on appeal from the general rate of $6.85 in 1964.

There are innumerable appeals of individual homes from the rate of $7.71 set this year. These appeals are being considered thoroughly and fairly. In addition to the interest of the individual home on appeal, the board is developing information about costs in relation to standards which will be invaluable.

The basic problem, however, remains. Appeals are decided on historical costs of operation of the particular home, not on the cost of providing the kind of care and environment best related to the essential nature of a nursing home. To meet this problem which is really the key to the future the board of rate setting, the department of public health and the federation are intent upon and working together to evolve as quickly as possible a classification program which will be a practical incentive to nursing homes to move forward by removing the logjam which now exists of inadequate rates to do the job desired.

We submit two documents: (1) a detailed survey being made of all nursing homes by the department of public health and (2) a less comprehensive survey of the Massachusetts Board of Rate Setting for nursing homes to get such a program off the ground and working by January 1, 1965, at the latest.

Anyone who thinks the evolution of such a program is simple is one who does not understand the complexity of the overall problems. Serving the interests of the community with regard for the elderly infirm, with fairness to nursing homes and with concern for the taxpayer requires a considerable degree of working together and mutual respect in an atmosphere free from recrimination and strife.

We would not have you believe that rates are the only problems. There are many others.

One of the most critical is the grave shortage of registered nurses and licensed practical nurses to meet requirements now and in the future. No matter what wages or working conditions are set, it would be impossible to secure the skilled help which nursing homes and others might want.

Continuing educational programs for the administrators and personnel of nursing homes is a necessity. In Massachusetts the federation some years ago conferred with Northeastern University and at its urging Northeastern inaugurated educational conference programs for nursing home personnel in the fields of business management and methods and certain professional aspects of nursing home care. These programs of Northeastern have extended throughout New England and beyond. These programs must be expanded with the opportunities created for many more nursing home personnel to participate in them.

Our relationships with the regulatory departments of government is good. This does not mean that we don't have problems and differences of opinion. Our most serious is with respect to the literal application of rules and regulations relating to physical properties of structures that have been operating for many years. The questions involved are not as to quality of nursing care or cleanliness or decent food or essential comforts. They relate to whether or not there is much if anything to be gained for patients out of certain changes in existing physical structures costing thousands of dollars.

These matters are being discussed and undoubtedly at all times there will be areas of difference of opinion to be rationally analyzed and resolved. We would hope that sound solutions could always be found.

Another area of our continued interest is the implementation of the program of accreditation of nursing homes inaugurated by the American Nursing Home Association in conjunction with the American Medical Association. Speeding this program is in the forefront of important things.

What about the Federal Health Insurance for the Aged Act, the so-called medicare law, as it relates to nursing homes in Massachusetts. These observations will, of course, be tentative pending analysis of the law in its final form and the rules and regulations still to come.

In assessing the impact of this act in its posthospital extended care provisions to nursing homes, it will be helpful to hold in mind that nursing homes, in general, in Massachusetts are homes for the elderly infirm and not just a transitional point between the hospital and home, that the avarage length of stay is 17 months, and that 75 percent of the patients in nursing homes are 75 years of age or over.

The new law picks up the reasonable cost of nursing home care for eligible individuals for 20 days following at least 3 days in a hospital and such reasonable cost, less $5 per day, for the next 80 days. Thus, about 3 weeks of full pickup is provided and about 10½ weeks of partial pickup.

These benefits are the maximum nursing home benefits allowed in a spell of illness. To establish a new spell of illness to start benefit rights all over again would require that the individual be out of a hospital and a nursing home for a considerable spell of time, which is not the history of the usual nursing home patient.

Thus these observations can be made:

1. When the nursing home benefits become available July 1, 1967, nobody then in a nursing home will be entitled to any benefits and will not thereafter be entitled until they spend 3 days in a hospital.
2. The nursing home benefit rights will help those not in need and who require short-term convalescent care, for it will pick up 3 weeks at full reasonable cost and 10½ weeks at partial reasonable cost.
3. It will help the individuals who can pay their own way and who require long-term nursing home care because it will pick up costs for a short time as indicated above.
4. It will help the needy person who would otherwise be entitled to medical care for the aged and who needs only short-term convalescent care simply to the degree that the rate paid under the system for nursing home care exceeds the similiar rate paid for medical care to the aged.
5. Its benefit to the needy person who requires long-term nursing home care is questionable since when the short-term benefits of the medicare law are over, the individual will have to switch, with all the formalities required, to medical aid to the aged.

Just what will be the impact in the future operations of nursing homes is hard to tell. Perhaps it will lead to a considerable increase in the number of individuals taking short-term convalescence in a nursing home rather than at home. Per-

haps it will lead to the development of more short-term convalescent facilities than now exist or a change in the operational procedures and methods of existing nursing homes to adjust to short-term convalescence as well as long-term care.

It is too early to judge. But the total effect could be very limited as it relates to the area we discuss here today; namely, the aged in need of long-term care.

Indirect effects could be beneficial; namely, the persuasion of the act toward agreements and working relations between hospitals and nursing homes.

The limited application of the act to long-term care of the aged points up the impelling necessity of resolving all difficulties standing in the way or relating rates paid to the cost of nursing home standards desired under our medical aid to the aged system.

Under the new medicare law benefits are paid as a matter of right and individuals can add to these benefits to secure better or additional accommodations or services. This is not so if the individual is needy and is entitled to medical aid to the aged. This seems incongruous. Those not in need can supplement the Government benefit to secure better services and accommodations but others cannot help needy people to secure better services and accommodations than the medical aid to the aged rate will permit.

Summed up, Massachusetts nursing homes have had many problems, they have tried to meet them and to point the way to solutions, there is reason for cautious optimism that public-aided rates will be realistically related to the cost of standards desired, that we still have many problems on which nursing homes, the federation and the governmental departments are working and that with a little bit of luck and a degree of mutual respect we can solve them.

APPENDIX A

Size and distribution of nursing homes, July 1, 1961—Length of stay

Licensed bed capacity	Number	Percentage	Licensed bed capacity	Number	Percentage
1 to 20	270	36.94	61 to 70	13	1.78
21 to 30	199	27.22	71 to 100	13	1.78
31 to 40	122	16.69	101 to 320	10	1.37
41 to 50	68	9.30			
51 to 60	36	4.92	Total	731	100.00

Distribution of nursing homes

Area	Number
Boston area	506
Beverly-Salem area	65
Worcester area	86
Springfield area	46
Pittsfield area	21
Barnstable area	7

LENGTH OF STAY

The Boston College Nursing School study of 136 Massachusetts nursing homes (1963 report) found the median stay was 17 months. Thirty-six percent of patients had been in the nursing home less than 1 year, 14 percent between 1 year and 18 months, and 10 percent had been in a home for 5 to 32 years.

APPENDIX B. AGE AND DISGNOSTIC CATEGORY OF NURSING HOME PATIENTS, MASSACHUSETTS

Diagnostic category (108 nursing homes)

	Total
Diseases of circulatory system	1, 119
Diseases of nervous system and sense organs	624
Diseases of bones and organs of movement	464
Symptoms, senility, and ill-defined conditions	386
Allergic, endocrine, metabolic, and nutritional	158
Neoplasms	114
Mental, psychoneurotic, and personality disorders	113
Other disease categories	130

Source: Boston College Nursing School study, 1963, 136 homes.

Age distribution (135 nursing homes)

	25 to 64	65 to 74	75 and over	Total
Total number	292	717	2, 938	3, 947
Total percentage	7.4	18.2	74.4	100.00

NOTE.—Patients ranged from 25 to 105 years with the median age being 80 years.

APPENDIX C

Bed status of nursing home patients and degree of incontinence

	Number	Percentage
Bed status:		
Complete bed rest	180	5.9
Bed and chair	884	28.9
Ambulatory with assistance	542	17.7
Ambulatory	1, 448	47.5
Degree of incontinence:		
All the time	594	19.1
At night only	119	3.8
Occasionally	486	15.6
None at all	1, 909	61.5

Source: Boston College Nursing School study, 1963, 136 homes.

Small homes had a greater percentage of bed patients and incontinent patients than large homes. Small homes are defined as having 3 to 30 beds and large homes as having 61 to 145 beds.

Appendix D. Comparison of Component Parts of Rates for Nursing Home Care of Public-Aided Patients in Massachusetts, Promulgated in 1962, 1963, and 1964

The Massachusetts Division of Hospital Costs and Finances for the years 1962 and 1963, and the board of ratesetting for the year 1964 determined the rate to be paid for the nursing home care of the public aided.

The identical rate of $6.85 per day was promulgated in each of the 3 years, except that in 1964 an additional amount of 31 cents per patient-day was allowed where a nursing home could show that it provided 2 or more hours of nursing care per day per patient.

The following is the manner in which the $6.85 rate promulgated in each of the 3 years was arrived at:

	1962	1963	1964
(a) Adjusted cost of operations	$5.18	$5.41	$5.97
(b) Increased cost of living factor	.06	.11	.10
(c) Return on invested capital	.49	.43	.22
(d) Salary equivalent for officers and/or proprietors	.83	.75	.49
(e) Other factors	.30	.15	.08
Total	6.86	6.85	6.86

Appendix E. Allowances in the Massachusetts Rate for the Nursing Home Care of the Public Aided for Various Items of Operating and Capital Costs

A basic rate of $6.85 per day for the nursing home care of the public aided was promulgated May 15, 1964, by the board of rate setting for nursing homes. The allowances stated by the board as being included in the rate of $6.85 are as follows:

Compensation for owners nursing, dietary, and managerial service	$0.49
Administrative wages	.04
Nursing care wages	2.79
Dietary wages	.335
Cleaning wages	.179
Wage order 25C	.08
Laundry wages	.02
Laundry	.129
Food	.885
Heat, light, power	.258
Insurance	.147
Repairs and maintenance	.127
Rent	.009
Taxes	.359
Motor service	.03
Medical supplies	.052
Miscellaneous	.182
Cost of living adjustment	.10
Depreciation	.29
Interest	.14
Return on investment	.22

APPENDIX F

Allowances in the $7.71 per diem rate for public aided patients in Massachusetts effective Jan. 1, 1965

Item	Amount
1. Nursing care wages	$2.81
2. Personnel wages and salaries exclusive of nursing personnel	.82
(a) Dietary	.44
(b) Household	.24
(c) Laundry	.04
(d) Administrative	.09
(e) Other	.01
3. Compensation for service of proprietors or officers	.69
4. Employment taxes, workman's compensation and insurance	.44
(a) Employment taxes	.27
(b) Workman's compensation and insurance	.17
5. Fringe benefits for employees	.10
6. Raw food	.87
7. Heat, light, and power	.23
8. Laundry	.11
9. Real estate, personal property, and corporation excise taxes	.19
10. Repairs and maintenance	.16
11. Medical supplies	.05
12. Other supplies	.11
(a) Office supplies, etc	.02
(b) Supplies, household and property	.09
13. Professional services, legal and accounting	.04
14. Administrative and general	.18
(a) Telephone	.06
(b) Advertising	.02
(c) Dues and subscriptions	.02
(d) Miscellaneous	.03
(e) Auto expenses and other	.03
(f) Other household expenses	.02
(g) Educational expense	-----
(h) Meetings	-----
(i) Travel	-----
(j) Entertainment	-----
15. Depreciation	.34
16. Interest on debt capital	.23
17. Return on capital investment	.27
18. Increased cost of wages and proposed health and safety regulations	.07
Total	7.71

APPENDIX G

Per diem rate for public welfare hospital, chronic hospital, and nursing home patients

All inclusive per diem rate for 136 Massachusetts hospitals:	
1959 average per diem rate	$20. 47
1964 average per diem rate	$29. 94
Increase	$8. 47
Percent increase	41. 3
All inclusive per diem rate for 12 Massachusetts chronic hospitals:	
1959 average per diem rate	$9. 78
1964 average per diem rate	$13. 46
Increase	$3. 58
Percent increase	36. 6
Per diem rate for nursing homes:	
1959 per diem rate	$6. 50
1964 per diem rate	$6. 85
Increase	$0. 35
Percent increase	5. 4

Source: Massachusetts Department of Public Welfare State letter 99 and 166.

APPENDIX H

Some fiscal facts about Massachusetts since 1959

	Increase over 1959 (percent)
APPROPRIATIONS—ALL STATE FUNDS	
$449 million in fiscal 1959 to $515 million in fiscal 1963 to $564 million in fiscal 1964 to $587 million proposed fiscal 1965	30. 0
GENERAL FUND	
$314 million in fiscal 1959 to $384 million fiscal 1963 to $448 million proposed fiscal 1965	42. 0
PERMANENT STATE SALARIES	
$139.5 million for fiscal 1959 to $210 million for fiscal 1964	50. 0
STATE AID TO CITIES AND TOWNS	
$105.5 million in fiscal 1959 to $147.6 proposed for fiscal 1965	40. 0
FEDERAL GRANTS FOR PUBLIC WELFARE PROGRAMS	
$61.5 million in fiscal 1959 to $90.5 million in fiscal 1963	47. 0
TAX REVENUE TO GENERAL FUND	
$290.8 million in fiscal 1959 to $340.8 million in fiscal 1963 to $372.5 million (estimate) in 1964 to $384 million (estimate) in fiscal 1965	32. 0
INCREASE IN WELFARE NURSING HOME RATE	
$6.50 per patient day in 1959 to $6.85 per patient day in 1964	5. 4

Mr. CONNELLY. Summarizing my statement, the federation feels:

(1) That Massachusetts laws and rules and regulations governing standards of care and safety in nursing homes are high;

(2) That much has been accomplished, particularly in the last year, in coordinating public-aided rates with the costs of standards of care and safety;

(3) That there is reason for cautious optimism that the coordination between public-aided rates and standards desire will soon be materially advanced under a program of classification of nursing homes now being studied by the State regulatory agencies with the cooperation of the federation;

(4) That this is the key to better nursing home care since over 70 percent of nursing home patients are public aided, and this percentage rises each year;

(5) That much has been done but much more remains to be done; and

(6) That the problem is not only sufficient income to do the job but also adequate personnel in the regulatory departments to enforce standards and to undertake projects and studies, the training of more licensed nursing personnel, and expanded opportunities for the training of nursing home administrators in business and professional matters.

That, Mr. Chairman, is my statement.

Senator NEUBERGER (presiding). Thank you.

Senator Kennedy, do you have questions?

Senator KENNEDY. Mr. Connelly, how long have you represented the Nursing Home Federation?

Mr. CONNELLY. I think it began in 1952.

Senator KENNEDY. Since 1952?

Mr. CONNELLY. Since 1952.

Senator KENNEDY. As I understand it, there are some 350 nursing homes that are represented by the federation.

Mr. CONNELLY. At the present time.

Senator KENNEDY. I am wondering if you can tell me whether the federation, itself, has adopted criteria or standards designed to uplift the kind of care given to the patients resident in these nursing homes?

Mr. CONNELLY. Yes. The federation has, together with the American Nursing Home Association, worked for years toward the evolution of an accreditation program.

Senator KENNEDY. Specifically, Mr. Connelly, what has the federation, itself, recommended even in the form of legislation or recommendations to the appropriate legislative committees here in the State to upgrade the quality of care and establish a set of standards by which the care provided to patients in these nursing homes could be measured?

Mr. CONNELLY. Well, I think the history of Massachusetts in the last 12 years has been in the affairs related to the elderly; a history of great activity by the Massachusetts Federation of Nursing Homes.

The federation recommended to the legislature, through a recess commission, the formation of the present board of rate setting for nursing homes composed of the commissioner of finance and administration, the commissioner of public health, and the commissioner of public welfare. The purpose of this was to coordinate rulemaking with ratemaking.

The federation supported legislative proposals providing for sprinkler systems in nursing homes, and, in fact, recommended this authority be given to the department of public safety together with the responsibility of promulgating a comprehensive code of safety for nursing homes.

The federation recommended the resolve adopted by the Massachusetts Legislature in the late 1950's for the creation of a recess study commission to consider and recommend on the problems of nursing homes and nursing home care. The resolve called for a commission composed of legislators, of all Government departments having any responsibility toward nursing homes, and of representatives of the elderly people, the hospitals, the medical and nursing professions, the nursing homes, and the general public. The purpose of this recommendation was to unite all groups having a connection and interest in nursing home matters in common understandings and common objectives. Though this commission came into being it was never brought together to function.

The Federation supported 33 of the 37 recommendations of a later recess commission, the only reservation being that public-aided rates had to be adjusted to enable most of the recommendations to be effected.

Before the regulatory authorities of the State it has supported, recommended, and cooperated with respect to the evolution of a classification system for nursing homes which we hope will soon be in effect for nursing homes. The federation together with the department of public health requested the Boston College School of Nursing to apply for a grant and to conduct a 2-year study of nursing care needs in nursing homes. The reason for this was to obtain the facts on which to improve standards and speed classification and accreditation of nursing homes.

The federation at the request of the department of public welfare assumed the responsibility of coordinating all groups in the Commonwealth in writing and securing the passage of the Commonwealth's medical assistance to the aged law implementing the Federal Kerr-Mills law. It is considered to be one of the best in the Nation.

Senator KENNEDY. Mr. Connelly, the thrust of my question, and maybe I did not state it clearly, is that any professional or most professional organizations, groups that represent various societies or groups of professional people, establish certain standards which they feel are not only the minimum standards but are standards which any members of an organization should live up to.

My question was whether the federation, itself, established criteria by which the minimum standards for these 351 nursing homes would be measured or whether you depend completely upon existing State regulations. I would assume from the first two or three pages of your testimony, that you did?

Mr. CONNELLY. Yes; we do——

Senator KENNEDY. So you——

Mr. CONNELLY. May I finish answering the question, Senator?

We do rely upon the State enforcement agencies to be the source of this. In this Commonwealth, four out of five nursing homes depend almost totally upon the income they receive from public rates.

Senator KENNEDY. Now——

Mr. CONNELLY. May I finish, Senator, please?

Since they do depend upon public-aided rates and since the rates through the years have been totally inadequate to meet what we consider to be the needs of the patients in nursing homes, therefore, how can we, ourselves, go ahead and institute standards of care, an accreditation device, to establish any of our standards of care higher than are the standards of care of the department of public health?

If a nursing home organization is composed, as it is, of two staff people out of the income that it has, how can it possibly then with two staff people, ever do the kind of job in determining whether they meet such standards that the department of public health does?

We cannot do it. Whenever they, in the past, determined then in a particular instance a home was not one that they wanted to be a member of the federation, they refused.[1]

Senator KENNEDY. Mr. Connelly, were you here this morning during the testimony of Dr. Knowles?

Mr. CONNELLY. Yes.

Senator KENNEDY. In looking over your appendix A, it seems that by your own figures the number of homes with licensed bed capacity between 1 and 20 numbers 270 which represents 36.94 percent of the total number.

I am wondering in light of what Dr. Knowles said, and the other testimony that we had this morning, whether you felt that these units could be economically viable?

Mr. CONNELLY. My own personal feeling, Senator, is that we will do a great disservice to the people of this Commonwealth and the reason—and the people for whom we are sitting here now, if we attempt to trend this toward the larger nursing homes. I have tried to emphasize my concept that in the minds of many people the nursing home is home and it should not be an institution.

Senator KENNEDY. Mr. Connelly, if you could now——

Mr. CONNELLY. I think we are going back.

Senator KENNEDY. Would you read my question?

(Question read by the reporter.)

Mr. CONNELLY. Is your question that probably these homes from 1 to 20——

Senator KENNEDY. That constitute 36 percent of the available bed capacity, whether you feel that those could be economically viable in view of the testimony that we heard this morning from the other witnesses? I would appreciate——

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[1] The following clarifying statement was subsequently received from Mr. Connelly:

The Federation does not have any present standards for membership superior to those required for licensure by the department of public health. The reason is that over 70 percent of nursing home patients are public aided and four out of five Massachusetts nursing homes are limited in what they can do by the income they receive for such public aided patients. To improve standards we must improve the ability of these homes to do so. For the federation to have higher standards for membership than the regulations of the department of public health require would serve no good public purpose for the effort must be directed toward enabling the 80 percent of homes dependent upon public aided income to do a better job. In general, the department of public health is in a better position with its inspectors to do a better job of determining whether homes live up to regulations.

Mr. CONNELLY. Would you explain what you mean by economically viable?

Senator KENNEDY. Can they be profitable under proprietary ownership?

Mr. CONNELLY. It depends on what you think of as a profit. Many of these small homes——

Senator KENNEDY. What is a fair return on investment?

Mr. CONNELLY. Well, Senator, these small homes are not——

Senator KENNEDY. Mr. Connelly, if I could get just an answer on this, it would be appreciated a great deal. If there is trouble in understanding the question, I will restate it. We are earnestly trying to find out.

We have heard a great deal of testimony on this whole question from Dr. Knowles and others about whether these people can have an adequate return or whether they cannot be provided an adequate return on investment.

Now, what I am interested in, you are the spokesman for the association, I want to know from you as a spokesman for the association, whether you feel that they can make good?

Now it does not seem to be a very difficult question, and I would appreciate it if we could have a responsive answer.

Mr. CONNELLY. Well it is a difficult question but I will try to answer it.

If the owner of a small nursing home also administers the home and, in addition, performs some other services in the home for which wages would otherwise have to be paid, then the home could be a profitable venture.

If the owner or owners of a home with 30 or less patients neither administer nor perform other functions in a home then, in the absence of exceptional circumstances I do not think the home could be a profitable venture. The exceptional circumstances relate to the number of private patients and the rates such patients pay.

Senator KENNEDY. So, in other words, you feel that the small nursing homes can be profitable if they are owner operated?

Mr. CONNELLY. Yes. Traditionally the smaller homes have been owner operated either by individuals or husband and wife teams and only when so operated do they have a chance to be considered a profitable venture, in the absence, of course, of exceptional circumstances.

Senator KENNEDY. All right.

Could you tell me if you feel that when the size moves to—say, for example, the 21 to 30 bed capacity, must that be owner operated or can that be operated by chain operators?

Mr. CONNELLY. Chain operators?

Senator KENNEDY. Well, an absentee owner.

Mr. CONNELLY. My own feeling is that any nursing home of less than 50 beds, in the absence of exceptional circumstances, must have a considerable degree of owner management and operation in order to function properly as a profitmaking venture. Ordinarily they cannot be ventures in which a person invests his money, as in stock, and leaves the management up to somebody else.

Senator KENNEDY. Now it would appear from what you have said that actually the number or the percentage of nursing homes which have licensed bed capacity of more than 51 account for less than 10 percent of the total number of licensed beds in the State.

Mr. CONNELLY. Yes.

Senator KENNEDY. So do you feel that 90 percent, then, as I would gather from your testimony, 90 percent of the licensed bed capacity in the State ought to be owner-operated in order to be economically viable?

Mr. CONNELLY. In the absence of exceptional circumstances, yes—if the profits, so called, are not to be taken from amounts needed for the care of patients.

Under appendix F of the federation's statement you will note there is an allowance of 44 cents per patient-day for dietary wages. For a 30-bed nursing home, $13.20 a day is, therefore, allowed to pay wages to kitchen help. Under Massachusetts regulations, kitchen help and nursing care help and cleaning help can't exchange their duties.

The simple question comes: Is it possible on 44 cents per patient-day or $13.20 a day for a 30-bed nursing home to pay fair wages to kitchen help to feed 3 meals a day to 30 patients plus employees?

This is why we say the smaller homes must be owner-operated to cope with such problems.

Senator KENNEDY. Mr. Connelly, I could not agree with you more, and that is why I wonder why there has been such a flourishing of new nursing homes in this State.

I think you have stated it much more competently and accurately than I possibly could.

Mr. CONNELLY. I agree with you, Senator. I think that the question is a very good one and the same question is being asked by many people who constructed nursing homes as to why they entered upon such a venture. [Laughter and applause.]

I find it difficult under the conditions that have prevailed in Massachusetts until quite recently, why people have invested money in the building of new nursing homes.

I have asked why, and it seems that though 70 percent of patients are public aided and only 30 percent are private patients, nevertheless, everyone believes private patients will flock to their doors, which is not so.

No new nursing home can meet its capital and other costs at $7.71 per patient-day.

Senator KENNEDY. Mr. Connelly, let me just say that I could not agree with you more, that I think that that figure has to be raised. [Applause.]

Mr. CONNELLY. And believe me, Senator, the federation and the nursing homes of the Commonwealth don't want any more than is needed to do the job that society wants done. The federation believes the regulatory departments should know the cost of the standards they set so that all nursing homes not meeting such standards though they are adequately paid to do so, can be put out of business.

Senator KENNEDY. Well, Mr. Connelly, as I say, I could not agree with you more, there has to be adjustment of that figure and it has to be upward.

A matter which concerns me, Mr. Connelly, I have this number of letters received just this morning here, a sampling of which I have gone through, which are overwhelming in the kinds of complaints made with regard to the nursing homes here in the State, and this is a matter of considerable concern to me, Mr. Connelly.

When you speak, as I know you do, for the federation, I am sure that you are conscious of these allegations and charges which have been made, and I talk about these letters as being well written and thoughtful.

I have been reading letters in the limited time I have been a Senator and I know a crank letter when I see one. These are some of the most heart-rending letters that you can imagine.

My only purpose, Mr. Connelly, is that inspired by the hundreds of letters that I have received, I find that we are not providing these kinds of services properly for the elderly citizens of the Commonwealth and I want to know why.

If something can be done about it, I think we ought to do something about it.

Thank you very much for your appearance here.

I have no further questions.

Mr. CONNELLY. I can't agree with you more, Senator, that whereever there is any instance in the Commonwealth of an individual not being properly cared for in a nursing home, then every power of the Government ought to be directed toward curing it.

Senator KENNEDY. I will do better. I will ask these people for permission, and I will send you copies of all their letters so that you, as counsel, can draw them to the attention of the appropriate people.

Mr. CONNELLY. Yes. [Applause.]

Senator NEUBERGER. The next witness is Dr. Henry Bakst, assistant dean, School of Medicine, Boston University.

STATEMENT OF HENRY BAKST, M.D., ASSISTANT DEAN, SCHOOL OF MEDICINE, BOSTON UNIVERSITY

Senator NEUBERGER. Dr. Bakst, you may either read your testimony or speak extemporaneously, any way you want to get your message across.

Dr. BAKST. I will try to hit the highlights as I go through my statement in order not to take up too much time.

(The statement follows:)

PREPARED STATEMENT OF DR. HENRY J. BAKST

THE PROBLEM

The issue of health care for the aging is primarily, but not exclusively, the provision of adequtae and effective management of chronic illness. It has been demonstrated repeatedly that the aging utilize physician services and the services of allied professional health personnel more frequently in a given period of time than do individuals in the younger age groups. Characteristically, they suffer from disease which is chronic, which is often progressive, and which is frequently multiple and disabling. Altered biological reactions often tend to make superimposed acute illness difficult to identify. Psychological factors result in compounding the problems of management. Care frequently is made more complex because of limited financial resources and associated social and family problems.

Hospitalization occurs more frequently than in the younger age groups, and when it does occur, is apt to be more prolonged. By and large, the personnel, services, and facilities of general hospitals are geared to short-term hospitalization and, once the diagnosis has been made, an appropriate regimen of management has been established, and the patient's condition has been stabilized, there is usually no further justification for continued high cost hospitalization. In the case of short-term, acute, self-limited illness, when these goals have been attained, most patients are ready to be discharged from the hospital and return to their home directly or do so after a short period of convalescence.

The characteristic situations noted above frequently preclude this course for the aging. Often a home in the true sense of the word does not exist. Usually, while continued general hospital care is not required, continued medical care still is essential. Not infrequently, the aging patient continues to require supervision, bed rest, medication, special care, or special procedures which cannot be provided at his home, if he has one, or at his usual place of domicile. Such patients are usually transferred to nursing homes and under these circumstances no longer continue to have the benefits of the kind of medical supervision they require. It is apparent that, while the medical care need tends to be continuous and requires a pattern of comprehensive, integrated, and coordinated service, the medical care which is provided often tends to be characterized by an ill-defined network of patient-care routes, by lack of understanding on the part of those who provide patient care, and by the absence of appreciation of their roles and responsibilities within the network.

This is the situation in most metropolitan areas and is equally true of the city of Boston. Health care services are splintered both as to the kind and duration of care. The splintering of services fosters confusion on the part of both the recipient and the provider of medical care as to the availability of health services and encourages a lower standard of care than is attainable through the coordination of these segments into an integrated pattern of comprehensive care.

One segment of comprehensive or total care is continuing care or that segment which is concerned with pre- and post-hospital care. The continuing care required after hospitalization may be obtained in a nursing home, chronic disease hospital, or the patient's home. Indeed, several institutions in the city of Boston have been engaged in coordinated home and hospital programs for some time. One of these has been in continuous operation for about 170 years and another for over 90 years. They have established beyond any reasonable doubt the ability of private, voluntary agencies to extend the capabilities and services of the hospital into the home of the patient.

HOSPITALS AND NURSING HOMES

In the Boston area, as in most parts of the country, general hospitals and nursing homes operate separately from each other. The result is two fragments of medical care, short term in the hospital and long term in the nursing home. It is apparent that these two phases of medical care should be united into an uninterrupted continuum. It follows that an integrated hospital-nursing home system is essential if a unified and continuous program of care is to be attained. The present lack of integration suggests a double standard for the level of quality of medical care depending upon whether a patient happens to be in a hospital or a nursing home.

Most of the accredited general hospitals are voluntary, nonprofit institutions. Most of the nursing homes are proprietary organizations. In many respects, the nursing home situation today is comparable to the pattern of medical school organization before the turn of this century when many medical schools were proprietary and whose standards of medical education were at a relatively low level. It is believed that the best interests of the patient would be served by a completely nonprofit system. This would necessitate the development of a voluntary, nonprofit system of nursing homes operating parallel to and integrated with the voluntary hospital system. However, the problem is current, and the present realistic need is for the joint establishment of relationships by hospitals and all types of nursing homes as the first step toward the eventual development of an integrated voluntary structure. This immediate step is now essential because of recently approved medicare legislation in which nursing home participation is dependent upon an agreement with a hospital covering the transfer of patients between cooperating institutions. The development of relationships between hospitals and nursing homes and the long-range development of a voluntary nursing-home system paralleling the voluntary hospital system should be of immediate concern not only to hospitals and nursing homes but to health and welfare agencies and allied community groups, all of which should be involved in planning for continuity of care.

QUALITY OF CARE AND LONG-TERM FACILITIES

Quality in long-term care facilities is a difficult and complex problem and is intimately related to the concept of comprehensive care. An excellent example is provided by a study made in Michigan which began in 1957 and was reported

in 1962.[1] In Michigan, county hospitals provided convalescent and nursing care and limited medical treatment to persons whose medical needs were met through State and local agencies. Most of the patients were elderly and had been hospitalized for several years because of chronic illness. Relatively few of these institutions were in a position to provide rehabilitation services. Most of them maintained a traditional pattern of passive, custodial care. The Michigan project was carried on for 3 years to demonstrate and measure the extent to which financial, personal, and social dependency of aged patients in county hospitals could be reduced by the rehabilitation of their functional abilities, by returning and utilizing their vocational and occupational skills, and by improving their social adjustment. On the completion of the restorative program one-third of the total experimental population was eligible for discharge to nonnursing settings.

A preliminary report of an ongoing continuous care study of chronically ill patients in New York City is also pertinent.[2] In this study, a group of chronically ill patients were reviewed at periodic intervals beginning at the time of hospital discharge and continued over a 2-year observation period. The study population was a predominantly medically indigent, low-income, elderly group with neuromuscular and musculoskeletal physical impairments resulting largely from cardiovascular disease. The initial post-hospital-discharge status suggested a high degree of successful adaptation to the demands and requirements of community living and was largely a result of the hospital process of selection for discharge of patients who had achieved adequate levels of medical stability and functional ability. However, of particular interest was the observation that continued successful adaptation seemed to be related to the ability of the patient to identify and aggressively pursue available health and related resources within the community. Two aspects of this conclusion deserve consideration. First, patients in this category, even when appropriately selected for hospital discharge, have a relatively short expectancy for maintaining their medical stability and functional ability. This is obviously a reflection of the nature of their health problems. Second, continued adaptation to community living is dependent on the patient's aggressive pursuit of health services. In many situations, the characteristics of their diseases and disabilities preclude such action. Thus, the need for a system of comprehensive and continuous care is emphasized again even under circumstances that may be considered optimal.

RECOMMENDATIONS

1. Hospitals, nursing homes, health and welfare agencies, and community leaders should aim toward the goal of a program of comprehensive and continuous care through the eventual development of a voluntary nursing-home system within or parallel to the voluntary hospital system. As an immediate responsibility, steps should be taken to initiate appropriate relationships between hospitals and all types of nursing homes.

2. Criteria for the quality of medical care provided through hospital-nursing home relationships should be developed. This should be the joint responsibility of hospitals since they are medically and administratively most advanced in the provision of medical care.

3. Criteria for the transfer of patients between hospitals and nursing homes should be established as well as an organized method of patient evaluation for transfer. This will require:

(*a*) The development and maintenance of continuing care relationships between hospitals and nursing homes.

(*b*) Early involvement of the patient's physician and the hospital staff in the patient's continuing care.

(*c*) General education of health personnel in regard to the specific resources available for continuing care.

(*d*) The provision of a means of effective communication between the physician, staff, and available community resources.

4. From a long-term point of view, the single most effective way in which the concept of comprehensive and continuous care will become a part of medical practice is by its inclusion in the process of medical education and training. It is recommended that such specific instruction be incorporated in the medical school curriculums and in postgraduate training programs.

[1] Rae, J. W., Jr., Smith, E. M., and Lenzer, A. Results of a Rehabilitation Program for Geriatric Patients in County Hospitals. J.A.M.A. 180: 463–468, May 12, 1962.

[2] Kelman, H. R., Muller, J. N., and Lowenthal, M. Continuous Care Study of Discharged Chronically Ill Patients. A progress report. Presented at annual meeting of the Association of Teachers of Preventive Medicine, Miami Beach, Fla., Oct. 14, 1962. (Mimeographed.)

5. To avoid confusion and the development of multiple unrelated types of health plans with lack of coordination of interrelated segments, it is recommended that communities establish central agencies to serve as a source of information on planning in process which affects continuity of care patterns and to serve as a coordinating focus for such planning in the best interest of patients and those who provide medical care.

Dr. BAKST. One of the points that ought to be made completely clear is that the issue of health care for the aging is primarily, but not exclusively, the product of adequate and effective management of chronic illness. It is inherent in the figures which Mr. Connelly just provided, namely, that approximately half or so of the patients who go to nursing homes remain in nursing homes for extensive periods of time.

The diseases with which they suffer are for the most part cardiovascular in nature, they are progressive, they are incapacitating and they are disabling.

The problem of the relationship between the general hospital and the nursing home is a real one and one which is of considerable duration in terms of years. Usually while continued hospital care is not required for patients with acute illness discharged from the hospital; in terms of most of the elderly with chronic illness, continued medical care still remains essential. Not infrequently the aging patient continues to require supervision, bed rest, medication and special procedures which cannot be provided at his home, if he has one, or at his usual place of domicile.

Such patients are usually transferred to nursing homes and under these circumstances, no longer continue to have the kinds of medical benefits they have had under supervision in the hospital itself.

It is apparent that, while the medical care need tends to be continuous and requires a pattern of comprehensive, integrated, and coordinated service, the medical care which is provided often tends to be characterized by an ill-defined network of patient-care routes, by lack of understanding on the part of those who provide patient care, and by the absence of appreciation of their roles and responsibilities within this network.

This is the situation in most metropolitan areas and is equally true of the city of Boston. Health care services are splintered both as to the kind and duration of care. The splintering of services fosters confusion on the part of both the recipient and the provider of medical care as to the availability of health services and encourages a lower standard of care than is attainable through the coordination of these segments into an integrated pattern of comprehensive care.

One segment of comprehensive or total care is continuing care or that segment which is concerned with pre- and post-hospital care. The continuing care required after hospitalization may be obtained in a nursing home, chronic disease hospital, or the patient's home.

Indeed, several institutions in the city of Boston have been engaged in providing coordinated home and hospital care programs for some time.

One of these has been in continuous operation for about 170 years and another for over 90 years. They have established beyond any reasonable doubt the ability of private, voluntary agencies to extend the capabilities and services of the hospital into the home of the patient.

In the Boston area, as in most parts of the country, general hospitals and nursing homes operate separately from each other. The result

is two fragments of medical care, short term in the hospital and long term in the nursing home.

It is apparent that these two phases of medical care should be united into an uninterrupted continuum. It follows that an integrated hospital-nursing home system is essential if a unified and continuous program of care is to be attained. The present lack of integration suggests a double standard for the level of quality of medical care depending upon whether a patient happens to be in a hospital or a nursing home.

Most of the accredited general hospitals are voluntary, nonprofit institutions. Most of the nursing homes are proprietary organizations. In many respects, the nursing home situation today is comparable to the pattern of medical school organization before the turn of this century when many medical schools were proprietary and the standards of medical education were at a relatively low level.

It is believed that the best interests of the patient would be served by a completely nonprofit system. This would necessitate the development of a voluntary, nonprofit system of nursing homes operating parallel to, and integrated with the voluntary hospital system.

However, the problem is current and the present realistic need is for the joint establishment of relationships by hospitals and all types of nursing homes as the first step toward the eventual development of an integrated voluntary structure.

This immediate step is now essential because of recently approved medicare legislation in which nursing home participation is dependent upon an agreement with a hospital covering the transfer of patients between cooperating institutions.

The development of relationships between hospitals and nursing homes and the long-range development of a voluntary nursing home system paralleling the voluntary hospital system should be of immediate concern not only to hospitals and nursing homes but to health and welfare agencies and allied community groups, all of which should be involved in planning for continuity of care.

Quality in long-term care facilities is a difficult and complex problem and is intimately related to the concept of comprehensive care. An excellent example of one aspect of the problem is provided by a study made in Michigan which began in 1957 and was reported in 1962. (Rae, J. W., Jr., Smith, E. M., and Lenzer, A. Results of a Rehabilitation Program for Geriatric Patients in County Hospitals J.A.M.A. 180:463–468, May 12, 1962.)

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A preliminary report of an ongoing continuous care study of chronically ill patients in New York City is also pertinent from another point of view. (Kelman, H. R. Muller, J. N., and Lowenthal, M. "Continuous Care Study of Discharged Chronically Ill Patients." A progress report presented at annual meeting of the Association of Teachers of Preventive Medicine, Miami Beach, Fla., October 14, 1962 (mimeographed).)

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The study population was a predominantly medically indigent, low-income, elderly group with neuromuscular and musculoskeletal physical impairments resulting largely from cardiovascular disease.

The initial posthospital discharge status suggested a high degree of successful adaptation to the demands and requirements of community living and was largely a result of the hospital process of selection for discharge of patients who had achieved adequate levels of medical stability and functional ability.

However, of particular interest was the observation that continued successful adaptation seemed to be related to the ability of the patient to identify and aggressively pursue available health and related resources within the community.

Two aspects of this conclusion deserve consideration:

First, patients in this category, even when appropriately selected for hospital discharge, have a relatively short expectancy for maintaining their medical stability and functional ability. This is obviously a reflection of the nature of their health problems.

Second, continued adaptation to community living is dependent on the patient's aggressive pursuit of health services. In many situations, the characteristics of their diseases and disabilities preclude such action.

Thus, the need for a system of comprehensive and continuous care is emphasized again even under circumstances that may be considered optimal.

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5. To avoid confusion and the development of multiple unrelated types of health plans with lack of coordination of interrelated segments, it is recommended that communities establish central agencies to serve as a source of information on planning in process which affects continuity of care patterns and to serve as a coordinating focus for such planning in the best interest of patients and those who provide medical care.

Senator NEUBERGER. Dr. Bakst, you have provided a new idea as an educator in the school of medicine. Were you here this morning when Dr. Knowles testified and we commented that some of this had to begin in the medical school?

Well, now, what are you doing at Boston University to enhance and further this idea?

Dr. BAKST. We have been heavily engaged in regard to certain aspects, indeed, many aspects of this problem. All of our students participate in our home-care program. This involves providing medical care for 20 to 40 patients with chronic illness in their own homes.

Senator NEUBERGER. Oh, in their home.

Dr. BAKST. These patients move from their homes to the hospital to nursing homes, back to their homes, so that this is a continuing experience for them.

Another relationship which we also have is responsibility for the provision of medical care for the inmates of a home which provide care for elderly women not far from the hospital.

These two situations involve all of our students in a practical and realistic experience with the problems of taking care of the elderly.

Senator NEUBERGER. You mention, also, in your third point criteria for the transfer of patients between a hospital and nursing home. Do I understand from that that you support the 3-day hospitalization requirement of the health-care bill?

Dr. BAKST. I don't see how the program could operate without it. Some period of evaluation is essential unless one admits the fact that everybody who has a complaint is going to end up in the same place with no control of nursing home admissions.

Senator NEUBERGER. The people who represent the nursing homes seem to take another viewpoint, that many patients could be admitted directly to the nursing home by their own physician.

Do you agree that that could be done in cases without any harm to the patient?

Dr. BAKST. I think this could be done in certain cases. There are a number of situations, for example, in which the patient has been fully evaluated in a hospital at a relatively recent date and is being followed by a physician at home. If such a patient does not need the

facilities of a hospital but does require nursing home care he could very well be referred by the physician.

Senator NEUBERGER. Isn't that a rather strong restriction in the law then that we have to fill the hospital beds for 3 days?

Dr. BAKST. From the point of view of general hospitals, I think it would be very desirable to have some way out in which at least a portion of the patients who have been adequately supervised medically or who have been under care who have been hospitalized at a relatively recent time, and it might be 2 or 3 months, would not have to return to the hospital but simply be referred to a nursing home directly.

Senator NEUBERGER. Yes, that seems like an extreme provision to me. It just is not realistic that that would have to take place because all the way through the functioning of the health insurance law we and the patient are dependent upon the physician.

He is the one who must admit the patient, the patient can't say, "I am 65, I am entitled to go to the hospital." The doctor must say it; and if the doctor can say it for admittance to the hospital he is equally competent to say the patient needs to go to a nursing home.

So the responsibility is with the doctor, it seems to me, where it should be.

Dr. BAKST. I am afraid the element of physician responsibility has not been very well emphasized today, particularly in relation to the problem of long-term care.

Senator NEUBERGER. Of course, we sometimes forget that there are people under age 65 who are going to go to nursing homes, and they still can go without going to a hospital for 3 days because they are not beneficiaries of the social security program.

Dr. BAKST. That is right.

Senator NEUBERGER. So why should it be a different law and ruling for one age 64 and one age 65? A great deal has to be the jurisdiction of the individual doctor.

I take it that you believe that proprietary nursing homes are not as good as voluntary nursing homes.

Dr. BAKST. I don't think it is a question, really, as to whether they are as good or not as good. I think the real point is that all the rest of the medical care system from the educational point of view, at the very beginning to the provision of service within almost all of our voluntary general hospitals, is essentially on a voluntary, nonprofit system. I think it gets kind of complex to introduce a profit enterprise into this pattern.

Senator NEUBERGER. You said in your testimony that most hospitals are of the voluntary, nonprofit type.

Well, now, why can't nursing homes function that way, too? Is that the point?

Dr. BAKST. That is exactly the point.

Senator NEUBERGER. Then how can these hospitals be voluntary, nonprofit, and take care of most of the sick people of this country? Why are not more of them proprietary? What is it that keeps them going?

Dr. BAKST. The hospitals?

Senator NEUBERGER. Yes. Do they get subsidies because they are tax exempt? If they are connected with a church, do they get free nursing and care? What is the reason?

Dr. BAKST. Well, I suppose that tax exemption plays a role. Most of the hospitals, a good many of the voluntary hospitals, have their origin with some religious group. This has been true for a long time. Others have their origin with other groups of individuals who have decided, and rightfully so in most cases, that a particular community needs a hospital and then go through the process of raising funds for this purpose.

This, again, is a community effort and not the effort of a single individual who intends to build himself a hospital for profit.

The other feature, in my experience, at least, is extremely difficult to operate a hospital for profit.

Senator NEUBERGER. It must be, but I wonder——

Dr. BAKST. I think less than 10 percent of all the general hospital beds are actually in proprietary hospitals in the country, as a whole.

Senator NEUBERGER. Do you think that there is any conflict of interest when a doctor owns a nursing home? Some doctors in this country own nursing homes and have financial interest in them.

Do you consider that conflict of interest, or is it perfectly ethical?

Dr. BAKST. I am not sure I know how to answer that question. I would assume that in most situations the doctor who owns the nursing home is really admitting the patients of the other doctors who are really responsible for the medical care of the patient, not the doctor who runs the nursing home.

This is a little bit different from the wife-husband nursing home operating relationship that Mr. Connelly pointed out in his testimony a little while ago, in which the small nursing home could be run very effectively with a wife who is a nurse operating the nursing home.

I think it is quite possible that a nursing home could be operated by a doctor without a conflict of interest, provided he was not sending his own patients into that nursing home.

Senator NEUBERGER. If he thought the nursing home was good enough for some other doctor's patients, it surely must be good enough for his own.

He is admitting that he was not running a very good nursing home. Politicians are always being accused of engaging in a conflict of interest but doctors never do.

But you speak a great deal about community organizations that must take an interest in this. Through what kind of organizational arrangement should medical care and supervision be brought into nursing homes? We are going to set up the community mental health centers and community centers for heart, cancer, and stroke, and so on.

Where are we going to get this organization?

Dr. BAKST. Many of the concepts which both Dr. Knowles and I spoke about today, for example, were actually discussed by a special committee of the Hospital Council of Metropolitan Boston, and it was at this point that Dr. Knowles and I disagreed in regard to private and nonprofit nursing homes. It was at this point where we disagreed about the comparability of the history of medical schools and of nursing homes.

This is a means and this could be a device through which such an organization or such a committee could function as a central resource for the transmission of information, for the coordination of services, and so on.

Senator NEUBERGER. What business does the Federal Government have in the standards of nursing homes, or the question of whether they are proprietary or voluntary? Why are we holding these hearings?

Dr. BAKST. Well, first of all, I think the Federal Government is obliged to be concerned about how the money which the Federal Government provides is spent. I don't see how anyone can deny this responsibility. Some implication for responsibility in regard to controls, at least minimal controls, is essential.

Now there was another part of your question.

Senator NEUBERGER. Well, that was the main one, you said what I wanted you to say. No one has said it before.

I would just like to make one comment regarding Senator Kennedy's question about the very small nursing home.

I think there is a real place for that small, maybe 10- to 20-bed nursing home, because this is about the only place left in this country today where an entrepreneur sort of a mama-papa type organization can really go in and set up a business of their own.

If they are going to be licensed and supervised and have people, I see no reason why we have not got a place left in this great country for something that does not belong to a Holiday Inn chain. [Applause.]

Or some other group. I am sympathetic because my family are all farmers, and they are small farmers, and I have seen so many small farmers gobbled up because they try to make a living as a family enterprise.

I think if they want to work awfully long hours, awfully hard, that they can do it, and they should not be discouraged from providing it. This is where I would think that deans of medical schools and the legislators could serve a very useful purpose.

Dr. BAKST. Yes, indeed.

Senator NEUBERGER. Senator Kennedy.

Senator KENNEDY. I want to ask you, Dr. Bakst, as to how many effective home-care programs are operating in the State? The medicare program makes provision for this kind of care and I was wondering whether you are familiar with these home-care programs which are now operating and what was their success or what is their success.

Dr. BAKST. I don't think there are any outside of the Boston area. Within the Boston area, there are either five or six. I mentioned the two oldest in the group. This, of course, provides a technique and a medium for providing care in the patient's home and if hospitalization is necessary, the same organization arranges for the transfer to the hospital. The hospital is the one which is providing the home care, so that the same staff is involved in each case.

These individuals, when they are discharged, if they are discharged back to their own homes, are being cared for by the same staff that took care of them previous to hospitalization.

In our own program, I personally know patients which we have taken care of in this way on the order of 16 to 18 years.

Senator KENNEDY. Well, for the four or five programs that are operated now, are you familiar with any of them, or do you have any personal knowledge?

Dr. BAKST. Yes.

Senator KENNEDY. You have been pretty well satisfied with the work they have been doing?

Dr. BAKST. They serve several functions. First of all, they provide a service which is unique and which is useful.

Secondly, they provide a remarkable educational experience for our students. I have had some feedback in this respect. Most of them are not quite as appreciative at the time they are going through this experience as they are 10 or 12 years later.

Thirdly, it represents a very significant community contribution in terms of the hospital itself.

Senator KENNEDY. Thank you very much.

Mr. MILLER. Madam Chairman, may I ask a question pursuing the line of inquiry just made by Senator Kennedy?

Senator NEUBERGER. Yes.

Mr. MILLER. You indicated there were four or five or six of these home health care services in Boston. Do you have figures as to the number of patients they are serving, or are capable of serving with the present staff?

Dr. BAKST. I can't give you the total but for our own program we see something on the order of 4,000 patients a year.

We make something on the order of 15,000 home visits a year.

The population breakdown is an interesting one because there are two peaks in it. There is a large group of young children whom we see, then it declines in the early adult period and then rises again with increasing age, but the main bulk is in the children's group rather than in the old-age group.

Most of the programs which are concerned with medical care of the aged in their homes, find it quite difficult to manage more than something on the order of 35 or 40 patients at any given time. This means that they have 35 or 40 patients distributed through the city to take care of and lack the convenience of having 35 or 40 patients in one building. It is a very time-consuming operation.

Mr. MILLER. One other question, Madam Chairman.

Do you have information on cost per patient or some other cost?

Dr. BAKST. Yes, I have a cost figure. It has not been revised for several years. I hesitate to mention it but the figure that we are still using is $3.50 a visit.

Mr. MILLER. Thank you.

Senator NEUBERGER. Thank you, Doctor.

The next witness is Allan Robinson, former counsel to the Special Commission To Study Convalescent or Nursing Homes in Massachusetts.

Mr. Robinson, your whole statement will be put in the record if you would like to abridge it.

Mr. ROBINSON. Thank you very much, Madam Chairman.

(The statement referred to follows):

PREPARED STATEMENT BY ALLAN ROBINSON, FORMER COUNSEL TO THE SPECIAL COMMISSION TO STUDY CONVALESCENT OR NURSING HOMES (MASSACHUSETTS)

My name is Allan Robinson. I am a practicing attorney in the city of Boston, and may I further say I consider it a high privilege, indeed, to be invited to testify before your committee.

In the latterly part of 1962 I was honored by an appointment as counsel to the Powers commission, so called, and served in that capacity until the spring of 1964.

The commission was an extremely active one; its executive sessions for the most part plenary; its entire membership utterly devoted to its leadership and genuinely dedicated to its mandate and ideals. I was proud to be a member of its staff.

During my incumbency I was privileged, among other things, to author, with the invaluable assistance of my colleagues, the first or interim report of the commission (Mar. 1, 1963); essentially, the second interim report (July 1, 1963), with the exception of the "foreword"; coauthor the third interim report (Jan. 24, 1964) to draft the credo of the commission: "The dignity of man must not be invaded, evaded or degraded"—and to draft the basic rate setting board, fire prevention, and other pieces of remedial legislation flowing from the investigation conducted by the commission.

I will not attempt to review in detail these reports or enactments. It is my sincere hope that your honorable committee may in some part be knowledgeable in respect to them; and I do expect others, perhaps, will either testify as to their substance or to the implementations of the recommendations we made to our legislature, statutewise or per regulation. As this statement progresses, I should like to refer to them on occasion. I may add that the acceptance pro tanto of such reports, recommendations, enactments and regulations, actual or prospective has been a source of much gratification to the commission, and we are, in all humility, thankful on behalf of humanity, our prime and only concern.

As we have previously said, and as has been so emphatically confirmed by medicare, within days, the simple fact is that almost every family in the country has been, is now, or conceivably could be in the foreseeable future, affected in some way by a nursing or convalescent home.

Steadily mounting concern is expressed by groups and individuals throughout the country regarding the availability of facilities to care for the chronically ill and aging. Particular interest centers on the nursing homes and related types of facilities, such as rest homes, the prevailing domiciles of the chronically ill and aging.

Repeated inquiries are made along these lines:

How many nursing homes are there?
How many people can they accommodate?
How many nursing homes are affiliated with hospitals?
How much does it cost to provide care?
What kind of patients do they serve?
What help is available for building new facilities?
What programs help to care for the elderly?

(In a later portion of this statement, as a generality, and specifically as counsel for the Massachusetts Rest Homes Association, I shall discuss the rest home as a facility related to nursing and convalescent homes in its proper perspective.)

Bearing directly on the mounting concern referred to in the preceding paragraph, regarding the availability of homes, is the timely and extremely competent duograph of our eminent commissioner of public health in Massachusetts, Alfred L. Frechette, M.D., M.P.H., and Samuel Levey, Ph. D., S.M.H., his "Administrator of Nursing Homes and Related Facilities," reprinted from the New England Journal of Medicine as recently as May 13, current:

"Study of the adequacy of the existing supply of beds and the need for additional beds is an ongoing project of the department. At present, the nursing home section of the division of adult health is engaged in an areawide planning survey to evaluate the present distribution and utilization patterns of nursing homes and related facilities. One objective is to develop criteria for delineation of service areas to project future bed needs. Another is to provide information on the patient composition of such facilities. Recent data indicate that approximately 72 percent of nursing home patients in the Commonwealth are public assistance recipients, which is somewhat above the national average.

"Because of the emergence of the large modern nursing home the smaller facility is finding itself in the midst of an increasingly competitive market situation. Many small homes have gone out of existence owing to the additional requirements of the departments of public health and public safety. The number of nursing homes has remained relatively stable during the past few years. In 1960 there were 732 nursing homes, with 21,915 beds, and in February 1965, there were 729, with a total bed complement of approximately 28,000. Notwithstanding the significant increase in total bed supply, the department of public health continues to receive a steady flow of applications for new nursing home projects.

"It is apparent that a single study or a series of studies cannot begin to ascertain accurately the real need—as distinguished from demand—for additional nursing home beds. A basic issue in this context is the problem of the 'appropriateness' of placements. Studies of nursing homes, such as the Boston College School of Nursing effort, indicate the marked variability of nursing homes and their patients in terms of their medical and nursing needs. The extent to which the nursing home provides care for the patient whose placement in a rest home may be more realistic, or vice versa, is an area of concern."

The last sentence should hold considerable significance for all of us. As I propose to discuss later, it is my firm belief that many patients are improperly placed in nursing and convalescent homes who properly belong in rest homes; not only for their own sake, but for the well-nigh incalculable conservation of the welfare dollar; which, after all, should be treated with reasonably decent respect.

With an almost inexplicable increase of beds in a business the owners have lamented is poor paying or profitless, a layman like myself can't help but wonder if a goodly part of this gold rush isn't prompted as much by a motive to get the high per diem dollar for servicing rest home types who are not in need of skilled nursing service at all, rather than for servicing humanity for its own sake. I have the audacity to suggest the licensing authorities ought to watch out for this kind of ducks-and-drakes intent and operation.

There are other passages in the Frechette-Levey article that give one cause for pause. For example, that portion that recites "the emergence of the large modern nursing home" vis-a-vis the victim of that war of attrition, the "small home." In this connection I could not help but recall what I once drafted for our report:

"We do discern, however, a definite trend in the proprietary ownership category toward such larger and even sumptuous establishments. Whether the palazzi of today will become the slums of tomorrow is a matter for conjecture. Already we have discovered to our sorrow that structural magnificence does not always equate with competent, compassionate care for the 'inmates.' "

In sequence, I can say in all good conscience, from what I have seen, heard, and sensed, there has been a very creditable escalation of amelioration and improvement in the area of nursing and convalescent homes since the third report of the commission. In my opinion, not a little bit is attributable to the esprit de corps and ability of the commission for public health and its licensure division at every level; the integrity of the department of public safety for the Commonwealth; the downright commonsense and fairmindedness of administration and finance; the openmindness of public welfare in its willingness to listen to reason and legitimate, demonstrable proof, while preserving its perfect right to protect the Commonwealth's interest from fakery and foolishness; and finally, the open-door policy, highly capable and intellectually honest constituencies and attitudes of the board of ratesetting.

I derive much pleasure from the latter result, for having drafted the legislation for the ratesetting board, I could not help but wonder what sort of people, inclusive of the hearing officer, would administer it. My personal specifications have been met. None on the commission, I am sure, could have asked for better or more.

However, lest the poor-type nursing and convalescent-homes people get too smug and lapse into their old ways, I am bound to remind them that I am aware of homes still being closed because they are not fit for human habitation, and that I am still beseeched and besought by distracted people who plead and pray: "Please do something for those poor souls." Why?

The commission and I, in the past, have always acknowledged there were many good homes. We did find too many poor homes; and we said so. We said the poor homes were very poor. We wore no man's collar. We called the shots as we saw them and saw no reason to recant. We were clobbered for this heresy unmercifully. Our suggestion to the industry then was: "Police yourself and eliminate the rotten apples." This advice seemed to fall on deaf ears, and in view of the pleas still being made to me, I wonder if this deafness has become permanent and incurable.

Have the leaders of the industry the strength of will to eradicate the blight, or are they all things to all men? Afraid of "losing a member"? And the false pride that goes with it? I don't know. They have all the answers. I am sure public health is doing its part and considering all its handicaps, extremely well.

Ergo it argues the root cause originates elsewhere. This time the industry cannot in all good grace or honesty protest most of its ills and woes and its inability to furnish care and service expected of them stems from an inadequate per diem rate for public assistance patients. Here and now let it be said and settled once and for all that the commission never for a moment denied the legitimate claims of the best and better elements of the industry to a fair and reasonable increase in the per diem rate. It did protest that poor homes should not equate with good homes in a base rate, and it did insist that any increase should inure solely to the benefit of the patients and not to the absentee fat cats who owned the facilities and couldn't care less about the human element that provided the basic formula for their hypocritical beggary; nor to the loan sharks who sat, and perhaps still sit astride many of the facilities, like fat spiders; and who have waxed rich on their shackled mortgagors, and will wax still richer with the positive potential inherent in the area of aging, whether from natural causes or recent governmental enactment.

Now, thanks to the commission, a ratesetting board has been established; the industry has seen its competence and tasted its beneficence. An equitable increase already has been granted with provisions for even more, if owners prove themselves entitled thereto.

Since the industry has gotten what it wanted, why should complaints still continue? Well, one of the reasons the industry will give you is the dearth of trained and competent nursing personnel. On its face, granted. As we say in the law, we can all take judicial notice of the paucity of such personnel. I'll go further and include any and all other personnel requisite or desirable for good operation of a nursing or convalescent establishment.

In conceding the point I hope it may be said of me that I have squarely come to grips with the problems of "help" confronting owners and managers; and that my analysis evidences not only insight but objectivity. I appreciate there is a dark side to the moon, and sincerely want to help as much as I can to give light to it. But, just as certain, an astronaut can detect the curvature of the earth, I discern there are two basic drawbacks to improvement in the nursing home industry; and both, I regret to observe, are attributable in substantial measure to the industry itself. With a full release from the thongs of self and pelf, much can be accomplished:

A. The first is in the area of better pay; better working conditions, such as vacations, sick leave, group health and accident insurance programs, as well as other and usual fringe benefits.

Now is the time for the industry to demonstrate maturity. Will it still "holler for the dollar," or will it grow up, take less profit (still keeping a good one), and compete legitimately with any other legitimate businesses for the labor market, giving what everybody else has to in this day and age to recruit and hold on to people who can fill the bill? You can't take it with you and you can't forever have your pockets lined with fishhooks is our sincere advice to those owners who want the "mostes for the leastes."

B. The second is "high money." If the nursing home owners and operators will really get off their hypocritical high horses and build or renovate the right way, they should be able to get all the money they want or need at fair rates and upon livable terms. And none would begrudge them the finest return they could make, by decent administration, of course, if they did so. All that's needed is a disposition on the part of the business to forgo the "fast buck" on a shoestring, keep out of the clutches of the "sharks" and play it straight. And let us say, "Good cess" to you, gentlemen, to those who do play it straight in the nursing, convalescent, and rest home industries, for these industries are in truth and fact, very big, much needed business, and contribute mightily to the economy of not only this Commonwealth but to the entire Nation. As I have said before in prior reportings, money in and of itself is not a dirty word, nor is bigness, as such, malum in se.

Having dissected the owners and operators of nursing and convalescent homes, what shall we say of the nursing profession, which provides Massachusetts with no more than 2 percent of theoretically available qualified personnel to minister to the needs of such a necessitous area as nursing and convalescent homes?

I should want to be the last to wound the sensibilities of the nursing sorority, but I should be something less than honest not to note that I had always supposed

professional nursing is but a short step removed from the Hippocratic oath, and nurses, registered nurses in particular, were reservists in the army of humanity, subject to callup in times of national emergency. I say that emergency is here, and that it will become worse before it gets better. Nurses—you are called to the colors. Don't leave it all to the licensed practical nurses, and do not risk a court-martial at the bar of public opinion, or for that matter before your own boards of registration.

Conceivably, although I should hate to see it happen, or don't know if it could be done legally, a legislature one day might decree nursing is a public trust and must be properly administered by those physically able and professionally qualified to do so; at least part time. Certainly, a great deal of public money must go into the training of nurses. Shouldn't something better than 2 percent come back to the taxpayer and your fellow man? We all know nursing and convalescent nursing is a bit on the seamy side, but you did sign up for the duration. Remember? Give us a break—please.

Some of us have looked upon the passage in Scripture: "The years of Man shall be as threescore and ten," merely as a well-turned phrase or cabalistic formula, but in the study of nursing homes one sometimes pauses to reexamine this passage and marvel at its sagacity. The average age in a nursing home in this State, as in most of the States, is more apt to be near 80. But octogenarians are not uncommon in the patient population and there are more in the age 90 group than one would suppose.

We wish we could report this is a happy attainment in life, but we really cannot, considering the conditions under which many of the patients live or exist.

In a search for causes and effects, no study of this nature could be complete unless it contained the vital information that the advance of medical science probably is the largest single factor contributing to the present need for nursing homes. In prolonging life, in cooperation with the Maker, of course, one wonders sometimes whether we are producing a blessing or a scourge. By 1980, it is suggested by astute observers and students of the problem, there will be 25 million Americans over 65. Many of these will be candidates for nursing homes. Whether this will be an occasion for rejoicing or cause for condolence will depend largely on how much improvement can be brought about in a presently unsatisfactory situation.

We hardly need stress the fact that the typical nursing home patient is so aged and infirm that he is helplessly dependent upon others. One of the "others" is Government. Government has, and increasingly will have a responsibility to subsidize as well as to protect him from exploitation, neglect, or abuse.

By the recitation of all the foregoing, one could readily form a judgment that nursing and convalescent homes for pretty nearly everyone in a pertinent age bracket is an inevitability. Must this be so? I hope not, and unashamedly pray not.

Our late beloved President, John Fitzgerald Kennedy, uttered these incomparable words:

"This increase in the lifespan and in the number of our senior citizens presents this Nation with increased opportunities; the opportunity to draw upon their skill and sagacity and the opportunity to provide the respect and recognition they have earned. *It is not enough for a great nation merely to have added new years of life—our objective must also be to add new life to those years.* * * * Retirement, however, should be through choice, not through compulsion due to the lack of employment opportunities. For many of our aged, social security and retirement benefits are not a satisfactory substitute for a paycheck. Many of those who are able to work need to work and want to work. But, often knowingly and sometimes unwittingly, industrialization and related social and economic trends have progressively limited the possibilities for gainful employment for many of our older citizens. Employment in the expanding sectors of our economy is too often attended by compulsory retirement programs or by age discrimination practices. Older workers, if not protected by seniority, are among the first to be laid off—and men 65 and older are twice as likely to remain unemployed for 26 weeks or more as are other unemployed workers. Denial of employment opportunity to older persons is a personal tragedy. It is also a national extravagance, wasteful of human resources. No economy can reach its maximum productivity while failing to use the skills, talents, and experience of willing workers. Rules of employment that are based on the calendar rather than upon ability are not good rules, nor are they realistic. Studies of the Department of Labor show that large numbers of older workers can exceed the average performance of younger workers, and with added steadiness, loyalty, and dependability."

And we, ourselves, quite contemporarily with President Kennedy, protested less eloquently, in our first commission report:

"Another cause of increased need for nursing homes may be traced to the effects of the national economy, national attitudes, and industrial practices. With arbitrary retirement upon the attainment of a certain age limit, the opportunities for other or continued employment of the older worker have become much more limited. The worker is left with several years of retirement, usually on a restricted income, and with little opportunity to contribute to the productive process. Under such circumstances, the maintenance of the family home or even an apartment or comfortably furnished room, becomes much more difficult. In such inactivity the seeds of degeneration find fertile ground."

We intended no homily by the foregoing. The problem is too deep rooted, too near the heart of the whole nursing home problem to deliver a tedious sermon; yet none should remain complacent or unheard. Human fabric and national economy are involved here. Rectification could save and preserve the bodies, minds, and human dignity of millions of estimable people as well as incalculable millions, yes, billions of public aid dollars.

I once wrote for the commission the following copy in connection with the credo my chairman directed me to prepare:

"A. There is that essential element in the creation of human beings which is commonly referred to as the dignity of man. It is the invisible, intangible fabric of intrinsic worth in which the human race is wrapped. It has been so from the beginning. It is our birthright and our lifetime sustenance. Only the soul is companion to it. Because of it, men have been enslaved, tortured, and martyred, and seas of blood have been shed in defense of it. Only the Deity knows its true compass and identity; and to It, and It, alone, belongs exclusive jurisdiction to expose or dispose. A commodity of such content and significance is entitled to the fullest protection of law and morality.

"The dignity of man must not be invaded, evaded, or degraded.

"Let us remember: Each human being possesses intrinsic worth and the protection of that worth is worthwhile. Any and every member of the human family is entitled to compassion and consideration."

"B. We do not wish to appear or act as self-appointed moralists. Yet these truths are self-evident:

"There are two essential ingredients in the creation of man, which no other creature may share; human dignity and the soul. Indeed one may be equated to the other without doing violence to the intention of our Common Creator. He has molded man to His image, and has decreed that the product of His handiwork shall be considered but little less or lower than the angels. He owns the exclusive right to his invention and will tolerate no interference with or infringement of the patent. He reserves the right to proclaim each human being possesses intrinsic worth and the protection of that worth is worthwhile. This is judgment by divine decree and we accept it and will fight for it.

"Let us all remember: The dignity of man must not be invaded, evaded, or degraded."

It is my fervent hope that one day your committee, or its successor, will help to establish a basis, nonviolative of constitutional provision or precedent, for the abolishment of arbitrary retirement practices merely or solely because of age, and give us the whole man. A whole man wanting to work, perfectly able to work, and wanting above all to preserve his God-given dignity, and in so doing sow and stimulate the processes of generation, and not degeneration.

Realizing the utopian nature, for the time being, of the foregoing, one must turn to the realities. If perfection may not be attained, what then?

Assuming arbitrary retirement with its attendant ills, or causes, whatever the nature, whereby the seeds of degeneration are sown, the first and most important line of offense and defense in the preservation of human fabric, and the conservation of public funds, is the rest home.

July 1 current, I addressed, as its counsel, on behalf of the Massachusetts Rest Home Association, to Dr. Levey, the administrator of nursing homes and related facilities, which of course included rest homes in this Commonwealth, an appeal to reason for justice and recognition of that indispensable arm of the humanities, the rest home. Facsimilies were simultaneously put in the hands of the executive echelons of the commissions of public health, welfare, administration, and finance, and ratesetting board. It would be a privilege to furnish your honorable committee with identical copies.

In this "declaration of rights" I had occasion to say, among other things:

"One would naturally suppose such a service would be known to all, and loved by all; that recognition and compensatory consideration commensurate with its

importance, service, and value would be taken for granted. Nothing could be further from the truth. Until now, it has been looked upon as a sort of necessary nuisance; barely tolerated, considerably underrated * * * and unmercifully berated; except by that long-suffering, dedicated group of men and women shackled to it as homeowners, and that vast legion of grateful souls who constitute its patient membership. The trouble is their cumulative voice comes out no louder than a whisper.

"How could most of us be guilty of such fallacious thinkmanship, and such financial shortsightedness? The answer is unpleasant but simple: Ignorance.

"This invaluable industry, now realistically more a profession than a business, has never, really, been discovered. Knowing this, and suffering from it, its membership is now immovably and unalterably committed and dedicated to the proposition rectification of past wrongs and future entitlements can no longer be delayed or ignored.

"The plain and simple necessity of the rest home industry, and the purpose for which this appeal and presentation is made, is apparent; it deserves to be, and on the basis of the theme and supporting material hereinafter developed and submitted, must be, included in any system of classification presently proposed and projected by the division.

"The industry respectfully represents that time is of the essence; that too long has its true nature and contribution to the community, as well as to the economy, gone unrecognized and unappreciated; that it cannot further endure the imbalances in treatment and financial recompense between itself and others rendering no more or better, or even less service than it does.

"As owners of enterprises that have had to suffer so much discrimination over the years, they are realistic enough to foresee and are under no illusion about, that unless their legitimate point is made and won for inclusion now as a segment of the proposed classification system, the opportunity may never again present itself and the industry could very well be irreparably damaged. In such an event, after the capital losses of the industry, the primary and chief casualties would have to be the patient population, the welfare and public assistances, and the licensing authorities. After that, of course, would come the tax revenue people and the beneficiaries who live and gain by the heavy contribution of the industry to the general economy. Does anyone in his right mind want such chaos, cruelty, and catastrophe? We doubt it and therefore respectfully bring this petition for redress to you.

"By way of brief foreword, let us say that it was recognized early that in order to make this appeal, mere slogans or emotional outbursts would hardly suffice. We therefore present, to the best of our ability, hardcore, incontrovertible facts, data, statistics, and authentic documentation in support of our position.

"As of 1964, 446 rest homes were listed and licensed by the Massachusetts Department of Public Health. By the forces of attrition 45 of these homes were lost to the industry since February 1, 1964. Within the past month, each of the 401 remaining homes received from the Massachusetts Rest Home Association, whom I have the honor to represent, a seven-page questionnaire looking for the development of a basis that would solidly sustain the thesis of the association that many rest homes are now providing without recognition or compensation limited nursing as well as medical care. This belief and other factors will be discussed extensively in following portions of this petition.

"The paid membership of the MRHA is 147, representing approximately 37 percent of the total number of 401 questionnaires sent out and received.

"As of June 15 current, 129 responses were received. We shall use this as a base. (Since then at least a dozen more have come in.) They comprised the following types of enterprise: 69 single proprietorship, 34 family business, 11 partnership, 14 management for corporation, 1 community service.

"Excluding the 'Management for Corporation' and 'Community Service' categories, both nonmembers of the MRHA, leaves a total response of 114 homes. Reflecting these 114 homes against a paid membership of 147 homes, reveals that in the first survey ever conducted by the industry to learn and analyze itself (a feat hitherto considered virtually impossible), 80 percent of our membership rose to the occasion beautifully and responded by direct transmission to me, speedily and with painstaking thoroughness, a mass of vital statistics in respect to rest homes, both stunning and startling. This original data is in my hands and available to you at all times for proof of authenticity and verification, together with the original envelopes of receipt, and calculator tapes.

"It is earnestly submitted that not only does this 'bible' substantiate our thesis, but it goes far beyond it in providing justification for our demand that the

industry be recognized for what it is: a powerful deterrent against decay in man, a taxpayer of no little consequence, and a heavy contributor to the general economy; for example, pharmaceuticals, medical services, payroll, taxes, food, manpower, auto expense, postage, stationery, rent, social security, unemployment insurance, insurance, repairs, fuel, water, furnishings, equipment, apparel, utilities, financing expenses; and numerous other expenditures which are generally overlooked or unconsciously minimized.

"The number of licensed beds responding were 2,115 which multiply out to a total residency occupancy of 771,975 resident days per year. These responder beds showed a 2,000-bed per day occupancy, or less than 1 bed vacancy per responding home per day. The average resident capacity comes out 1,999.8 beds occupancy.

"In answer to a query seeking to elicit general information, repliers rated present demand for rest home beds in a range from 'good' to 'poor,' assigning a number of grounds therefor, some of which were attributable to variance in per diem rates, the appearance of new facilities by which their facilities suffered in contrast, and improper placement of patients.

"Ninety-seven of the same group felt that a reclassification of all geriatric facilities could offer the community and Commonwealth better service at a lower cost; 72 thought rest homes should be classified and have rates established in proportion to the services offered; and the same number agreed rest homes should be classified under the general heading of nursing homes as a related facility.

"The response to the interrogatory following: 'Do you agree that some rest homes could be classified as "Limited Care Facilities"?' was emphatic, and considering the background and evolution of a rest home and the attitudes of rest home owners themselves, of the utmost significance: 111 declared themselves in agreement, only 9 opposed, 9 did not answer.

"And in answer to the inquiry following on the heels of the preceding one, 90 of this group, with the same emphasis, felt rest homes should try to qualify as medical facilities as defined in and by other jurisdictions, in order to obtain more Federal funds.

"The amount of real estate taxes paid by the basic group of 129 in 1964 totaled $76,326.12. It should be remembered 129 is only 30 percent as to the total number of licensed homes within the Commonwealth. Certainly, by any fair projection, the remaining 70 percent paid, proportionately, as much as the 30 percent. This is hardly a bagatelle.

"What is the bare bones figure representing direct operating cost in 1964 for this basic group? $2,054,575.89. Project this again, 30–70, and see what you get. And this does not even begin to reflect the true contribution to the general economy, because it is impossible to garner the figures of the indirect and collaternal items pertinent to the existence and operation of the industry.

"As our executives point out, the Commonwealth spends large sums to encourage the tourist trade, a perfectly commendable area, to be sure, but seasonal only, and, by no stretch of the imagination, vital to life and living. Yet here is an industry, if it is not out of mind, underfoot, grinding out the grist every day, helping in hitherto unsuspected and undiscovered ways to preserve the bodies, minds, and human dignity of its citizens, as well as helping to pay its own way by turning back to the State's economy and prosperity huge sums of money in the process.

"And what kind of gross investment of only 30 percent of licensees has our 129 homes grouping reported? The answer: $32,000 average. Is this a two-bit business? Are we 'joints' or 'glorified flophouses'?

"And the range of that 30 percent group in terms of net business worth is $20,000 to $30,000 with a $24,000 average.

"How authentic are all the foregoing figures? The group embraces 20 CPA's, 41 public accountants, and 17 lawyers. Less than a third keep their own accounting records, and we do not doubt those.

"What kind of people do we have operating and/or administering our reporting rest homes only?

"(*a*) High school diploma	61
"(*b*) College degree	19
"(*c*) Graduate school	14
"(*d*) At least 10 years' experience	74
"(*e*) Registered nurse or graduate nurse	13
"(*f*) Licensed practical nurse training	24
"(*g*) Special schools	16
"(*h*) Administrators with nurses training	76

"This compilation speaks for itself. We daresay there could have been infinitely more licensed practical nurses especially out of the 'f' subdivision if advantage had been taken of the 'grandfathering' provisions.

"Now let us see what personnel we normally have (replier included):

"(a)	Registered nurse on 1 or more shifts. (Registered nurses required in nursing homes only if 50 or more patients and most homes have only 20 to 30)	11
(b)	Licensed practical nurses (graduate) for 1 or more shifts	26
(c)	Night coverage, 11 to 7	40
(d)	Laundress	46
(e)	Cleaning women	50
(f)	Cook	62
(g)	Helpers, kitchen, other	48
(h)	Maintenance or janitorial	49
(i)	Public health nursing facilities such as Visiting Nursing Association	35

"NOTE.—Eighty-five offer intraining to personnel, 30 do not, 14 are mute on this subject.

"Inasmuch as 120 out of 129 reporters assert a shortage of nursing personnel in their area, we sincerely submit a greater supply of such personnel would result in much heavier employment of them."

"Sequentially we should like to discuss 'residents' next. Your draftsman and the industry are presently bound by the thongs of semantics. We sincerely believe the term 'resident,' as required by the division, inadequate and inaccurate. We claim people in present-day rest homes, under present-day conditions, now being revealed to us and yourselves by reappraisal, enlightenment and these statistics, more closely approximate and merit an honest definition of 'patient' rather than 'guest' or 'resident' which they definitely are not in most of the rest homes of today.

"Still using the formula of 129 homes, the following compilation results:

"Patients were received from the following sources:

"(a)	Private hospitals	4
(b)	General hospitals	18
(c)	State hospitals	21
(d)	Private M.D.'s	61
(e)	Social agencies	56
(f)	Reputation in community	95
(g)	Church affiliation	1
(h)	Newspaper ad	1

"We come now to a segment of the statistics adduced by the returns, which requires, in our opinion, discussion at some depth, both at this point and further on in this presentation.

"A subsection of the questionnaire reads as follows: 'How many residents do you have that have been confined in mental institutions?'

"And the answer was: '236' (124 on extended visit).

"Rest homes as a rule keep a resident discharged from a mental hospital 1 year, then indefinitely. Presently 169 have complete discharges.

"By dint of their unnecessary and unwarranted debasement, rest homes are, and one might say, almost forced to be, the dumping ground for mental people. The mental facilities are terribly overcrowded and welcome distribution to other placement sources, especially in the gray areas and borderline cases; nursing and convalescent homes shun them like the plague because it is felt that a depressing effect will result to its other clientele, and even when they want them, can't have them because of placement disapproval; and the inevitable results: the rest homes

wind up with the poor souls. In the opinion of some, including myself, this is apt to be a good break for this type of placement, because there may not be the chasteness of Grecian architecture in the average rest home plant but what is much more important, and this from my own personal observations, there's an awful lot of heart. And if I understand the latest thinking of your division, you care less for plant, and more for patient care.

"With such a type of patient, and the type of personnel presently to be found in rest home operation, some homes have become extremely knowledgeable in the field of mental health and psychiatry. I am sure the latter is practiced informally, without benefit of academic degree, to a high degree, and with success, in many homes, but, alas, sans sanction or remuneration.

"There are several schools of thought as to and any number of definitions of a rest home. To the struggling owner and operator it is a headless horseman, running in all directions but getting nowhere. Sure, he knows better and deserves better, but nobody seems to pay any attention to him. So, like any cornered animal with its back to the wall, he's made up his mind to fight for his life.

"And let us make it plain he does not propose to preside at his own funeral. Nor does he propose to permit nursing and convalescent homes, with whom we have no running feud or lack of rapport, to pick up his hard-won capital investment on the cheap, especially when it is common knowledge that many of the smaller nursing and convalescent homes are not one whit better in appearance and plant, do not furnish or serve as good or better food or care than rest homes; but do have a high percentage of ambulatory patients who exclusively belong to rest homes and emphatically do not belong in skilled nursing establishments.

"Further, based on 129 homes:

"1. 660 present residents go out every day.

"2. 330 present residents go out weekly.

"3. 131 present residents go out monthly.

"4. 446 present residents go out occasionally.

"5. 537 are confined to the home or can leave only under supervision.

"6. 164 carry out most normal functions such as bathing, dressing, eating, and toileting without any assistance.

"7. 278 need only room, board, and shelter care.

"8. 1,628 present residents require care beyond supervision and shelter arrangements, which could be considered 'limited nursing care,' and in conjunction with the foregoing, seriatim:

"9. Oral medication is required by present patients as follows:

(*a*) Once daily	390	(*d*) Only as needed	319
(*b*) Twice daily	353	(*e*) At bedtime	309
(*c*) 3 times a day	573	(*f*) Other	102

"10. 241 use narcotics or sedatives.

"11. 100 require injections on a regular basis; 96 require injections only occasionally.

"12. 197 require special kinds of treatments occasionally or on a regular basis.

"13. 114 need special dressings, regularly or occassionally.

"14. 64 are provided rehabilitation services.

"Augmenting the foregoing, and again based on 129 homes, 84 homes provide social and recreational programs on a regular basis.

"Of the 129, 124 homes provide for the religious needs of their residents.

"(*a*) 117 homes keep a patient register.

"(*b*) 120 doctor's order book.

"(*c*) 84 patient progress notes.

"(*d*) 63 nurses' notes.

"(*e*) 89 narcotic and sedative count.

"(*f*) 84 medical referrals.

"There are listed immediately below 105 different medications, called series A (a supplementary list of 32 medications, called series B, also could be included), many of which cannot be self-administered by our type of patient, that are being administered currently, or have been administered within the past 6 months, by our basic group of 129 homes. Not only is the aggregate prodigious, but astounding.

Medication	Number
For pain:	
Morphine	2
Demerol	33
Codeine	24
Delauded	3
Percodan	8
Darvon	66
Dionin	1
Dolantin	7
For sleep:	
Nembutal	43
Seconal	27
Noctec	28
Ethorbral	4
Amytal	16
Evipal	3
Doriden	40
Tuinal	24
Series A	
For restlessness:	
Phenobarbital	63
Thorazine	56
Mellaril	36
Compazine	43
Stelazine	37
Prolixin	4
Meprobamate	18
Mesopin	2
For temperature:	
Aspirin	109
Phenacten	2
Acetanilid	1
Heart, circulation, blood:	
Caffeine citrate	2
Quinidine sulfate	8
Reserpine	27
Serpasil	36
Deupres 500	10
Ilidar	4
Lanoxin	28
Digoxin	57
Digitalis	78
Getaligin	7
Eskabarb	4
Ferronord	6
Feosol (iron deficiency)	24
Duo C.V.P. capsule (bleeding under the skin)	4
Premarin (hormone) (for flashes)	3
Genitourinary:	
Diamox (diuretic)	24
Hydrodiuril (diuretic)	65
Gantricin (antiseptic)	36
Azo gantanol (antiseptic)	7
Utropin	5
General infections:	
Tetracyline capsules	11
Panalba	13
Declomycin	20

Medication	Number
General infections—Continued	
Neomycin	20
Sufathaladine	10
Penicillin	48
Ointments:	
A. & D	31
Desiten	27
Kenalog (cortisone)	7
Butesin picrate	4
Boric acid	49
Nupercamal	12
Vioform hydrocortisone	18
Ben Gay (counterirritant)	56
Polysporin (antibiotic)	4
Ergophene	3
Enzactin (fungicide)	2
Vapor-rubs (decongestant)	41
Gastrointestinal tract:	
Castor oil	18
Mineral oil	48
Glycerin	15
Dorbane	7
Paregoric (antiperiatalsis)	41
Belladonna derivatives	38
Compazine (antispasmodic)	27
Bizmuth and paregoric	13
Kanulase (belching)	3
Syntrogel (antiacid)	7
Amphogel (antiacid)	27
Sodium bicarbonate (antiacid)	32
Segnogen (antiacid)	1
Haley's M.O. (antiacid)	66
Vitamins:	
Daylets	17
Unicaps	77
Betalyn	5
Vitamin B-12 (liver injection)	45
Intrinase tablet	2
Bevidoral tablet	0
Bexitab tablet	3
Cough sirups, expectorants:	
Terpinhydrate, codeine	25
Brown's Mixture	5
Cheracol	29
Benylin expectorant	32
Ipsotol	7
Ammonium chloride	9
Specifics:	
Proloid (for thyroid)	8
Propylthcouracil (for thyroid)	1
Soma (muscle spasm)	4
Tolserol (muscle spasm)	1
Bonine (dizziness)	8
Artane (tremors)	20
Dimetapp (sinusitis)	4
Norgesic (joints)	5
Panalba (muscles)	16
Orinase (diabetes)	40
Insulin (diabetes)	33
Dilantin (anticonvulsant)	32

"Ten years ago rest homes were designated and known as boardinghouses. The designation and implication still sticks in some quarters. Let it be underscored we have no quarrel with boardinghouses, and intend no slur, but we do challenge the imputation we still are boardinghouses.

"Laying the respective rules and regulations governing nursing and convalescent homes side by side with those governing rest homes discloses very little differentiation, except in respect to higher degree nursing-patient care and equipment. A careful reading of all the foregoing and conscientious analysis thereof readily confirms and makes it too plain for argument that except for an accident of birth, so to speak, we could and do equate with many nursing homes, who get $7.71 per day minimum, and even exceed that, in some cases. Boardinghouses may not be mentioned in the same breath. Unfortunately, boardinghouses can taunt us that we are in no position to turn our noses up at them, because the incredibly sad and scandalous fact is that despite all we have reported, since July 1, 1954, when the public assistance rate was $20 per week, only one general increase has been granted the industry; namely, from $3.57 to $4.25 per diem. Hasn't anyone heard of the statistics even kids in the grammar grades employ to debate the escalation in living costs, etc., during that period—and still going on every minute?

"Out of this Nation's welter of definitions attached to rest homes, or comparable institutions, all of which we have digested, we arrive at the conclusion that the overwhelming preponderance of our homes go far beyond mere custodial classification.

"It was said by the draftsman of this petition in Senate No. 970, this Commonwealth, 'Second Interim Report Special Commission To Study Convalescent or Nursing Homes,' created by chapter 138: Resolves of 1962, July 31, 1963 (pp. 21, et seq.):

" 'Within the next two decades we expect that at current rates of longevity and population growth the 17 million Americans now over 65 years of age will have swelled to 25 million. Will this be a blessing or a scourge? Much depends on what we do now in the way of meeting the existing problems and planning a proper preventive medicine and nursing care program. Human fabric and national economy are involved here. Rectification can save and preserve the bodies, minds, and dignity of millions of our fellow citizens, not to mention the countless millions of public assistance dollars.

" 'The conclusion arrived at by us and others is that "most elderly have strong preference for privacy and for maintaining independent living arrangements rather than for living in an institution, even after they are unable to take care of themselves." They will resist entry into a nursing, convalescent or rest home, until they can resist no more.

" 'If a "better standard of life and more active, useful, and meaningful role in a society that owes them much and can still learn much from them," were afforded them, the saving in human wear and tear and dollar aid, plus benefit to the national economy would be stratospheric.

" 'Let us strive, then, to help our elderly folk with their perfectly natural and understandable resistance movement and let us be sympathetic to a conclusion that institutional living arrangments should be limited to the old and very infirm who cannot live with and be cared for by relatives or friends. Such arrangements should be the last alternative.

" 'And even when the inevitable arrives and one must conclude that an elderly person should or must be placed in a facility in the nature of a nursing home, let us take good note of the fact that "studies have indicated that a considerable number of persons may be in nursing homes who require less than skilled nursing home care."

" 'In such cases, in Massachusetts this would signify residence in a rest home, which would, in my opinion, very well or even better serve the elderly patient than would a nursing home.

" 'We daresay many persons are now misplaced in nursing homes, and we must, in simple justice, observe that none of us should require the person who can carry out most functions of normal life to be placed in an environment where for the greatest part only the chronically ill are being cared for. * * *

" 'We could hope for nothing better than to have people placed in the precise facility where they belong. If it turns out that the correct occupancy shall be rest home rather than nursing home, so much the better. Not only will our consciences be gratified but we shall be happy for the saving to the taxpayer arising from the per diem differential.'

"We say that proper placement in a rest home as against another facility, improper under the circumstances, is preventive medicine.

"My association people for the most part are family people. They adopt their residents as members of their own family. True, they did for the most part evolve from boardinghouse operations, but they have met the challenge of the times. There not only has been evolution in their operations, but a revolution; and they are prepared to go further if encouraged by classification recognition and decent per diem rates.

"As family people they can and do appreciate the helpless, the hapless, and the homeless. They are not absentee landlords. You'll find them on the home grounds in personam, 24 hours of the day—cooking, cleaning, catering, and worrying. I have seen more warmth and humanity in 20 rest homes than I have in a hundred other and different institutions. How well they know that a person misplaced in a nursing home, with its inactivity and morbidity, might just as well have been banished to a sort of snakepit, or limbo, compared to their own type of operation; they do try to help such a person from going to seed, to spare him a spiritual Siberia. If the authorities will but agree if one can walk and needs no more than what our people provide, he belongs in a rest home rather than a nursing or convalescent home. And as we have said before, the salvage in terms of human wear and tear, spirit and mind, as well as of tax money of the Nation would be well nigh incalculable.

"We submit we are by active practice and necessity an institution providing medical care. By any fair construction we certainly render limited nursing care as well.

"Thus we come face to face with the 'raison d'être' for this entire proceeding:

"It is our thesis that many, if not most, of the rest homes in this commonwealth are de facto medical care and limited nursing care facilities, and as such should be integrated as a species of nursing home classification, in any plan or project, particularly now, or hereafter, proposed or projected, by your and any other pertinent department or division. They could fit into the point system ideally.

"Any rest home not qualifying, and there are those, shall remain and be classified for what it is: nothing more than a mere boarding house or domiciliary facility, and left to the natural and normal consequences resulting therefrom as to advantages and disadvantages. To rule and hold otherwise would be to subject, if not doom the best and better homes to a level of consideration equating with the bad, indifferent, and contented-to-remain-where-I-am homes, with all its disparity, inequity, and annihilation of incentive to improve or maintain the already improved status of many rest homes.

"If the division is convinced its pending classification for nursing and convalescent homes is an incentive program, why not extend it to deserving rest homes? Why not, after minimal, intermediary, and intensive care provisions for the nursing and convalescent group, an intervening category, in the latter set up for the progressive poor relation or country cousin rest home? It would be perfectly feasible and administratively possible, we maintain, for the authorities to promulgate such prerequisites as will satisfy and guarantee to them, that quality service and equipment which will be expected and demanded by the ordination of the subgroupment hereby suggested and requested; and which already exists on the part of many dedicated and progressive rest homes, de facto.

"By granting such inclusion, the entire tone of our industry is raised immediately, reflecting credit on itself and the authorities.

"We plainly state the objectives of rule changes are to:

"(1) Upgrade the quality and type of care available in rest homes;

"(2) Permit classification of rest homes within a greater classification based upon the availability of staff and equipment to provide the medical care and limited nursing care required by patients in the home;

"(3) Place patients in the exact niche where they belong, with all human and economical preservation and conservation of public assistance funds flowing therefrom;

"(4) Meet the Federal requirements for vendor payments to eligible patients in a species of nursing home under MAA (medical assistance for the aged), and Public Law 86–778 (the Kerr-Mills Act), and other pertinent and available payments and assistances hitherto unavailable; and

"(5) To upgrade the standards for construction, and maintenance and fire safety in rest homes."

We rest the case for the rest homes on all the foregoing. If the patient properly belongs in a nursing home as against a rest home, may I further cite our commission's observations:

"Having established that foremost of today's health challenges are the problems associated with an aging population and with the increase in chronic and long-term diseases, from which practically all aged patients in nursing homes suffer, it will

immediately be seen that the only home a nursing home patient (average age 80) will have until he dies is the nursing home."

Well may one ask just what does that give him? The answer well may be: "Board and lodging—with yard." Does this mean a yard with an old-fashioned garden in it? We're afraid not. The "yard" we regret to say, is the 3 feet allowed between his bed and the other fellow's.

Having been sentenced by the processes of life to such a fate, it is incumbent upon all of us to try to regulate the facilities that house him with such fairness and firmness that the presently poor image of substandard homes, or homes which do not deserve an "association by guilt" opprobrium, will improve to the point that we may all gratefully acknowledge "this home" is good enough for our fathers and mothers and those we hold dear. By the foregoing, we do not mean to convey the impression that patients should expect nursing homes to be run with the spit and polish of a military academy, or that patients may expect "pate de mockingbird" or pheasant under glass; or other delicacies the average person sees but infrequently. We do believe that in addition to decent quarters they are entitled to compassionate, considerate, and adequate care, and enough wholesome food considerately prepared to sustain them; and if their digestive apparatus and physical condition is such, a sufficient and particular variation to meet their peculiar needs and conditions. Those are the terms humanity demands, and under which they are placed or enter a nursing home, for which, let us remember, either the patient or government pays.

In a finalization of this written statement, let me reiterate improvement is discernible. Whatever accolades the commission received for its efforts were not accepted for itself. Rather, it accepted them for the principle that one is his brother's keeper and in the hope that at long last recognition and relief is beginning to emerge for the plight of those many thousands of our people who have been guilty of no greater crime than to grow old and feeble, who poverty stricken, the objects of public assistance, without kith or kin, and unfortunate enough to find themselves some sort of bewildered prize in the cockpit of mixed motives with which a substantial part of the nursing home business has been afflicted.

But as previously said herein and in our reports, it must in all fairness be counted and remembered that nursing and convalescent homes are here to stay. They are utterly necessary. They will become more necessary every day. The preponderance is good. The greater majority of their entrepreneurs worthy and dependable. They represent large investments, large payrolls, heavy tax revenue, and money potentials in every direction. They are as deserving of protection and consideration as the next fellow. But let them not for an instant forget need is one thing, and greed is another. If they want equity, let them do equity. Let them not be led by the nose or taken in by the slick and pushy do-gooders, who more often than not have something to cover up in their own operations.

We have every confidence the licensure division will continue to see through the chicaneries of the "now you see it, now you don't" characters in the business. To date it has done, in my estimation, a magnificent job. But let it also not be lost sight of what we said in our second interim report:

"The commission sincerely feels better laws, the recommendations already proposed and those to follow, the transfer of dominion from the bureau of hospital facilities to the division, and first-class enforcement, will all conduce to help materially in erasing or ameliorating those violations we have reported herein, as well as future infractions.

"Granting that the foregoing augurs well for the future, we nevertheless caution all concerned that we continue to favor rigid State regulation and that we still continue to like the following admonition by the Ohio Association of Nursing Homes to the Division of Social Administration in the Ohio Department of Public Welfare:

"Finally the Ohio Association of Nursing Homes urges the division to enforce its regulations strictly and uniformly throughout the State, without regard for the immediate hardships such enforcement might occasion in a few individual cases. The nursing home industry has a momentous job to do and it must raise itself up to a high level of service in order to do it. Without the aid of a hard-nose State regulatory policy the raising up will be considerably more difficult to accomplish. Every instance of enforcement laxity in the interest of today's expediency is an ultimate setback for the industry as a whole.

"We feel that any dilution of such a goal of regulation is a compromise with mediocrity and a surrender to a clamorous bloc more likely to be devoted to money than to morality.

"We reacknowledge discernible improvement, which, of course, is gratifying, for the dedicated members of this Commission feel that if the lot of but one un-

fortunate member of one society has been made more tolerable through its efforts, the angels may well sing for joy. But we are still not satisfied; we not only wish but insist that the rules and regulations of our own State shall be more rigidly enforced.

"In our interim report we recited that, in the great city of New York, steps were recently taken by the regulatory authority to better the image of proprietary nursing homes in the adoption of a code establishing very rigid standards. From newspaper reporting on the subject we concluded these standards conformed to a mean between Hill-Burton and Federal Housing Administration requirements and specifications. These, of course, were considerably more stringent than conditions prevailing in the city prior to passage of the code, and certainly more rigid than what we have had and are still having in Massachusetts.

"We further said: 'The cries of anguish that arose from the ranks of the owner-operators in New York City have reached to all owners of the Nation. They contend that the new code is unrealistic and ruinous, and will serve only to close many homes and throw helpless old people into the street.'

"This could very well have been, we stated, and on the other hand, we reasoned it could have been an appeal to terror and a specie of blackmail directed toward the nursing home population, its relatives, or friends, such as we experienced, contrived to drive a regulatory agency or a factfinding commission such as ours into expedient compromise.

"I seem to recall we, too, had a lot of reaction; and pretty much the same complaint that the 'new code is unrealistic and ruinous, and will serve only to close many homes and throw helpless old people into the street.'

"While it is true many old homes have folded, regrettable but inevitable in a war of attrition foreseen by everyone, I have yet to hear of helpless old people being thrown into the street. Somehow they have been absorbed, and I prayerfully hope to something better in living conditions.

"As for 'ruination,' how about those extensions and expansions in the old homes, and those extra beds in those plushy new homes since our reports and hundreds more applicants clamoring at the gates of the club for admission?

"Certainly, this commission has not the slightest desire to alarm the populace or to do injustice to that segment of the nursing home industry which operates with compassionate care and consideration. Gratefully we acknowledge that the overwhelming consensus of our citizenry and the press confirms we have practiced what we preached.

"Indeed I drafted the following statement for the commission's second report, which the commission and I sincerely and deeply felt:

" 'As we stressed in the interim report, this commission bears no preconceived animosity toward owners and operators. Even if it had the power, the intent to conduct an inquisition would be totally lacking and, for that matter, unthinkable. But, we are not naive and unrealistic with respect to the world about us. It does not necessarily follow that if Government raises rates, standards will automatically be raised. The standards set by Government may be high, but those of too many homes to this writing are not; nor would they, in our opinion, be higher with the increase.

" 'On the other hand we believe there are many estimable, dedicated people in the nursing home business but we are inclined to believe that among too many nursing home owners, the primary concern is their own pecuniary gain and economic survival rather than unimpeachable standards for their charges. By all this, we do not wish to appear benighted fanatics or unrealistic crusaders who are ignorant or blind to the existence of a commodity known as money. Money is not a dirty word, nor is profit motive malum in se. The commission has not the slightest objection to the nursing home industry flourishing and prospering, provided, as our chairman president, the Honorable John E. Powers, has emphatically enunciated on every appropriate occasion and from every forum that if standards are high and the patients truly become the direct beneficiaries of any increase, no fairminded person should bar the way to an equitable increase in the daily rate. And this may it be stated in perpetuity has been the position of the commission from inception.

" 'To this end, he initiated and we have recommended the guidelines hereinbefore delineated that deal with the establishment and functioning of a classification of nursing and convalescent homes in this Commonwealth.' "

As a relatively helpless human being, the nursing home patient is entitled to kind, humane, and courteous treatment. His behavior at times may tax the patience of the staff, but the home is being paid to care for him because of his advanced age and illness which may make him a difficult patient at times. Indeed, the State of Oregon specifically recognized the existence of such a behavior pattern and its treatment so important that it has seen fit to regulate as follows:

"All personnel directly involved in caring for resident aged persons in homes duly licensed shall be of suitable temperament and understand the need of aged persons."

We could wish for comparable recognition and regulation in our own Commonwealth. We recommend it.

Virtually every responsible jurisdiction in the Union has enacted stringent laws against cruelty or indifference to the welfare of patients. Yet, abuses do exist and probably will continue to exist. The age, aloneness, separation from their families, and disabilities of the victims make them easy prey to unscrupulous people and petty tyrants.

We have found, too, that by dereliction, or whatever the reason, it is a fact and a strong probability that innumerable patients incapable of comprehension, otherwise incapacitated, or lacking management and assistance our laws guarantee to them, are deprived of the pittance afforded them by governmental provision. As a consequence, incalculable millions sincerely donated to the victims for their little comforts are siphoned off by vultures.

Indulge me, again, if you will please, a repetition of this point of the commission's credo: "The dignity of man must not be invaded, evaded, or degraded." While there are many happy exceptions, the abode of a nursing home patient in an undesirable home is drab; his whole existence is drab. His entire milieu is ideal for the propagation of hopelessness.

When one first enters the typically poor quality home, reaction is apt to be one of shock. He is too suddenly transported from a world of youth, opulence, activity, and optimism to an antithetical hell populated by shabby, senile decay.

We should assure any endeavor conducted on a high and humane plane looking to the establishment of contact between the world and its forgotten people in the nursing homes not only deserves recognition but commendation and recommendation.

Speaking my own mind, I note that in these times, many celebrities and other estimable people lend so much of themselves in time, purse, and personality to worthwhile causes. In fact, one senses friendly contests between such people to see which one can outdo the other in good works. Alas, we find no such ardor or drive for the nursing home population. We just don't find any ardor or any drive.

The reasons are easy to find:

There is nothing glamorous in decadence. We know how hard it is to put up with a vacant stare or a grisly grin. The character in the tableau is old and gnarled and past his prime. He's a terminal case. It is argued youth should have the priority, and rightly so. Yet one may ask: "Are we not our brother's keeper? There but for the grace of God go I."

I hope that one day there will be a movement in the direction of the formation of a voluntary association in all communities that will have as its motive and heartfelt intent the humanitarian motto: "I am my brother's keeper," and will occasionally visit or take out for a little drive or short excursion some of these lost souls; or at least drop in for a few moments, wherever they may be lodged, and greet them with a kind word. I can assure all who read this statement, hardly more would be needed. You could be rewarded by a smile of such radiance it will warm you on the coldest day and in your darkest hour.

It is my honest hope this statement will not appear too lengthy to his honorable committee. It is hard to compress a lot in a little. I am deeply grateful for the opportunity to bear witness.

So may I say in closing, from "The Book": "Woe to him that is alone when he falleth; for he hath not another to help him up. * * * So I returned, and considered all the oppressions that are done under the sun: and behold the tears of such as were oppressed, and they had no comforter; and on the side of their oppressors there was power; but they had no comforter."

And still out of "The Book" come also the words: "Open thy mouth, judge righteously, and plead the cause of the poor and needy, yea, 'open thy mouth for the dumb in the cause of all such as are appointed to destruction.' "

This we have attempted to do and shall continue to do, if permitted.

STATEMENT OF ALLAN ROBINSON, FORMER COUNSEL TO THE SPECIAL COMMISSION TO STUDY CONVALESCENT OR NURSING HOMES (MASSACHUSETTS)

Mr. ROBINSON. Madam Chairman, honorable members of this committee, and staff, my name is Allan Robinson. I am a practicing attorney in the city of Boston. May I further say I consider it a high privilege to be invited to testify before your committee.

In the latter part of 1962 I was honored by an appointment as counsel to the Powers commission, so-called, and served in that capacity until the spring of 1964.

The commission was an extremely active one; its executive sessions for the most part plenary; its entire membership utterly devoted to its leadership and genuinely dedicated to its mandate and ideals. I was proud to be a member of its staff.

During my incumbency I was privileged, among other things, to author, with the invaluable assistance of my colleagues, the first or interim report of the commission (March 1, 1963); essentially, the second interim report (July 1, 1963), with the exception of the foreward; coauthor of the third interim report (January 24, 1964); to draft the credo of the commission: "The dignity of man must not be invaded, evaded, or degraded," and to draft the basic ratesetting board, fire prevention, classification, and other pieces of remedial legislation flowing from the investigation conducted by the commission.

It is difficult to compress a lot in a little so I will not attempt to review in detail these reports or enactments. It is my sincere hope that your honorable committee may in some part be knowledgeable in respect to them; and I do expect others, perhaps, will either testify as to their substance or to the implementations of the recommendations we made to our legislature, statutewise or per regulation. I further hope sincerely the committee will read as much of the written statement it finds time for.

It is very gratifying to note, however, that most of our recommendations have been enacted and perhaps many of our statutory recommendations will appear in the department regulations which probably are in the process of formulation or promulgation at this time.

As we have previously said, and as has been so emphatically confirmed by medicare, within days, the simple fact is that almost every family in the country has been, is now, or conceivably could be in the foreseeable future, affected in some way by a nursing or convalescent home.

Steadily mounting concern is expressed by groups and individuals throughout the country regarding the availability of facilities to care for the chronically ill and aging. Particular interest centers on the nursing homes and related types of facilities, such as rest homes, the prevailing domiciles of the chronically ill and aging.

At this point I should like to depart from my little written oral, so to speak, and respectfully beg the indulgence of this honorable committee for the opportunity to present a little bit of something in behalf of the rest homes, especiallly in view of Senator Neuberger's remark about mental patients, the report of Boston College, and the remarks of Dr. Levey, the director, who, in my opinion, I may say

at this time, has done a very, veryoutstanding job under the circumstances that he has had to labor under, and I use that word advisedly.

I say further in a later portion of this statement as a generality, and specifically as counsel for the Massachusetts Rest Homes Association, I shall discuss the rest home as a facility related to nursing and convalescent homes in its proper perspective.

Bearing directly on the mounting concern referred to in the preceding paragraph, regarding the availability of homes, is the timely and extremely competent duograph of our eminent commissioner of public health in Massachusetts, Alfred L. Frechette, M.D., M.P.H., and Samuel Levey, Ph. D., S. M. Hyg., his administrator of nursing homes and related facilities, just reprinted from the New England Journal of Medicine.

To put it very briefly, they point out 72 percent of nursing home patients in the Commonwealth are public assistance recipients. While the number of homes has remained static for some years the department of public health continues to receive a steady flow of applications for new nursing home projects. They agree with the Boston College School of Nursing study a basic issue is the problem of "appropriateness of placements":

> The extent to which the nursing home provides care for the patient whose placement in a rest home may be more realistic, or vice versa, is an area of concern.

I could not concur more wholeheartedly or emphatically in a finding or philosophy of this kind. It is my firm belief that many patients are improperly placed in nursing and convalescent homes who properly belong in rest homes; not only for their own sake, but for the well-nigh incalculable conservation of the welfare dollar which, after all, should be treated with reasonably decent respect.

With an outwardly almost inexplicable increase of beds in a business, the owners have lamented is poor paying or profitless, a layman like myself cannot help but wonder why these posh new homes and hundreds more are clamoring at the gates of the "club" for admission. In other words, I raise in my own mind the question that Senator Kennedy did and I think that a lot of other people would raise. To put it bluntly and in the language of the street, if this is such a crummy business, why is everybody breaking his neck to get into it? This I can't see.

There are other passages in the Frechette-Levey article that give one cause for pause; for example, that portion that recites "the emergence of the large modern nursing home" vis-a-vis the victim of that war of attrition, the small home. In this connection I could not help but recall what I once drafted for our report:

> We do discern, however, a definite trend in the proprietary ownership category toward such larger and even sumptuous establishments. Whether the palazzi of today will become the slums of tomorrow is a matter for conjecture. Already we have discovered to our sorrow that structural magnificence does not always equate with competent, compassionate care for the "inmates."

I am trying to be as fair as I know how about this. In sequence, I can say in all good conscience, from what I have seen, heard, and sensed, there has been a very creditable escalation of amelioration and improvement in the area of nursing and convalescent homes since the third report of the commission. However, lest the poor type nursing and convalescent homes people get too smug and lapse into their old ways I am bound to remind them I am aware of homes

still being closed because they are not fit for human habitation and that I am still beseeched and besought by distracted people who plead and pray, "Please do something for those poor souls."

Why? Here, Senator Kennedy, I am absolutely attuned to you because we were deluged with such heart rending letters when we were in the midst of our investigation that sometimes it was not quite bearable to read them through. I am convinced, as you were, that there is an area of discernment as to whether something is a crank letter in composition, or whether it comes from the heart and there is a real cry for help.

The commission and I, in the past, have always acknowledged there were many good homes. We did find too many poor homes, and we said so. We said the poor homes were very poor. We wore no man's collar. We called the shots as we saw them and saw no reason to recant. We were clobbered for this heresy unmercifully. Our suggestion to the industry then was, "Police yourself and eliminate the rotten applies." Even our little rest home people do that.

This advice seemed to fall on deaf ears, and in view of the pleas still being made to me I wonder if this deafness has become permanent and incurable. Have the leaders of the industry the strength of will to eradicate the blight or are they all things to all men? Are they afraid of losing a member and the false pride that goes with it? Blinded by the glitter of the golden coffers of the money monopolists in the business? I don't know. They have all the answers. I am sure public health is doing its part and, considering all its handicaps, extremely well.

Let us hope real hard they keep on resisting the blandishments of the big money Loreleis who can be real charmers. Honest public officials can be awfully naive at times. Ergo, it argues the root cause originates elsewhere. This time the industry cannot in all good grace or honesty protest most of its ills and woes, and its inability to furnish care and service expected of them, stem from an inadequate per diem rate for public assistance patients. Here and now let it be said and settled once and for all that the commission never for a moment denied the legitimate claims of the best and better elements of the industry to a fair and reasonable increase in the per diem rate. It did protest that poor homes should not equate with good homes in a base rate, and it did insist that any increase should inure solely to the benefit of the patients and not to the absentee fat cats who owned the facilities and could not care less about the human element that provided the basic formula for their hypocritical beggary. I remember very well the testimony of Dr. John Knowles in respect to absentee landlordism today and the venality of it. He was fabulous, in my opinion, and I drank in every word, and he was honest. I could not help but think that we had parallel thoughts in respect to that.

Nor to the loan sharks who sat, and perhaps still sit astride many of the facilities, like fat spiders—and he spoke about the second, third, and fourth mortgages, too, and there we had a lot in common as well—and who have waxed rich on their shackled mortgagors, and will wax still richer with the positive potential inherent in the area of aging, whether from natural causes or recent governmental enactment. I still see some of the fat spiders around, and I am depressed to note in the highest councils of the industry. At first they went underground, running real scared. Now they have emerged fatter,

bolder, and more cunning than ever. It is my instinctive belief they are trying to buy respectability with a facade of "do-goodism" and will ingratiate themselves with their purse and ingenuity into the highest echelon of the foremost medical facilities along the line suggested by our title, "Affiliation With Medical Facilities," pages 80–81, second interim report, by supplying heavy money to carry out much needed experimentation. I feel very strongly about that.

If they can buy "in," they are "in," because medicare requires sanction by a hospital before benefits can be availed of and their favors are bound to be rewarded. Hospital administrators, licensure directors, beware! Don't let these harpies take you. The ends do not justify the means!

Now, thanks to the commission, a ratesetting board has been established; the industry has seen its competence and tasted its beneficence. An equitable increase already has been granted with provisions for even more if owners prove themselves entitled thereto.

Now at this point I would like to say, departing from this script here, I am proud to say I helped to set up the ratesetting board. I drafted the legislation for it. I am familiar with it. I could not help wonder what type of people would administer it, and I want to say here now my personal specifications have been met, and I do not think anyone on the commission would have any contrary thought or idea. The men on it are as fair as they can be, as competent as they can be; they are just fine, including the hearing officer. We are getting a good break having that body. I do not pass on the amount of money that the industry ought to have. We got them a ratesetting board. Whatever the board says is fair and equitable, all of us go by. I do rebel and I am upset by the justification of counsel for the federation who as much as tells us to our teeth that he could not have improvement within his own ranks, that he could not do this and he could not do that, unless and until he got an increase in the rate. Neither could he tell Senator Kennedy. In other words, it occurred to me that what he was trying to say to us was this: "If the price is right, we might." There is where I rebel. [Applause.]

Mr. Robinson. Thank you.

Since the industry has gotten what it wanted, why should complaints still continue? Well, one of the reasons the industry will give you is the dearth of trained and competent nursing personnel. On its face, granted. Just as certain as an astronaut can detect the curvature of the earth, I discern there are two basic drawbacks to improvement in the nursing home industry; and both, I regret to observe, are attributable in substantial measure to the industry itself. With a full release from the thongs of self and pelf, much can be accomplished:

A. The first is in the area of better pay, better working conditions, such as vacations, sick leave, group health and accident insurance programs, as well as other and usual fringe benefits.

Now is the time for the industry to demonstrate maturity. Will it still "holler for the dollar" or will it grow up, take less profit still keeping a good one? (Here I want to say without trying to hurt the better element, the best element of the industry, that as far back as our first or second report in 1963 we were satisfied that the nursing homes figured at least $1,000 a year profit per bed and that was on the basis of $6.85. I know that will get murmurings and all that sort of thing but this came from authorities and not from ourselves. What-

ever it was it was not the starvation that we were led to believe that prevented better care and more compassion for suffering human beings.) At any rate compete legitimately with any other legitimate businesses for the labor market, giving what everybody else has to in this day and age to recruit and hold on to people who can fill the bill. You can't take it with you, and you can't forever have your pockets lined with fishhooks is our sincere advice to those owners who want the "mostest" for the "leastest."

B. The second is "high money." If the nursing-home owners and operators will really get off their hypocritical high horses and build or renovate the right way, they should be able to get all the money they want or need at fair rates and upon livable terms. None would begrudge them the finest return they could make, by decent administration, of course, if they did so.

We are trying to be as fair as we can to these people. All that is needed is a disposition on the part of the business to forgo the "fast buck" on a shoestring, keep out of the clutches of the sharks and play it straight. And let us say, "Good cess" to you, gentlemen, to those who do play it straight in the nursing, convalescent, and rest home industries, for these industries are in truth and fact very big, much needed business, and contribute mightily to the economy of not only this Commonwealth but to the entire Nation. As I have said before in prior reportings, money in and of itself is not a dirty word, nor is bigness, as such, malum in se.

We hardly need stress the fact that the typical nursing home patient is so aged and infirm that he is helplessly dependent upon others. One of the others is government. Government has, and increasingly will have, a responsibility to subsidize as well as to protect him from exploitation, neglect, or abuse.

By the recitation of all the foregoing, one could readily form a judgment that nursing and convalescent homes for pretty nearly everyone in a pertinent age bracket is an inevitability. Must this be so? I hope not, and unashamedly pray not.

Our late beloved President, John Fitzgerald Kennedy, uttered these incomparable words:

> It is not enough for a great nation merely to have added new years of life—our objective must also be to add new life to those years. * * * But, often knowingly and sometimes unwittingly, industrialization and related social and economic trends have progressively limited the possibilities for gainful employment for many of our older citizens. For many of our aged, social security and retirement benefits are not a satisfactory substitute for a paycheck. Many of those who are able to work need to work and want to work.

We, ourselves, quite contemporarily with President Kennedy, protested less eloquently in our first commission report:

> Another cause of increased need for nursing homes may be traced to the effects of the national economy, national attitudes, and industrial practices. With arbitrary retirement upon the attainment of a certain age limit, the opportunities for other or continued employment of the older worker have become much more limited. The worker is left with several years of retirement, usually on a restricted income, and with little opportunity to contribute to the productive process. Under such circumstances, the maintenance of the family home or even an apartment or comfortably furnished room, becomes much more difficult. In such inactivity the seeds of degeneration find fertile ground.

We intended no homily by the foregoing. The problem is too deep rooted, too near the heart of the whole nursing home problem

to deliver a tedious sermon; yet none should remain complacent or unheard. Human fabric and national economy are involved here. Rectification could save and preserve the bodies, minds, and human dignity of millions of estimable people as well as incalculable millions, yes, billions of public-aid dollars.

I once wrote for the commission the following copy in connection with the credo my chairman directed me to prepare:

> A. There is that essential element in the creation of human beings which is commonly referred to as the dignity of man. It is the invisible, intangible fabric of intrinsic worth in which the human race is wrapped.

Senator KENNEDY. Mr. Robinson, could I interrupt.

Mr. ROBINSON. Should I conclude here now?

Senator KENNEDY. We will include your entire statement in the record. In the press of time we would be delighted to enter your entire statement in the record.

Mr. ROBINSON. Thank you very, very much.

Senator KENNEDY. I would like to ask you just one or two questions.

Mr. ROBINSON. By all means, Senator, by all means.

Senator KENNEDY. Mr. Robinson, I think there are but few people in the Commonwealth who have made as detailed a study as you have.

Mr. ROBINSON. Thank you. Thank you, sir.

Senator KENNEDY. I know the work of the Powers committee and how intimately involved you were with it. Senator Powers and members of that committee and particularly yourself are to be commended for the diligence you showed in its preparation and in the enactment of several of the recommendations.

Mr. ROBINSON. Thank you.

Senator KENNEDY. And I think all the people of the Commonwealth are in your debt for these services.

Mr. ROBINSON. Thank you, Senator.

Senator KENNEDY. I was wondering if you thought that it would be in the best interest of our nursing homes if we had a statewide nursing home code with overall regulatory authority involved in a single State agency?

Mr. ROBINSON. Well, you mean incorporating, sir, the welfare and public health and/or would it be confined mostly to compassionate consideration, care of patients.

Senator KENNEDY. Well, I would think, first of all, an across-the-board agency that would have the primary responsibility and the administration of overseeing how these nursing homes would run and issue carefully documented rules and regulations providing adequate services and of arranging the full spectrum of services that would be given and I imagine would also cover the financial aspects.

At least have some authority in investigating the financial arrangements. Do you feel that such a board would be helpful or not, or what is your attitude generally? Do you feel that it is necessary?

Mr. ROBINSON. I honestly feel this way, Senator, that if Dr. Levey had a bigger budget and had more people considering the reformation that has come about—and it has been stunning in the short time he has been there—that he could do a much better job.

He is doing a fine job now and from third person objective observation, I think he is having quite a sweat most of the time, but he takes it like a man, and while I don't know the man too well I owe it to him to say so.

Senator KENNEDY. You think he has the tools with which, if he was given these other resources, he would be able to do the kind of job that you feel needs to be done here in the State.

Mr. ROBINSON. Yes, sir. Yes, I do.

Senator KENNEDY. And I would gather from your testimony you share with me a concern that the organization of the federation itself has not been providing the kind of policing that is in the best interest of those that live in nursing homes.

Mr. ROBINSON. I don't think they have. I think it has been laissez faire and they didn't want to step on anybody's toes and they have been overawed by money and position and promises and they have just gone along. I would say so to Mr. Connelly or if not, I certainly say it to you, sir.

Senator KENNEDY. Have you ever heard of a Joseph Kosow?

Mr. ROBINSON. Yes, sir.

Senator KENNEDY. Who is Joseph Kosow?

Mr. ROBINSON. Joseph Kosow is a fellow that had an office on the same floor with me at One Court Street for a while, now owns the building at 31 State Street. I call him a fat cat and I don't want to——

Senator KENNEDY. I think you would probably have to be a little more descriptive. [Laughter.]

Mr. ROBINSON. Well, I think he has the nursing home industry in the palm of his hand; and let the chips fall where they may.

Senator KENNEDY. On what do you base that?

Mr. ROBINSON. From talks with people who have borrowed money from him.

Senator KENNEDY. Would you describe the nature to the best of your knowledge of the kind of operation that Mr. Kosow runs?

Mr. ROBINSON. Well, I bear in mind what we reported in the first report, it has become history and I think he was at the bottom and the mover in a transaction where a man signed a note of considerably in excess of a million dollars and got $500,000 or $600,000 less than the face of the mortgage.

Finally, this man wound up in bankruptcy and lost all of his homes which somehow or another later found their way into "geriatrics" and we had a little taste of that today, sir, through your able examination and the man lost everything including his personal possessions and those of his wife.

I did not know who he was but I got the facts on excellent authority. As a matter of fact, the receiver who was appointed by the court recovered a finding for a sizable sum of money after the trial before Judge Forte and I understand these facts came out from Mr. Kosow, the thing found its way into other channels and other people and I don't think it was a pretty picture and that was one example of it.

Senator KENNEDY. Now do you feel that Kosow was either the hidden owner or the actual owner of mortgages for a number of nursing homes in this State?

Mr. ROBINSON. Yes, sir; I do.

Senator KENNEDY. Would you from your own knowledge speculate on the basis of your background as the counsel on the committee whether you feel what percentage, or could you give us some idea as to the scope of Kosow's holdings?

Mr. ROBINSON. No; I don't, but I would say with quite a feeling of security, Senator, that he owned a lot of these homes and he had lent a lot of big money on a lot of others at very high rates.

Senator KENNEDY. Now you say high rates. Do you know from your own personal information what these rates were or approximately?

Mr. ROBINSON. In the case that I cited I think it went to about 40 percent a year and everybody agreed when the papers were drawn that the man could not possibly have met a very heavy weekly payment. This I recall.

Now I will say this, Senator—and as we reported, in our second interim report, fellows like Kosow changed the format—after they went underground there for a while they would write a mortgage for what appeared to be a respectable sum of money, about 7 percent, but they played ducks and drakes with the purchase price figure. That was fictitious. They had a formula that nevertheless worked the thing out for them on a depreciation and other bases, and I am sure we reported it.

It does not come to my mind right now what it looked like on the slide rule, but we worked it out in the second report I have here.

Senator KENNEDY. From your own experience would you say that the rates of interest which are charged to those that own nursing homes are high or low or exorbitant? Can you characterize that?

Mr. ROBINSON. I would say at the time we were investigating they were atrocious and that is why a lot of people just could not make the grade. Whatever they got they would have to plow back into keeping their heads above water and keeping their equities up.

About all they got out of it was a weekly wage as manager, Senator, and hardly more because the property was owned by the mortgagee right off the bat.

Senator KENNEDY. On that point could you give us any indication as to the percent of nursing homes that were held in this kind of a situation?

Mr. ROBINSON. No.

Senator KENNEDY. I am trying to drive at the point of nursing homes that are not owned by those that run them either by their actual name and title or because of financial interest.

Mr. ROBINSON. I could not give you percentages but as I say when we were investigating we were satisfied there were a lot of them.

Senator KENNEDY. There were a lot of them owned or at least were heavily indebted or mortgaged?

Mr. ROBINSON. Yes.

Senator KENNEDY. Where they did not accurately reflect the title in which the nursing home was under.

Mr. ROBINSON. Yes, and this is why we tried so very hard to get through and did get through a stringent "suitability and acceptability" law as Dr. Levey will tell you. In other words, we wanted to know if there was funny money and we wanted to know who the real owners were and expose the true interest and not the dummies. This we tried to achieve and I think we have to some extent because if you will go up to Dr. Levey's department now you have to prove your case as to whether or not you really are on the level; and this I like.

Senator NEUBERGER. You seem to indicate that the organization either of the nursing homes or the rest homes could clean up its own house. I think you used the words "rotten apples." How can the organization get rid of the bad apples in its group?

Mr. ROBINSON. Well, we had a very recent example, Senator Neuberger. We have 5 or 6 clippings from a Springfield paper where the rest home people, about 147 of them at any rate that I would represent, learned of a man that owned and operated a rest home that just left at a certain hour every day and didn't come back until the following morning. He abandoned all of these poor souls to their fate and it was only by the grace of God that nothing happened up to this point.

Now our rest home people learned about that and got in touch with Dr. Levey, organized themselves into a grievance committee so to speak, told this man that he would have to do better and didn't get any relief; so between Dr. Levey and our group this home was closed out within the last few days.

This is an example of it. It can be done because the poor homes are known but if you want to be a good fellow to everybody and you have mixed motives then you just don't clean out the rotten apples from the barrel. This is how I feel about it.

Senator KENNEDY. What is the nature of the abuses in the poor homes? Could you categorize them for us?

Mr. ROBINSON. Well, Senator Kennedy, they were filthy for one thing; there was abuse; there was misappropriation. The personnel was not qualified. You would get a lot of people dressed in phony uniforms and caps who were literally picked off the street you might say and put in there as aids or even personnel much more qualified than that.

That is why I was glad to cooperate with the State house people, the director of nurses, Mrs. Shuman, when she asked me to do what I could about having the legislation passed that from now on and from that time on aids; for example, who are subordinate assistants but not registered personnel could not act as registered personnel and could act only under the supervision of qualified registered personnel.

They had been trying for 16 or 17 years to achieve that and we were delighted to do what we could about it because the way the statute read just prior to that, literally, the most horrible person in the world could have gone into any one of these homes and acted as qualified personnel with impunity.

Senator KENNEDY. On the abuses that you saw—were they more characteristic of the smaller or larger homes?

Mr. ROBINSON. I would not say so, sir. I would say that you got abuses in some homes that were only 2 or 3 months old; not enough food, neglect; and their plea was, "Well, we are just getting into motion. We are hardly off the ground. What do you expect?"

We found many times there is really no differentiation. I will say that I found smaller homes that public safety would not pass, shall we

say, but nevertheless had an awful lot of heart in them and that people were being taken care of with compassion.

This I will say and Senator Neuberger, I agree with you on that, absolutely, yes. I will say that. Definitely. And this is what we say about our rest homes, they are all small but they are family people and they care, they do care.

Senator NEUBERGER. Are these people aware that they don't have to go to the moneylender like the one you cited Mr. Kosow—that they apply for FHA financing and building and loan financing?

Mr. ROBINSON. We said so and we have Small Business Administration and we have a Development Corporation Act right here within the Commonwealth, Senator, as you very well know, but these people just don't want it.

I don't know how it is today but once upon a time they could walk in to Joe and literally buy a $100,000 home without putting down a nickel. Now what would one expect to be the outcome from that? Without putting down 5 cents they could buy themselves a $100,000 home.

Of course he would write it on his terms, he would take the financing charges off the top and would have so much payable per week and at such a rate of interest. Before one got through he was paying in the thirtie's and around 40 percent at least. Compounded it would run considerably more than that perhaps.

This is what was going on to a very great extent. Now today with the attrition of the small home what have you got? You have got homes that would cost large sums of money to build and are modern, of class 1 and class 2 construction, which means that one can walk into any bank, savings bank or comparable money lending agency, especially if the home is capable of multiple use and not exclusively for nursing homes so that if anything happened to the home it could be used for something else. You can get good money at good rates, but if you wanted to go into something less than that you would be going through the same process most likely.

Senator NEUBERGER. I guess we must hurry on. It is getting late and we have five more witnesses?

Mr. ROBINSON. I feel very guilty if I am taking the time.

Senator NEUBERGER. No, no.

Mr. ROBINSON. I do want you to know that I am proud to be here today and I thank you very much for the opportunity.

Senator NEUBERGER. We are delighted to have you. [Applause.]

We will now call Mr. William Lally and Mr. William Bonney.

It is not the fault of the witnesses that we are here a long time but we get interested and ask questions because we feel it is very important.

Now I believe you do not have a prepared statement.

Mr. LALLY. No, I do not.

Senator NEUBERGER. Mr. Lally you are director of the department of welfare for the city of Boston?

STATEMENT OF WILLIAM F. LALLY, DIRECTOR, DEPARTMENT OF WELFARE, CITY OF BOSTON, AND WILLIAM H. BONNEY, HEAD SOCIAL WORK SUPERVISOR, DEPARTMENT OF WELFARE, CITY OF BOSTON

Mr. LALLY. Yes, I am.

Senator NEUBERGER. And Mr. Bonney is the head social work supervisor?

Mr. LALLY. Yes.

Senator NEUBERGER. Proceed.

Mr. LALLY. Madam Chairman and Senator Kennedy, I am delighted to be here although I am not quite certain in what capacity I should say. The industry, as I have heard it called so often, is certainly a much maligned industry. However, in a sense of fairness and justice I must say that I as a public welfare administrator am indebted to many nursing home operators. Some of them are truly fine people, some of them run truly fine homes.

I suppose my purpose in being here today is because the city of Boston through its public welfare department is the largest purchaser of nursing home services in the State of Massachusetts.

We are now purchasing approximately $10 million worth of nursing home care a year in addition to close to another million dollars in additional services being rendered at nursing homes. This expenditure totals almost one-fifth of the total welfare expenditure for the year.

Much has been said about quality of care. We as a social service agency can only be concerned with the quality of care. We have no authority in rate setting, we have no authority in setting rules and regulations although we as a welfare agency have participated extensively in every study that has been made in the nursing home area in the past several years and I am sure there are many more competent people here to discuss the various aspects of administration than I.

We merely are a social service agency. There are many people in nursing homes and you know and I know that nursing-home care is not short-term care.

As a general statement, nursing-home care is end of line. When a person goes to a nursing home they are there, for the most part, for the rest of their lives. The concept of nursing homes has changed radically in the past few years.

Whether or not we want to continue as nursing homes or whether or not we want them to continue as large institutions remains to be seen. Whether or not the small nursing home service serves its purpose or whether or not the large and impersonal institutions are best, remains to be seen.

I am not impressed by physical settings. I am not impressed by large nursing homes. There is something about a small nursing home that is missing in larger institutions. There is something of a personal touch that is lacking in the large institution. Yet I want to be quick to say in many of the voluntary large institutions the care is superb. Whether or not large proprietary nursing homes could be of the same service I don't know.

We, as I have stated, are not consulted about rates, the rates are set for us. We do not select the nursing homes for the patient. If a patient is in a hospital this is generally done by the hospital social service.

If a person requests, we offer a list of homes in the vicinity the patients would like. He or his family then select the nursing home they like best.

I do want to say that for the most part when we have made suggestions or offered constructive criticisms, the nursing home operators are cooperative, they are willing to do what we suggest. We sometimes are critical of Dr. Levey's department but then I should not be because I know that he is faced with the same situation that I am, a paucity of help, and the demands made on his department are as heavy as the demands made on my department and it is easy to criticize and not always easy to remedy the situation.

So much so that we have set up internally our own inspection system. There has been some criticism of this but as long as I am a director of welfare spending $10 million I intend to insist that we get quality care for our people. I am not sure what you would like to know from me but if there is anything you would like to ask me I would be happy to answer you.

Senator NEUBERGER. Why don't we also hear from Mr. Bonney, and then we will fire away.

Mr. BONNEY. I have not had much chance to prepare anything. I just came back from Maine last night. I did talk with Mr. Constantine briefly. Mr. Lally, I think has expressed basically my feelings.

We have good nursing homes which are large and small and we have good ones which are proprietory and good ones which are charitably operated. Basically we have had a great deal of success in dealing with operators on a constructive basis. Dr. Levey's office has been most helpful to us.

We have worked out some very profitable channels of communication which prior to a few years ago did not exist. Again, I am not exactly sure what you would like from us. If you have some specific questions, either of Mr. Lally or myself, we would be glad to answer.

Senator NEUBERGER. This is a Federal Senate committee and your welfare budget must have a pretty sizable Federal contribution, does it not? How much is it?

Mr. LALLY. The total welfare budget for the city of Boston is approximately $55 million a year.

Senator NEUBERGER. $55 million?

Mr. LALLY. Of this amount approximately $21 million is returned from the Federal Government. The contribution of $20 million from the Commonwealth of Massachusetts and the balance from the local community.

Senator NEUBERGER. Twenty, twenty, and fifteen.

Mr. LALLY. Yes. Generally speaking. In the medical portion of the Kerr-Mills bill, of course, this is a 50 percent contribution from the Federal Government, 25 percent from the Commonwealth of Massachusetts, and 25 percent from the city of Boston.

Senator NEUBERGER. How long have you been in your present position?

Mr. LALLY. For the last 9 years but connected with the welfare department for over 30 years.

Senator NEUBERGER. How did you take care of this before the Kerr-Mills bill was passed?

Mr. LALLY. The State of Massachusetts under its laws has since 1937 been acting under the provisions of the Social Security Act in providing nursing home care.

Senator NEUBERGER. So then you have saved a great deal of money with the passage of the Kerr-Mills Act?

Mr. LALLY. We saved some money. [Laughter.]

Senator NEUBERGER. But you transferred your welfare patients to come under Kerr-Mills wherever possible, did you not?

Mr. LALLY. Yes we did. We were getting approximately a third, now we are getting 50 percent.

Senator NEUBERGER. But this should have given you an opportunity to pay more toward nursing home care than you could have otherwise.

Mr. LALLY. I think it has been pointed out repeatedly the rates are set by the rate setting board and the local communities have nothing to say about it.

Senator NEUBERGER. Yes, but you as a great spender of $55 million ought to go to the legislature and plead for better appropriations.

Mr. LALLY. The legislature does not appropriate the money; this is appropriated by the local municipality.

Senator NEUBERGER. Well, then city council, the government that runs your city. You mean to say they just draw a figure out of the air and you can't say that you could provide better care now that the Federal Government has come in with $21 million, we have saved $21 million so we can afford it.

Mr. LALLY. But we have not saved $21 million. We have increased spending, we are getting one-third higher.

Senator NEUBERGER. In other words $21 million came in you didn't have before?

Mr. LALLY. Oh, no. Not $21 million. Five or six million dollars we didn't have before.

Senator NEUBERGER. Under Kerr-Mills, you mean?

Mr. LALLY. Yes.

Senator NEUBERGER. But the rest of that was just——

Mr. LALLY. At the same time hospital costs and nursing costs have gone up to consume this so that the local cost in the city of Boston has also increased a couple of million dollars in the last few years.

Senator NEUBERGER. Why don't you defend yourself and say that Massachusetts has unusually good benefits under Kerr-Mills?

Mr. LALLY. They most certainly do. We are one of the most liberal States in the country.

Senator NEUBERGER. I know.

Mr. LALLY. Exceeded only by one or two.

Senator NEUBERGER. I think it is always wise to pat yourself on the back if you are so proud of your welfare program.

Do you see any great difficulties for you as a city welfare director with the passage of the new social security bill?

Mr. LALLY. I have mixed emotions about the new social security bill. I think it will help a segment of our population. As I pointed out for the most part nursing home care is long time care. We have many patients in the nursing homes now 10 years and the short time care allowed under medicare really isn't going to help much.

Senator NEUBERGER. Now you have a problem as everybody does in financing this. In the city you very carefully confine your beneficiaries to people who actually reside within the city limits of Boston.

Mr. LALLY. Yes we do.

Senator NEUBERGER. You don't——

Mr. LALLY. We don't have many patients outside of Boston. However, if Boston residents choose to go to a nursing home outside of Boston they may.

Senator NEUBERGER. And you pay?

Mr. LALLY. Yes.

Senator NEUBERGER. All right. Senator Kennedy?

Senator KENNEDY. I would like to ask you whether there have been any serious shortcomings in the handling of patients' funds in these nursing homes.

Mr. LALLY. Occasionally we hear of this that funds are taken and deposited in the patient's fund. When we confront a nursing home operator they have never refused nor denied the existence of this.

Senator KENNEDY. If they denied it what steps do you take to notify the appropriate authorities?

Mr. LALLY. We have not had occasion to notify the appropriate authorities. If the nursing home operator had the funds. They have never denied this. We provide in addition to the nursing home care $15 a month. This is a local grant. This has nothing to do with the Federal contribution but this is exclusively a local expenditure. And occasionally on the first of the month a son or daughter will show up and take the check for $15 ostensibly to buy the things that the patient wants and this is it. There is nothing we can do about this, this is the patient's funds to do with as he or she wants.

Senator KENNEDY. Have you had any complaints that the $15 has been misappropriated?

Mr. LALLY. As the director of the department I have had only one or two complaints of this sort.

Senator KENNEDY. What was the nature of those one or two complaints?

Mr. LALLY. Just that the nursing home was withholding the funds. When we confronted them they admitted it.

Senator KENNEDY. And they would give it to you?

Mr. LALLY. Yes.

Senator KENNEDY. Could you elaborate a little bit on your inspection system? You said you have an inspection system. What is this system exactly?

Mr. LALLY. They drop in unannounced at various times of the day. There are certain rules and regulations promulgated by the State with regard to the diet, the publishing of a menu. We examine the drug book, the patient's book, the finance book. We check the bedding, check whether the patient has been bathed, check the diet, drop in at mealtime and look at the trays.

Senator KENNEDY. How long has this inspection been going on?

Mr. LALLY. About 5 or 6 years.

Senator KENNEDY. What has been the result of these inspections?

Mr. LALLY. We are critical in many instances. Sometimes we find the bed linen has not been changed and of course this could well happen, it was soiled recently, we point this out to them.

Senator KENNEDY. Have you found anything else besides bed linen not being changed or meals being cold or anything of that sort?

Mr. LALLY. No. This is all we inspect for.

Senator KENNEDY. That is all you inspect for?

Mr. LALLY. Yes.

Senator KENNEDY. I wonder if you find any other kinds of abuses or have you found any abuses?

Mr. LALLY. No. I am not defensive about nursing homes, I am very critical of them and I would be quick to point out any deficiency.

We sometimes have removed patients from nursing homes because heat has not been provided or the meals were not good.

Senator KENNEDY. Let me show you a letter I received from a citizen. Actually it is only one of those in a large stack of letters.

Mr. LALLY. Yes.

Senator KENNEDY. I have only had a chance to open maybe five or six of these although I have reviewed a good sampling. I just opened this a little while ago and the thing that causes me some concern is that here you have been—you have had an inspection system and this is the kind of thing that I am wondering whether you have come in contact with.

They give a name which I won't repeat now:

> I am 56 years old. My occupation is a truckdriver—

And so on. He describes the care that was given to his mother:

> First of all the building was one of the finest around, one of the finest I have ever seen, only 4 months old at the time of my mother's admission. She was in a room with another patient. I am concerned about her also, but I best confine my comments regarding my mother's interests.
>
> At this time I will not name the coverup attempts on their part. Mother was put in a chair tied with a posey to restrain her as well. She was left there from 7 in the morning until 8 p.m. at night. There were days when she would not have had anything to eat if it had not been brought to her from home. You may think I am overstating this.
>
> For instance, on a certain day I went to my mother and she had only had toast and tea. The woman from the other bed told me that it was true, that her daughter got her toast and tea. I went to see the head nurse to find out about only serving toast and tea. She threw her hands up in the air. She said she didn't have toast and tea.
>
> I in turn told her that she did have toast and tea as the daughter of the other patient got it for her. She in turn insisted that they didn't have toast and tea in the house that day and I took it to mean they didn't serve it that day or that they didn't have none at all.

This goes on. The point I am saying is that this charge was made by someone about the treatment of individuals. Another letter here is from a person who is in the washroom of a nursing home and this letter is rather interesting. There are a number of misspelled words in it.

She complains that she is interested in doing the dirty sheets but that they won't give her enough soap. She complains she doesn't get enough soap. She says unfortunately I have to return the sheets upstairs even if soiled and she says I write this because I am trying to do my job and I cannot get the job done.

These are not really a broad or cross section of the sampling. I wonder if in your inspection system whether you find any instances such as this? Whether I am to assume that the over 1,000 pieces of correspondence received, which I must say have extremely impressed me and impressed me quite deeply, and I think if the welfare depart-

ment finds or draws different conclusions about this then this is of significance. It either indicates that to a certain extent that we should not put much credibility into these kinds of charges or that otherwise you must wonder whether the inspection system of the welfare department is coming to grips with the problem.

Mr. LALLY. Senator, there may or may not be some merit to these cases. I think to the ordinary lay person that when they read the person is tied to a chair that has a rather appalling connotation.

This is far from the truth because many of these devices are a perfectly satisfactory and medically recommended way to keep a patient from falling out of a chair. They must do this. The patients could not sustain themselves otherwise.

As to the meals I can't comment on them because I don't know. I do know recently when I visited a nursing home myself. I talked to a patient who has the same complaint about having had nothing to eat and I promptly said, "Well, I am going to discuss this with the management right away."

Then the patient changed his mind. He said, "Well, I didn't like what they gave me so I gave it to another patient."

Senator KENNEDY. Could you put another interpretation that they don't want to be caught complaining and not be served anything to eat?

Mr. LALLY. Yes; that is possible too. I want to point out again that while I am not defensive about nursing homes in any sense of the word I am extremely critical of them and I think most nursing home operators here will attest to this.

Senator KENNEDY. Well, as I mentioned before, Mr. Lally, these letters have deeply impressed me and my only urging is that in your inspection whatever happens or whatever system you have, I certainly hope that as a principal place of responsibility for the disbursing of funds that you take a deep and abiding personal interest, as I know you have in the past, but I think that the outpouring of mail and sentiment which I have seen, the testimony that I have witnessed not only here but have been reading concerning this committee in other parts of the country indicates that this is and should be a matter of deep concern. I know that you certainly will continue your interest in it and I hope that you redouble your efforts.

Mr. LALLY. Senator, we have approximately 3,000 patients in the nursing homes in Boston, a thousand in hospitals, and there are some 20-odd social workers working on this. This is their job. Their sole job to be sure that the patient receives the best care both medically and nursing home wise. I assure you——

Senator KENNEDY. The only thing that concerns me about your testimony is that it has been of such a nature that you, I would gather from your testimony, that you are not aroused, you are not really concerned about these abuses. There is nothing that you have testified to this afternoon that would indicate any kind of indignation, concern, and I think this is of interest.

Mr. LALLY. I am amazed at the stack of letters and in my long time in the business I have never received that many letters.

Senator KENNEDY. That is just this morning's mail. That, and the early part of the afternoon's mail.

Mr. LALLY. I am quick to investigate every complaint immediately that is addressed to me about nursing homes.

Senator KENNEDY. These are the ones that have been addressed to me. Now I would say that in the samplings I have seen some letters from patients' relatives indicate that the nursing homes have provided very essential and important and useful services to members of their families. But I have been impressed by the really heart-rending stories that most of these letters tell. As I said, in the brief period that I have been a Member of the Senate I have rarely seen such an outpouring of letters of concern over any particular problem.

I certainly hope that you continue your interest as I know you will.

Mr. LALLY. Thank you.

Senator NEUBERGER. Mr. Constantine has a question.

Mr. CONSTANTINE. Mr. Lally, do you have any information or knowledge of any of your staff members having been offered payment by nursing home operators in order to direct patients to their homes?

Mr. LALLY. No, I have not.

Mr. BONNEY. The Department has a very rigid and inflexible rule that we do not accept gratuities of any sort for our services. Furthermore, I thought Mr. Lally made it rather clear that we do not make placements ourselves except in cases of dire emergency in the event for example that we must evacuate a home which has lost its license and the particular patient may not have a nearest of kin, then legally we stand as next of kin and we will then assume responsibility for a suitable placement. Gratuities of any sort are out.

Mr. CONSTANTINE. Did you ever have any experience with a home or group of homes which purchased television sets with the personal funds of patients?

Mr. BONNEY. Once.

Mr. CONSTANTINE. When was that?

Mr. BONNEY. I would guess possibly a year and a half to 2 years ago.

Mr. CONSTANTINE. Could you tell us which homes were involved?

Mr. BONNEY. At this time it was a geriatrics home.

Mr. CONSTANTINE. Geriatric services or corporate operations?

Mr. BONNEY. Now corporate operations.

Mr. CONSTANTINE. Thank you.

Mr. BONNEY. Incidentally we did collect the money back.

Mr. CONSTANTINE. You collected the money back?

Mr. BONNEY. We did.

Senator NEUBERGER. The next witness will be Dr. Count Gibson, chairman, Department of Preventive Medicine, School of Medicine, Tufts University.

Are Mr. Murphy and Mrs. Cohen in the audience? We will try to get to you very soon.

STATEMENT OF COUNT D. GIBSON, M.D., CHAIRMAN, DEPARTMENT OF PREVENTIVE MEDICINE, SCHOOL OF MEDICINE, TUFTS UNIVERSITY

Mr. GIBSON. Madame Chairman, Senator Kennedy, ladies and gentlemen, I am Count D. Gibson, chairman, Department of Preventive Medicine, School of Medicine of Tufts University. I am also a member of the home and ambulatory care of the American Hospital Association.

I do not have a prepared statement. I would like to make my remarks concerning the interrelationship of the general hospitals, the

nursing home, and organized home care in the community. I think it important that we all identify some of the elements involved in the passage of the medicare law, the presence of this subcommittee here today, and attempt some prognostication about where we are headed.

I would like to underscore that a large fraction of the problem that faces us relates directly to the advances of medical science. Pneumonia is no longer the friend of the aged but with our ability to cure pneumonia we make it possible to expand the lifespan, and chronic physical disorders in a steadily increasing measure occupy our time and attention. Literally then the problems we face are unprecedented in our society and we must indeed find new ways of caring for them.

I would like to make a few remarks about Ma and Pa because I think they are important. It seems to me that in the general area of rest homes for elderly people who do not have major physical problems that this is a splendid area for care. As I will indicate a little later it is quite possible that organized home care can play a role in providing medical backup to such homes.

In my opinion when we get to the level of individuals with severe, chronic long-range disability we are no longer in the framework of Ma and Pa. I think Mr. Henry Ford built his first car with very little assistance from anyone else. But today when we know of the many complicated ways in which disability can be retarded; indeed, improvement can be made in such lesions as vascular accidents, in arthritis; I think it is no longer appropriate for this kind of a problem to be dealt with in a small, limited home.

I am sure there is a proper balance involved in the size of the long-term care unit. It should not be too huge lest personal attention be lost—yet on the other hand it needs to be large enough not merely for efficiency but to make it possible to provide an appropriate complex of services and health personnel that will permit the maximum maintenance of health and function in the patient population.

Turning then to the relationship between the hospital, nursing home, and organized home care, I would like to express my profound disappointment that organized home care has grown so slowly.

I would like to make some remarks in elaboration of Dr. Bakst's remarks earlier and perhaps Dr. Knowles this morning, although, unfortunately, I could not be here to hear Dr. Knowles.

In the area of organized home care for chronic illness, I am aware of only three programs in the city of Boston and I cannot identify any others in the State at the present time. Several efforts have been made, some were started, and I apologize if I have overlooked any at this time.

These three are as follows: The Home Medical Service of the Boston Dispensary which was started in 1796. The Home Medical Service of the Boston University Hospital. Dr. Bakst was too modest to indicate that he had directed this program for many years. The Beth Israel Hospital, which was started in 1953.

Since that time, there have been a number of national commissions, collaboration between the U.S. Public Health Service and the American Medical Association, remarkably and warmly, and the Blue Cross Association; and I regret to report that since the Beth Israel program was started here in Boston, there have been no fresh starts of organized home care in this city.

It is not all that difficult to begin, and I would like to describe briefly our own program to indicate its relationship to nursing homes.

We operate a 40-bed chronic disease hospital scattered through the city. Our capital cost per bed has been zero. The per diem payments that are made to these patients through an arrangement which we worked out with Mr. Lally and the welfare department, with the approval of the State, are $5.50 a day. This covers all of the health costs, it covers the physician, nursing, and medical social service which is intensive for these patients. It includes all medications, equipment, and consultations by such individuals as psychiatrists and surgeons, as well as physical therapy and occupational therapy. We provide most of these services ourselves and some we purchase from organizations such as the Visiting Nurse Association.

Now, you can't make bricks without straw. Where does this come from? This comes from the fact that a family member assumes many of the functions of cook, housekeeper and as time goes on, with what they can acquire in skills from the professions, they include the functions of nurse and physical therapist.

The work of such an organized home care program, taking care of patients with advanced disorder, must have available from the hospital a guarantee of instant readmission to the hospital if problems take place. It must have a 24-hour on-call arrangement that will provide a physician immediately if a condition deteriorates.

I read how small our homes are today and how young people don't care about the elderly any more. All I can tell you is there are far more patients in the city of Boston than anywhere nearly matched by the availability of organized home care programs at the present time. I would like to point out in our present census we have three patients with paralysis of all four extremities. We have a number of patients with severe vascular accidents. Some may not improve, others are making a slow, steady improvement and will be able to be discharged.

Home care represents often a temporary location for the patient, at other times, longer range. The average stay of our patients is 8 months in our organized home care program. On occasion, when a member of the family who is rendering the care is ill or must be away, we must find an alternative placement. For over half of our patients, their disability is too severe for them to be admitted to a nursing home and in this case we must refer them to a chronic disease hospital.

So I would suggest that for the figure of $5.50 a day and no capital investment, we have a mechanism that is extremely fruitful as an adjunct. Let me say that in terms of the proprietary nursing homes we have an important health asset to the community. We have several proprietary nursing homes that we utilize in our nursing care program who do an excellent job. We chose them carefully, they cooperate, often with our assistance. They have improved at writing orders and of medications, and the food is good. I have seen one or two here in the audience today with whom we have had very warm and successful relationship.

I would like to underscore that as we head for the future we will have a lot higher fraction of chronic illness in our population than we now have, stemming directly from the benefits of medical research as we play with organ transplants, etc. We will have patients whose life span has been expanded. The dilemma faces the community, faces the Government. Shall the pattern of proprietary nursing home establishments be extended and developed or shall we encourage the growth of alternative ways?

I feel that organized home care, unfortunately, is looked on by too many of our hospital physicians as country culture, it is back to the horse and buggy days, and we have gotten away from house calls. They fail to understand the sophisticated instrument it represents, the important component of care can be given by an individual to whom you cannot give enough money, usually the wife or the daughter.

So that this is an instrument which is not a panacea but the care for a large amount of chronic illness that we have can be started very simply. It requires a commitment by the hospital staff, the administration of the hospital and there is no effort in trying to get community support and participation, there is no trouble at all, and I am giving this as a background.

So I regret to state within the framework of my fellow physicians I on the one hand, and in the American Hospital Association on the other, after all of this time around the country we can identify only about 75 programs for home care for chronic illness.

I would like to cite Michigan, the remarkable role that Michigan Blue Cross has played. In a matter of 7 years, there are now 20 organized home care programs embracing 35 hospitals in this State and I feel that the great success of this program in large measure is due to the vision of Dr. Edward Harmon, who is the medical director of Blue Cross. And the participation from Detroit that has a community-centered home care program involving a number of hospitals all the way to Albion, Mich., which is a very small town, indeed, and in which the program furnished a public health nurse, the first ever to be employed in this county.

So when we talk about cost, I believe this is critical. I feel that the way in which medicare was written in terms of the home care services is far inadequate. I see the dilemna of setting up a benefit which is available to only a few. Perhaps a hundred home visits with the technicians that would be a start that will encourage people. I hope so, and I hope the Federal Government will take an important role in educating hospitals and communities about its use.

Let me turn next to the hospitals themselves. Now hospitals are fond of calling themselves the health center for the community today, and that is a nice slogan. What I am going to propose is not going to be brought about universally immediately, but I would like to suggest that this hospital, this general, acute, voluntary hospital, take a responsibility to provide an appropriate setting for each patient at the proper time for the proper level of his illness as long as he wishes to use it.

In this regard it seems to me that the hospital—it states that your acute illness is over, we must find some other place for you to go—must be brought back to this notion of a health center and that our general hospitals in their building should be encouraged to develop long-term care units as integral parts of the hospital structure.

By doing this, one has all the advantages of the same professional personnel, the organization of records, the facilities when they are needed on occasion, sophisticated institutional care. And certainly a physically different location right next to the acute hospital is appropriate for people for whom chronic illness is now a career and not an episode. I can't see anything wrong with this at all. It seems to me to make abundant sense because our problem will rise faster than the hospitals.

We need all the resources of our proprietary nursing homes that we have at the present time. I would certainly like, in terms of a future thrust, however, to see an increasing focus for patients with severe chronic illness centered around our hospitals. Our hospitals are receiving much attention, many grants, they have flourished and done well. Now it seems to me they should be encouraged to extend the scope of their responsibilities because until they assume responsibility for chronic illness, they are not the health centers for our communities as they would like to be.

Let me add a few thoughts about proprietary and voluntary. I think this was kicked up just a little bit. I will underscore again the need for all the resources that we now have and the many fine people doing fine jobs in proprietary nursing homes.

I believe community accountability and participation of the population in the affairs of our institutions is an important ingredient. I think the Office of Economic Opportunity is startling a number of people in its identification of leadership and those populations that are participating in their care and this will increasingly be, I think, in some of the health care plans that are being experimented with at the present time by the OEO.

I think as a general principle, that when you have an identity of the community with the facility that this is a sound and wise and responsible principle and is a direction that I would like to see things going in.

I would like to add another point. We have talked about the hospital expanding outwards with long-term care. I think you can turn it around and take public housing as an excellent model for experimentation. I believe it is the city of Toronto that has done an interesting job here in a public housing complex for the elderly that permits progression as the resident deteriorates to where he needs more and more care so that he can stay in his same community—to where he now needs his meals brought in and increasingly he needs more attention until, finally, he is in an area we call a nursing home but he continues in the same residential complex. This deserves a large amount of experimentation, as well.

These are my remarks. [Applause.]

Senator NEUBERGER. Very interesting. You have proved in this community what can be done, but how many teaching hospitals are there in the country?

Dr. GIBSON. Senator Neuberger, I would point out the hospital in Kent County and a number of community hospitals which have organized community home care programs with their physicians that have nothing to do with schools and teaching hospitals at all.

I think it is particularly unfortunate that the teaching hospitals have not exercised their leadership and indeed, many community hospitals have done a much better job so far. This is not new. I think any good community chronic hospital can set up without difficulty.

Senator NEUBERGER. Under the health care program, of course no doctor services are provided for unless you choose to join the voluntary plan.

Dr. GIBSON. Yes.

Senator NEUBERGER. So this could not be social security program.

Dr. GIBSON. Of course the physician component at times, himself, in organized home care would not be chargeable, but under a per diem you could pick this out without any difficulty.

I would point out that a medical director could indeed be hired in terms of coordination and every program needs a medical consultant and/or director to make sure the policies are going well.

His salary can be put into the overhead of the program. Otherwise, I think that without the physician's personal services involved, he can go to the patient and bill the patient separately or not bill him. No one goes without attention because he does not have funds.

If that is the case, I think all of the administration and the nursing and the physical therapists and occupational therapists could be provided, and that would be a giant step ahead in this way.

Senator NEUBERGER. I think this is somewhat emulated, or maybe it started in some of the Scandanavian countries where there are similar programs which provide nursing sisters.

It seems to me they were ahead on this years ago when I went to look at it.

Dr. GIBSON. Yes, they have similar ones.

Senator NEUBERGER. You make a case and it sounds economic. To what do you attribute the slow growth; the lack of acceptance of this program?

Dr. GIBSON. Chiefly, cultural factors, Senator Neuberger, for the past 20 years the whole thrust and direction of physicians has been the hospital and hospital administrators still measure each other by "how many beds do you have, and you have a 900-bed sort and a 500-bed sort." I think there has been too much fixation on the hospital bed itself rather than on the function and scope of service to be provided.

Senator NEUBERGER. Doctors, themselves, like to practice in the hospital, though, don't they? Isn't it easier than to go to homes?

Dr. GIBSON. What I would like to indicate is that they think it is easier for them to practice in a hospital. Actually, if you set up proper zoning which is about 20 or 25 minutes around a hospital, half of the patients in our program can be reached easier than to go from the one end of the hospital to the other.

So that it is organization that counts. They fail to understand this, this is quite true. I think they have not had a model.

Senator NEUBERGER. So, you do not have to indoctrinate the public with this agency, you have to indoctrinate your own doctors?

Senator KENNEDY. I just wanted to congratulate Dr. Gibson for very splendid testimony. I think you have put your finger on something which is certainly my feeling of the hope we have in this committee. What we are really interested in doing—what we are ultimately interested in is to make sure that there is adequate care at the right time and place; appropriate to the needs of each patient. I think Dr. Gibson has stressed a very important ingredient in the provision of long-term care through home care programs. I think it is very helpful.

Thank you.

Senator NEUBERGER. Thank you.

Mr. MILLER. Two brief questions. You made reference to the graded housing situation in Toronto. Is this not, in essence, the same concept that is being employed with much greater frequency among the homes for the aged sponsored by church denominations and faiths of all types in this country?

Dr. GIBSON. Yes. You certainly would find increasing elements of that in our homes for the elderly. I despair that they will be able to keep up with the demands that are made. I have identified public

47-467—65—pt. 6——9

housing as a very logical area where one could move with new programs of this kind.

Mr. MILLER. My second question was perhaps covered in your response to Senator Neuberger's question about the costs of the home health service. Are there indications that the welfare department does not pay more than the cost of care?

Dr. GIBSON. Yes.

Mr. MILLER. The $5.50 which you referred to, does that take care of all of the costs of such care?

Dr. GIBSON. It, of course, does not cover any of welfare recipient's budget for the food, clothing and shelter. It covers all the medical care components, all of them.

Mr. MILLER. Is there payment for a physician, also?

Dr. GIBSON. Yes, there is. These are all welfare patients and in our program we provide the medical care.

Senator NEUBERGER. Thank you.

We will have the last two witnesses who are Mr. Campbell Murphy, director of special services for the United Community Services of Metropolitan Boston, accompanied by Mrs. Deborah Cohen, associate director, division of aging, United Community Services of Metropolitan Boston.

Is United Community Services another name for United Fund or Red Feather?

STATEMENT OF CAMPBELL G. MURPHY, DIRECTOR OF SPECIAL SERVICES, UNITED COMMUNITY SERVICES OF METROPOLITAN BOSTON, ACCOMPANIED BY MRS. DEBORAH COHEN, ASSOCIATE DIRECTOR, AGING PROJECT, UNITED COMMUNITY SERVICES OF METROPOLITAN BOSTON

Mr. MURPHY. Yes, it is Welfare Council or Health and Welfare Council. We do the planning and coordinating, research for about 340 member organizations in the Boston metropolitan area; cover 78 cities and towns. We also do the budgeting for the Massachusetts Bay area United Fund for the the monies allocated to local agencies in the city of Boston and in 48 surrounding cities and towns. We have a board of directors of 65 people, and a corporate body which includes representatives from each of the member organizations plus citizens at large.

Senator Kennedy is a voting member of our corporate body.

Senator NEUBERGER. All right. We are pleased to hear from you.

Mr. MURPHY. Just very briefly, in view of the lateness of the hour, our testimony ties in very closely with what Dr. Gibson has just presented, and perhaps I can do no better than to say we endorse his ideas very strongly and hope that the planning, coordinating and research work we are doing here in Boston in the next few years will be helpful in carrying out some of the proposals he has suggested.

It impressed me in the testimony earlier here today that it is of real significance here in Boston that although this is one of the world's major medical centers, that there is the degree of concern about services for chronically ill older people that has been expressed in the mail to this committee. It is certainly something that can't be overlooked.

It obviously does mean that there are a great many people who are not getting the delivery of the type or quality of health services to which they believe they are entitled.

In our own experience in working with agencies here in Boston, regardless of the merits of the various programs available, the whole question of delivery of services has been a serious one.

We have found in the poorer areas of Boston, for instance, of the women who come into Boston City Hospital for delivery of children, something like 60 or 70 percent have never had any medical care during the prenatal period.

We find areas in Boston where a very large proportion of people never take advantage of the immunization programs that are available. I think some of the same things are true in the lack of use of services for older people.

I would like to suggest one further thing that with the development that the medicare program, even though there are rather stringent limits in the amount of service that may be made available under certain categories, it is extremely important with this extension of additional care that there be adequate distribution of services, and I can only emphasize very strongly that unless we have very well organized plans for delivery of medical care developed, that the new services provided by law will not be given adequately.

I would like to turn this presentation over to Mrs. Cohen for a brief statement on some of the types of things that we are developing at the present time in terms of trying to develop adequate combinations of medical care services for older people. These proposals will make it possible for more older people to stay in their own homes utilizing hospitals and recuperative centers during and following periods of acute illness.

Mrs. COHEN. You have a copy of the report. I won't go into detail about our Committee on Aging because it really is late and I think you have all been wonderful to have as much patience and to listen so intently as you have.

I am particularly interested in mentioning first the real problems that we have here of communitywide planning. One is the high percentage of population over 65.

Boston has 12.3 percent; Metropolitan Boston, 10.9; United States is about 9.2. Then there are tremendous population movements because of land-taking for urban renewal, highways, and so forth.

A large percentage of the 50,000 families that are going to have to be moved will probably be older people. And this is a traumatic experience, it is traumatic for young families and it is certainly very difficult for older people.

I would like to tell you a little bit about the role that UCS has had in nursing home care and long-term care. We believe as some of the speakers before us, that nursing homes, private or nonprofit, are just not the whole answer to long-term care for the aging.

Nursing homes ought to be places where people go to recover from illness, not places where they go to die. From a one-way street, we must take them a two-way street. First, we must provide community services to keep as many older people as possible out of institutions, but if we have got to use them and we do in many cases, we get them out as soon as possible and return them to the community.

You have attached to your materials the health hospitals, guide that was worked out by the health and hospital division of UCS. Here we have the beginning of a referral system, there are two sheets in there, one for the hospital, one for the nursing home, and this at least is the beginning of trying to bring about better communication and better relations between hospitals and nursing homes.

Our subcommittee on nursing homes and you have here, too, listed all the names of the different people that are working on our committees, has held workshops for nursing home personnel with hospitals and other agencies to promote better communication between them.

Then I just mention two projects. You have a good deal written about them but I will really just take a minute or two. One is what we call the Brookline Residence and Recuperative Center. The city of Brookline has 16.5 percent of population over 65. This is fourth highest among cities in the State of Massachusetts.

Nearly 1 year ago, ministers and lay representatives of various Brookline churches began consideration of the need of housing and recuperative services for the elderly in Brookline.

The purposes for which the corporation is formed are to provide housing and related facilities and services for elderly families and persons on a nonprofit basis, especially designed to meet the physical, social, and psychological needs of the aged and contribute to their health, security, and happiness. To plan, construct, operate, maintain, rehabilitate, alter, convert, and improve housing and related facilities and services for elderly families and persons.

Thus, long-term care can be translated into comprehensive care serving people who are regarded as individuals with respect, understanding and sympathy for their problems.

Now this project depends for success on a combination of Federal programs, such as CFA 202, if they decide to use that rather than HRA—FHA 231 or 232, Hill-Burton, and provisions for rent subsidies in the new housing legislation. It will be concerned with preventive health care, provisions for diagnostic and ongoing health care, home care, and safe, decent, secure housing at rents older persons can afford to pay.

It is also possible with the new rent subsidies passed by the Congress that we will provide apartments in this housing for those of very low incomes so that we can begin to have sort of a mixture of income groups and not isolated to very low-income from the middle-income groups.

Now, Peter Bent Brigham Hospital has accepted the supervision of comprehensive and continuing health of this project. We have, up to date, we have five Protestant churches, one Jewish temple. Hopefully, we will get more and we are also approaching the Catholic groups in Brookline.

We have taken our story to all of the agencies in the city, the planning board, redevelopment authority, the public housing Authority, the Brookline Board of Selectmen. I have here, and I will give them to you, all kinds of newspaper articles that have appeared in the local paper concerning this project.

Well, this is enough of that. I will just take another minute to tell you about our protective services project. We are one of six communities in the United States chosen by the National Council on Aging, which is the voluntary agency concerned with all problems of

aging, to set up a demonstration project under the protective needs of older people.

This means that we are concerned about those older people who don't really have anyone concerned with them who live alone, who are isolated from the general community. You have seen them yourself walking in the streets of New York. You have seen them in Boston Common, you have seen them on streets rummaging through garbage pails.

There are these people who were well when they got into public housing but now they are not capable of taking care of themselves and are fearful of telling anyone about their ills because they enjoy living in public housing and they don't want to be evicted, not that they would be, but I think they have this prevalent fear.

So we are working with the Boston Housing Authority to set up a project which will be a training demonstration and will give intensive casework to older people who have already been identified as people who, if they don't get certain community care, will eventually get into a crisis situation and in a hospital or in a State hospital because they will be committed, or else they will have to go into a nursing home.

Now with those of these projects, we are primarily concerned with the lack of community facilities in helping carry out this continuing health care.

We believe in a combination of Government and private people, for example, the projects of the Government for middle-income housing now for nonprofit groups to build nursing homes, it is a very wonderful thing, and we are only sorry that more people don't really take advantage of it.

Senator NEUBERGER. Thank you. Mrs. Cohen and Mr. Murphy. Your full statement will be in the record.

(The statement follows:)

PREPARED STATEMENT OF CAMPBELL G. MURPHY, DIRECTOR, SPECIAL PROGRAMS DEPARTMENT AND MRS. DEBORAH B. COHEN, ASSOCIATE DIRECTOR, AGING PROJECT, UNITED COMMUNITY SERVICES OF METROPOLITAN BOSTON

FUNCTION OF AGENCY

United Community Services of Metropolitan Boston is the overall planning, budgeting, coordinating and research organization for health and welfare services in the Massachusetts Bay area. It serves the 78 cities and towns in the Boston standard metropolitan statistical area. It has some 180 financially participating member agencies for services they provide in 49 of these cities and towns. There are 140 additional member agencies—including governmental agencies on local, State, and Federal levels and voluntary agencies with other sources of financing.

UCS is linked to the total process of urban renewal and provides leadership in coordinating public and private agencies. It works in close cooperation with the Massachusetts Commonwealth Service Corps (the official State agency for the antipoverty program) with the Massachusetts Council on Aging and with other State agencies in the fields of rehabilitation, public health, public welfare, and mental health.

UCS is affiliated on a national level with United Community Funds and Councils of America, the National Social Welfare Assembly and the National Council on Aging. On a local level it works closely with Action for Boston Community Development (ABCD), the antipoverty agency for the city of Boston.

ORGANIZATION

United Community Services is incorporated as a nonprofit organization under the laws of the Commonwealth of Massachusetts. Members of its corporation include two representatives from each member organization plus additional citizen representatives. Senator Edward M. Kennedy is a voting member of the corporation. The 65-member board of directors is elected by the corporation.

47-467—65—pt. 6——10

FINANCIAL SUPPORT

Financial support comes from the Massachusetts Bay United Fund and grants from both public and private sources.

FUNCTION OF UCS AGING PROJECT

To develop appropriate services to keep older people out of institutions and to make it possible for them to live in their own homes in a normal, familiar neighborhood environment as long as they can.

With the heavy commitments UCS already has for use of Red Feather money, it is proposed that the aging project primarily seek outside funds for major programs.

Needs highlighted by a study, "Services for Older People," completed in 1961 by Dean Emeritus Richard K. Conant of Boston University School of Social Work are receiving broad attention. The UCS aging project has adopted these problems as the focus of its attention.

1. Public housing projects for the aging: Provision of needed social services, such as casework, group activities, health services.
2. Training of personnel for working with older people: This is being developed with Boston University School of Social Work on various levels: (*a*) Updating personnel already working with older people, and (*b*) training new workers and volunteers.
3. Older people living in family public housing projects: Developing demonstration health care and nursing services, as well as activities for leisure time.
4. Establishment of a centrally located multipurpose senior citizens center: The center would provide counseling, group activities, information and referral services, and a health maintenance clinic.
5. Inclusion of needed services for the aging in neighborhood service centers.
6. Provision of adequate low-rent housing for older people not eligible for admission to public housing projects: Recent surveys have highlighted this need. The aging project will identify groups needing such nonprofit or low-profit housing and areas in which they might be located; it will also identify organizations which might sponsor such housing. (NOTE.—During the past 3 years in Denver, Colo., 26 such housing developments were started under planning council leadership.)
7. Training or retraining of middle-aged persons for appropriate employment in cooperation with Action for Boston Community Development (ABCD), a broadly based agency formed to serve as the conduit for a series of grants from the Ford Foundation and the Federal Government to finance a variety of experimental health, educational, and welfare projects in Boston.
8. Urban renewal program will require examination of existing services for older people and the determination of ways to alleviate problems where they occur and prevent their occurrence whenever possible.

Staffed by an associate director of UCS Department of Special Programs, with master's degree in social work, and training and experience in community organization.

GENERAL FACTS

"Senior citizens are not just some indefinable group separate and apart. They are our mothers and our fathers. They are 'ourselves' in a few short years. They are those of us who have made a contribution to society, and to our country. They are those who have given their energies, their skills, and their children for the good of society. Society must not ignore them when their hair is grey and their shoulders bent." [1]

For a least a decade, demographers and other social scientists have been pointing out that the rapid aging of the population of the United States is bringing about a "silent revolution" in our society which will have far-reaching effects throughout our economic system and social institutions. As yet there has been little indication that the Nation as a whole has understood the full significance of the marked shift in our population profile toward the older age brackets, or that it is prepared to face up to the social consequences of this shift.

The time has come for us all to take a fresh look at the over-65 age group, and to make special provisions now to "reintegrate" these individuals into our social system. Though in general it is appropriate for our health and social welfare programs to be equally applicable and available to all age groups of our population, it is also appropriate that due attention be given to the special needs of

[1] Senator George A. Smathers, Senate Special Committee on Aging, Apr. 24, 1963.

certain age groups. It would seem, in this connection, that "crash" programs of various kinds directed toward the needs of the aging on a national scale are as warranted and necessary today as were the special efforts to further the health and welfare of children that were first undertaken in the 1920's, and that are still carried out today through the Children's Bureau of the Federal Government and other national and State agencies.

The United Community Services Committee on Aging has accepted this modern challenge to explore and experiment anew with aging, because it believes that care given the elderly may well be the measure of our civilization.

In the United States older people constitute about 9.2 percent of the population. In the Boston metropolitan area, 282,000 people out of a total population of 2,589,000 are over 65, making 10.9 percent elderly; this is higher than the national average. In the central city of Boston, the percentage of elderly is even higher—12.3 percent.

The average income of the Nation's 17.5 million people over 65 is $1,758,000 with 2 million older women having no income at all. In Massachusetts, there are 144,000 single people over 65 who live on less than $1,000 a year.

We thus have a flood of factual data on problems of the aging, and the committee on aging has specific plans of action which seek to improve the well-being of many aged through broad scale community programing. For this implementation we must have the kind of help outlined in the community services bill discussed here today.

Problems of communitywide planning for the aged in Metropolitan Boston

The particular problems in Boston center around these facts:

(1) The higher percentage of population over 65 than in most cities;

(2) The tremendous population movements because of land taking for urban renewal, highways, etc. It is estimated that up to 50,000 families in the metropolitan area may be forcibly removed in the next few years. A large percentage will be older people. When the aged move, many will undergo the tensions of a displaced person. As if this were not difficult enough, there are not sufficient dwelling units available to house these people at rents they can afford to pay.

Seventeen percent of the entire housing supply in the metropolitan area is either substandard or lacking basic facilities such as plumbing. The vacancy rate is less than 2 percent, whereas a normal housing shortage is based on 4 percent to 5 percent vacancy rate. In Boston, the 1960 Census officially listed 30 percent of housing units as deficient, deteriorating, or dilapidated. Over 4,000 adults live in lodging or rooming houses in the South End—just one part of Greater Boston.

(3) Long-term and role of nursing homes: Nursing homes, private or nonprofit, are not the answer to long-term care for the aging. Nursing homes ought to be places where people go to recover from illness, not places where they go to die. From a one-way street, we must make them a two-way street. First, we must provide community services to keep as many older people as possible out of institutions, but if they have to use them, we get them out as soon as possible, and returned to the community.

UCS has been involved in improving nursing home care.

1. The health, hospitals, and medical care division, Edward B. Kovar, director, has compiled and sold at cost in 6 months over 150 blocks of referral forms, each block containing forms for 50 referrals, making a total of 7,500 forms. These are used solely for communication between the nursing home and clinic or emergency ward in hospitals.

2. The subcommittee on nursing homes of the UCS Committee on Aging has held workshops for nursing home personnel with hospitals and other agencies to promote better communication between them.

3. The Brookline Residence and Recuperative Center: Nearly 1 year ago, ministers and lay representatives of various Brookline churches began consideration of the need of housing and recuperative services for the elderly of Brookline.

The purposes for which the corporation is formed are to provide housing and related facilities and services for elderly families and persons on a nonprofit basis, especially designed to meet the physical, social, and psychological needs of the aged and contribute to their health, security, and happiness. To plan, construct, operate, maintain, rehabilitate, alter, convert, and improve housing and related facilities and services for elderly families and persons.

Thus long-term care can be translated into comprehensive care serving people who are regarded as individuals with respect, understanding and sympathy for their problems.

The Brookline project depends for its success on a combination of Federal programs, such as CFA 202, FHA 231 or 232, Hill-Burton, and provisions for

rent subsidies in the new housing legislation. It will be concerned with preventive health care, provisions for diagnostic and ongoing health care, home care, and safe, decent, secure housing at rents older persons can afford to pay.

In December 1964, Rev. Walter Van Hoek of the Harvard Church, Dr. James Walker from the Peter Bent Brigham Hospital, Mrs. Deborah Cohen from United Community Services, and Richard Stetson, M.D., chairman, UCS Special Programs Department, discussed this proposal with the Brookline Board of Selectmen, planning board, redevelopment authority, and public housing authority.

In March 1965, interested civic leaders representing various churches were organized into an informal association; temporary officers were elected and Rev. Roland S. Larsen retained as executive director.

At the present time the association is seeking formal sponsorship of various interfaith bodies, and when the charter is received the goals and specific plans of the corporation will be presented to the community.

This is a nonprofit corporation, paying real estate taxes and the facilities will be open to the community regardless of race or creed. The recuperative center will be served by the medical specialists of the Brigham Hospital, and the corporation will seek a constructive relationship with private physicians.

4. Protective services for older persons: Boston is among five cities and a county in Colorado selected for a national pioneering project to determine the needs of the elderly for protective care and services, authorized by the National Council on Aging. The other study centers will be Chicago, San Diego, Houston, Philadelphia, and Jefferson County, Colo.

The Boston project will be administered by the UCS in cooperation with the tenant and community relations department of the Boston Housing Authority.

The study will center around 100 selected senior citizens in Boston public housing projects who are alone in the world with few friends or family, many ills and few financial resources. The study will attempt to find out what community services are necessary to prevent a crisis situation in the life of a senior citizen, who in crisis is often sent to a hospital, to a mental institution, or a nursing home. The result of this many times is death, because of help given too little, and too late.

Senator KENNEDY.

Senator NEUBERGER.

Senator KENNEDY. I would just like to commend both of you for your testimony.

As Mr. Murphy mentioned, I am very much honored through my association with the fine work that this wonderful group does.

As a member of this committee, I want to extend to you my appreciation of your appearance here for the experience which you brought to the members of this committee.

Senator NEUBERGER. In that you are the concluding witnesses on this hearing of one very full day in Boston, I think the committee feels it has really run the gamut of all sorts of suggestions and a good many of them which are rather new and interesting. We are interested in community projects such as yours which is taking some constructive steps. We appreciate all of the witnesses we have had today. This concludes the Boston hearing.

Senator KENNEDY. May I just say one word, Madam Chairman. As a member of this committee, I would like to commend our audience here today who attended this hearing. I think they have demonstrated an interest in something which this committee is concerned about. I think they have conducted themselves in a very fine manner. I certainly think that all of us have benefited from these hearings.

I want to express my appreciation for their interest and I know that there are many out here who have indicated that they would like to testify—that they would like their views known. I see a number of people here who speak for the elderly, who speak for a number of different groups, and I think as the chairman indicated earlier today, the record would be open for any of their statements, any of their

views which will be helpful to this committee. I certainly invite their participation.

I know that the concern of this committee will continue and we certainly look forward to hearing from any or all of you, not only on the management and other matters that we concerned ourselves with today. So I would like to thank you for your patience and your participation today.

Senator NEUBERGER. Thank you.

We are adjourned. [Applause.]

(Whereupon, at 5:15 p.m. the subcommittee adjourned.)

(The following letters and statements were subsequently received for the record:)

SEPTEMBER 7, 1965.

Hon. EDWARD M. KENNEDY,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KENNEDY: On August 10, 1965, you conducted hearings, in Boston, Mass., for the Senate Subcommittee On Long Term Care of the Aged. You will probably recall that one of the witnesses before the subcommittee employed the occasion to unleash a diatribe of vituperation and invective directed against me. Those remarks received considerable publicity in the press. Because the remarks made against me were not only irresponsible but also false and malicious, I wish to take this opportunity to bring the true and irrefutable facts to your attention, and to the attention of the subcommittee.

I respectfully submit for your information and consideration the following CPA reports, namely:

(1) Certificate of Blonder-Freedman Co., certified public accountants, covering all my interests in and dealings with nursing homes as of August 10, 1965, both direct and indirect, and both by way of ownership, equity interest, finance transactions and otherwise. This certificate does not include the activities of Industrial Finance Corp. and Pioneer Management, Inc., which are covered in the Price Waterhouse reports referred to below.

(2) Report of Price Waterhouse & Co., dated September 1, 1965, covering the activities of Industrial Finance Corp. in the nursing home field as of August 10, 1965.

(3) Report of Price Waterhouse & Co., dated September 1, 1965, covering the activities of Pioneer Management, Inc., in the nursing home field as of August 10, 1965.

(4) Report of Price Waterhouse & Co., dated September 1, 1965, covering the much discussed loan made by the Court Street Venture No. 1 to Frank C. and Mary C. Romano, and my interest therein.

From these reports the following irrefutable facts appear, beyond contradiction or dispute, namely:

(1) I own a lawful 50 percent interest in two nursing homes in Massachusetts.

(2) Companies with which I am connected have lawful financing transactions with 26 Massachusetts nursing homes.

(3) The lawful interest rates charged by Industrial Finance Corp. average about 12.8 percent per annum, and by Pioneer Management, Inc., average about 8.2 percent per annum.

My ownership of Massachusetts nursing homes amounts to one-third of 1 percent of the total of nursing homes in the Commonwealth. There are 730 licensed nursing homes in Massachusetts, valued at approximately $130 million with an aggregate capacity of approximately 26,000 beds. My ownership, out of this total, is 50 percent of two nursing homes with an aggregate capacity of 296 beds. It will be apparent to you and to the subcommittee, that for a witness to charge that I control the nursing home industry in Massachusetts is patently false and malicious. It so happens that the two nursing homes in which I have an interest are the most beautiful, modern, well-staffed, and best equipped in the Commonwealth. They are models of what good nursing homes should be.

The accusation that companies with which I am connected charge 40 percent in interest rates is likewise totally irresponsible. The charge is a sheer falsehood, and the falsity is easily ascertainable. For a witness to inflict such vicious remarks on the subcommittee, without a single fact to support his allegations, is an affront to the subcommittee, and an act of unmitigated irresponsibility.

The insinuation that the number, size, or amount of loans secured by mortgages on nursing homes imports any impropriety is so manifestly lacking in merit or business common sense as to constitute an exercise in nonsense. The enclosed reports gives you the true amounts of the loans and the interest rates charged.

The investigations of your subcommittee may uncover situations in the nursing home industry which need correction. I offer the subcommittee every cooperation and any assistance which I can render. And I close with confidence that you and the other members of the subcommittee will not allow yourselves to be used as a forum for the falsehoods, hatreds, and vindictiveness of malicious and irresponsible people.

I respectfully request that you include this letter and the enclosed CPA reports with the files of the subcommittee. You are entitled to have the truth, and these CPA reports give you the truth, in a form that you can rely upon.

With renewed assurances of my continued esteem, and with admiration for your great public service, I am,

Sincerely yours,

JOSEPH KOSOW.

PRICE WATERHOUSE & CO.,
Boston, September 1, 1965.

Mr. JOSEPH KOSOW,
President, Industrial Finance Corp.,
Boston, Mass.

DEAR MR. KOSOW: You have requested that we examine documents in your files relating to a loan made in 1959 by the Court Street Venture No. 1 (in which you were a participant) to Frank C. Romano, Mary C. Romano, and nine nursing homes located in Massachusetts.

According to the signed copies of the loan agreement between the parties dated September 18, 1959, and a copy of the related note from Frank C. Romano et al. dated October 14, 1959, the loan had a principal amount of $700,000 to which was added interest to maturity at 20 percent per annum ($592,084.67), bringing the face amount of the note to $1,292,084.67 and was payable in 359 weekly installments of $3,600 each. The loan was secured by first or second mortgages on the nursing home property plus other secondary collateral.

We also examined a signed copy of the Court Street Venture No. 1 loan participation agreement dated July 29, 1959, and signed copies of subsequent assignments through October 13, 1961, made by the various participants, which indicated that the extent of your direct participation in the joint venture was as follows:

1. From July 29, 1959, to September 28, 1959, you held a one-sixth interest, or 16⅔ percent.
2. On September 28, 1959, you obtained, by assignment from one of the other participants, a further interest of 8⅓ percent, bringing your total to 25 percent; however, on that same day you assigned your full interest (25 percent) to Industrial Finance Co., Inc. (a predecessor of Industrial Finance Corp.).
3. From September 28, 1959, to October 13, 1961, you held no direct interest in the venture.
4. On October 13, 1961, you obtained, by assignment from one of the other participants, an interest of 8⅓ percent, which on the same date you assigned to Industrial Finance Co., Inc., again eliminating any direct interest in the venture.

We understand that this loan agreement was subsequently terminated.

Yours very truly,

PRICE WATERHOUSE CO.

PRICE WATERHOUSE & CO.,
Boston, September 1, 1965.

Mr. JOSEPH KOSOW,
President, Industrial Finance Corp.,
Boston, Mass.

DEAR MR. KOSOW: In accordance with your instructions, we have examined the notes receivable files of Industrial Finance Corp. to ascertain certain information relating to any direct loans outstanding to nursing homes as of August 10, 1965.

Our examination disclosed that as of August 10, 1965, Industrial Finance Corp. held 19 notes with balances receivable directly from nursing homes. The aggregate

outstandiing balance on these notes at August 10, 1965, as shown by the records which we examined, was $2,453,456.16 and the average interest rate on these notes amounted to approximately 12.8 percent per annum. Each balance outstanding on these notes was confirmed directly to us as of that date by the borrowers.

According to the company's records, except for one loan secured by a first mortgage, all of these loans were secured by second or third mortgages on the nursing home real estate or chattel mortgages on personal property in the nursing homes and, in some cases, also included other secondary collateral and/or guarantees by third parties.

We also confirm that, according to the company's stock records, you are not a stockholder of Industrial Finance Corp.

Yours very truly,

PRICE WATERHOUSE, Sr.

PRICE WATERHOUSE & Co.,
Boston, September 1, 1965.

Mr. JOSEPH KOSOW,
Treasurer, Pioneer Management, Inc.
Boston, Mass.

DEAR MR. KOSOW: In accordance with your instructions, we have examined the notes receivable files of Pioneer Management, Inc., to ascertain certain information relating to any direct loans outstanding to nursing homes as of August 10, 1965.

Our examination disclosed that as of August 10, 1965, Pioneer Management, Inc. held a total of seven notes all of which were receivable directly from nursing homes. The aggregate outstanding balance on these notes at August 10, 1965, as shown by the records which we examined, was $2,396,491.13 and the average interest rate on these notes amounted to approximately 8.2 percent per annum. We attempted to obtain direct confirmation of each balance as of that date directly from the borrowers and we received confirmation of all of the notes except one, which had a balance outstanding of $248,780.56.

According to the company's records, all of these loans were secured by second or third mortgages on the nursing home real estate or chattel mortgages on personal property in the nursing homes.

Yours very truly,

PRICE WATERHOUSE Co.

BLONDER-FREEDMAN Co.,
Boston, Mass.

Mr. JOSEPH KOSOW,
Boston, Mass.

DEAR SIR: At your request we have made an examination of your books and records, and also the books and records of all corporations, joint ventures, trusts, and other entities in which you are interested, for the purpose of ascertaining the following:

1. The totality of your ownership interests, if any (direct and indirect), in nursing homes, wherever located, as of August 10, 1965;
2. The total of your business transactions, if any (direct and indirect), with nursing homes, wherever located, as of August 10, 1965. This to include all financing transactions and all other business dealings of every kind and description, in existence as of August 10, 1965.
3. The totality of ownership interests, if any (direct and indirect), of all entities with which you are connected, or in which you have any interest or control, in nursing homes, wherever located, as of August 10, 1965.
4. The total of the business transactions, if any (direct and indirect), by all such entities, with nursing homes, wherever located, as of August 10, 1965. This to include all financing transactions and all other business dealings of every kind and description, in existence as of August 10, 1965.

Excepted from the above examination and from this report are nursing home interests and business dealings, if any, of Industrial Finance Corp. and of Pioneer Management, Inc., whose books and records are being examined, for the same purposes, by another firm of certified public accountants. In making our examination, as aforesaid, for the above stated purposes, we have followed and applied sound, accepted, and customary accounting procedures.

As a result of this examination (and excepting only the two corporations mentioned above, for whom a separate report is being prepared by other account-

ants) we certify that the total personal nursing home interests and business transactions pertaining to nursing homes of Joseph Kosow, and the total nursing home interests and business transactions of all such entities in which he has any interest or control, are correctly and completely set forth in the following report; all as existing on August 10, 1965.

Respectfully submitted.

BLONDER-FREEDMAN CO.,
Certified Public Accountants.

JOSEPH KOSOW

PERSONAL NURSING HOME HOLDINGS

Item 1: Joseph Kosow, personal nursing home ownership. Interest in his own name or in the name of any member of his family, or in the name of any entity, trusts, or nominee holding for Joseph Kosow.

None.

PERSONAL NURSING HOME LOANS

Item 2: Joseph Kosow nursing home loan transactions, personal, or in the name of any member of his family or in the name of any entity, trust, or nominee holding for Joseph Kosow.

Loan to Mr. Leo Kosow, brother:

Treasurer of:	
Cedar Corp	$500
American Nursing Home, Inc	10, 000
Claflin Corp	6, 500
Worcester Nursing Home, Inc	23, 000
Total	40, 000

Unsecured notes, noninterest bearing.

JOSEPH KOSOW CORPORATE

INTERESTS IN NURSING HOME OWNERSHIP OR LOAN OR CONSTRUCTION TRANSACTIONS

Item 1: West Management, Inc.—Massachusetts corporation—Joseph Kosow, 50 percent corporate equity ownership.

A. Under construction in Bloomfield, Conn., not in operation.

B. Under construction in West Haven, Conn., not in operation.

Item 2: South Management, Inc.—Massachusetts corporation—Joseph Kosow, 50 percent corporate ownership and wholly owned. Subsidiary Allston Nursing Home, Inc. (Massachusetts corporation).

A. Owns and operates Allston Nursing Home. Inc., at 533 Cambridge Street, Allston; first mortgage, Charlestown Savings Bank.

B. Owns and operates Commonwealth Nursing Home located at 1501 Commonwealth Avenue; first mortgage, Dorchester Savings Bank.

THE COMMONWEALTH OF MASSACHUSETTS,
SPECIAL COMMISSION TO STUDY CONVALESCENT OR NURSING HOMES,
Boston, Mass., August 9, 1965.

The attached documents given to the committee in the hand of Mr. Constantine had been accepted by the Special Commission to Study Convalescent or Nursing Homes.

ARTHUR J. CHAMPIGNY,
Commissioner.

We are attaching the resolve under which we were created which has been continued by further resolves in 1964 and 1965.

GERTRUDE K. WEINER,
Legal Counsel to the Commission.

THE COMMONWEALTH OF MASSACHUSETTS

RESOLVES OF 1962, CHAPTER 138

CHAPTER 138. RESOLVE PROVIDING FOR A STUDY BY A SPECIAL UNPAID COMMISSION RELATIVE TO THE LAWS RELATING TO CONVALESCENT OR NURSING HOMES, AND TO THE STANDARDS AND COSTS THEREOF

Resolved, That an unpaid special commission, consisting of three members of the senate, five members of the house of representatives, and three persons to be appointed by the Governor, is hereby established for the purpose of making a study of the laws governing convalescent or nursing homes, and the medical and nursing care of recipients of public aid, the standard of care which should be provided to such recipients, the cost of such care, the comparative cost to the taxpayer of convalescent or nursing home care in private convalescent or nursing homes and in public institutions, the administration and operation of said convalescent or nursing homes, the qualifications of the personnel employed therein, and such other matters as may be necessary to provide better nursing care and attendance, and reducing the costs thereof.

Approved July 21, 1962.

THE COMMONWEALTH OF MASSACHUSETTS,
SPECIAL COMMISSION TO STUDY CONVALESCENT OR NURSING HOMES,
Boston, Mass., August 17, 1964.

Senator JAMES S. MCCORMACK,
Commonwealth of Massachusetts, Department of Commerce,
Boston, Mass.

DEAR SENATOR MCCORMACK: I have been unable to reach you—therefore, I am consulting you by mail.

Following is a partial list of recommendations for legislation urgently needed to accomplish some of the purposes for which the special commission to study convalescent or nursing homes was established.

First I must call to your attention that by September 14, 1964, the rate setting board will start holding hearings on classifications of nursing homes and nursing care services.

No member of the commission is against the principle of higher rates for additional and better nursing services, but it becomes imperative for us to insist that at least two prerequisites be met by the nursing homes before they can become eligible to be considered for classification:

Prerequisite 1. That the nursing homes accept and use the standardized uniform accounting system, which will become the basis of the formula on which increases will be figured.

NOTE.—All nursing homes should receive increases based on a standard uniform system, allowing no one nursing home accounting advantages over his competitor. It might be wise for the licensing agency to send free to the nursing homes one set of the necessary accounting forms in order to encourage acceptance of the uniform system. The U.S. Public Health Service has a comprehensive accounting manual already prepared that can be used for this purpose.

Prerequisite 2. That the individual nursing home and the public welfare department sign contracts establishing the kind and quality of services to be rendered to the public assistance recipient and the rate of payment therefor

NOTE.—Both parties obtain many advantages under such a contractual plan. Some of the benefits: 1. Quick correction of inadequacies in services or payments. 2. Effortless upgrading in all the services—such as nursing care, complete patient records, acceptance of standard accounting practices, more and better personnel, improvement of physical facilities, etc. Every area of upgrading rewards the nursing home by higher classification and avoids demerits for failure to provide adequate services. 3. The public assistance recipient will benefit by the close supervision of the welfare department over services, standards, and facilities. 4. The public welfare department will have the authority to reduce, suspend, or revoke payments to nursing homes that fail to perform their contractual obligations.

NOTE.—In order not to add clerical burdens on public welfare departments I have constructed one general contract to be signed between the public welfare and each nursing home. The addition or removal of a patient will be handled

under the monthly payment plan, but each patient so added or removed will become part of the general contract.

NOTE.—Under our second prerequisite of signed contracts and under the right to withhold payments for failure to perform services, I predict that all violations will be so quickly and so effectively corrected by the nursing homes that the public health department will rarely have to bring action to revoke a nursing home license.

The following recommendations are not prerequisites to classification but this third recommendation could be an advantageous prerequisite:

Prerequisite 3. A program to license administrators for nursing homes.

1. All licensees shall have proper educational qualifications for this post.
2. An enabling "grandfather clause" would license all administrators currently serving in that capacity, but I would base renewal of these licenses on continuing educational courses in better administration practices.

   NOTE.—Such courses might be offered to personnel by the public health department.
3. I would establish a board of examiners for licensing administrators who would set qualifications, prepare, give, and grade examinations.

   NOTE.—I have secured information from the Professional Examination Services of New York. They have perfected examinations for nursing home administrators which are used in Oregon. Oregon is enthusiastic about this method of examination for administrators.

The following recommendations concern personnel.

IV. Health examinations or health certificates yearly for all nursing home personnel.

In order to avoid further exploitation of the mental health dischargees that have been placed in nursing homes as employees under the rehabilitation program, and in order to allow supervisory followup of these mental health dischargees by the rehabilitation service, I would urge that:

V. Only one mental health dischargee be employed in each nursing home except where the nursing home administrator obtain written consent from the department of public health for each additional employee in this category.

VI. That the mental health dischargee serving as a nurses' aid, and all other persons serving as nurses' aids shall wear a distinctive uniform that is different than a nurse's uniform.

NOTE.—Special penalties or demerits should be incorporated into this provision enforcible when a nurses' aid practices deception on the public by wearing a nurse's uniform and cap.

Please note that this recommendation appeared previously in the commission's second interim report.

VII. The power of attorney "shall not be assumed by an administrator or a nurse, or any employees of the nursing home, or by anyone having any financial interest in the nursing home for any patient, unless ordered to do so by a court of competent jurisdiction.

The nursing home license should be subject to revocation upon proof of conversion of the patient's property.

NOTE.—Perhaps this kind of legislation will guard the $15 personal checks for the patients in nursing homes.

The following recommendations are concerned with licensing:

Under Massachusetts Gen. Laws, chapter 111, section 71—the licensing provision reads—"An application of a new owner for a license shall have the effect of a license for a period of 3 months when acknowledged by the department"; and under the acts of 1963, chapter 783, following the commission's recommendation, the law limits provisional licensing to 6 months.

I would like to present a detailed procedure for implementing these two laws; which will be very effective in promoting quick compliance by the nursing home to all requirements necessary in order for them to obtain a permanent license for the year.

VIII. The acknowledgment given by the public health department shall take the form of a temporary 90-day license. The words "90 days" and "temporary" shall be stamped in bold red letters across the face of the license. The new license shall, prior to receiving this temporary license, return to the department of public health the license of the prior owner. The temporary license shall be prominently displayed in the nursing home to which it has been issued. This temporary license will expire automatically at the end of the 90 days and cannot be extended.

If the nursing home has not fulfilled the requirements that entitle them to a permanent 1-year license, and since the law allows a 6-month period for provisional licenses, I would recommend the following regulations for the last 3 months of the 6-month provisional license period.

If the nursing home has not fulfilled the requirements necessary to receive a permanent yearly license, then the licensing authority shall issue to the nursing home a 30-day provisional license. The words "30 days" and "provisional" shall be stamped in bold blue letters across the face of this document. The licensing authority should also boldly write in across the face of this provisional license the expiration date of the license (30 days from date of issue). In order to obtain this license for display the nursing home must return to the public health department the expired temporary license.

If it is necessary the licensing authority shall at the expiration of the first provisional 30-day license issue a second 30-day provisional license, and if necessary issue a third 30-day provisional license.

These licenses will have the word, "second," or the word "third" and the words "30 days" and "provisional stamped" in bold blue lettering across the face of the license.

No further 30-day provisional license can be issued and if the nursing home is not eligible for its permanent yearly license then it becomes an unlicensed home.

NOTE.—I doubt whether any nursing home will find it necessary to go to the trouble and expense of obtaining four licenses in a 6-month period. I venture that all requirements necessary to obtain a permanent license will be met in 3 months, or in 4 months at the very most.

NOTE.—I have taken the trouble to detail the above procedure so completely because the licensing authority has not yet worked out an improved licensing procedure where the provisional license automatically expires at the end of the 6-month period.

The following recommendation seeks to enlarge the inspection staff of the licensing authority by adding specialists as inspectors in an area that should be closely supervised because it deals with narcotics and other harmful drugs:

IX. That the public health department be authorized to appoint at least two pharmacists as inspectors to visit the nursing homes in Massachusetts, in order to control the use and disposal of unused drugs and narcotics, in nursing homes.

The following recommendations are concerned with educational advancements:

X. That the public health department encourage and enlarge consultation services in all areas where the nursing homes of Massachusetts need assistance.

XI. That the public health department be authorized to partially subsidize tuition fees for nursing home personnel when they take courses approved by the department of public health for the betterment of the nursing home service.

XII. That the department of public health enlarge their education courses, and that they hold regional workshop for the benefit of nursing home personnel.

XIII. That the department of public health, or any other State or Federal agency they can involve to assist them, recruit and train nurse's aids, and also recruit and give refresher courses to nurses who are now not practising their vocation.

I have left for the last—the most important legislative reform needed.

I predict that the following recommendation will eventually become the law of the land, because the nursing home industry has become a public service industry in the same category as a public utility or an insurance company.

XIV. I therefore recommend that the laws and regulations governing the incorporation and licensing of nursing homes be amended so as to limit the purposes for operating nursing homes to nursing home care.

NOTE.—The Massachusetts laws governing insurance companies limiting their purposes solely to insurance business is a good example in point.

Such legislation will gradually eliminate the holding companies, the realty corporations, the manufacturing concerns, the finance companies and many others whose remoteness from the operation of the nursing home is not in the best interests of the public. The legal responsibility of these remote holding companies, etc., although thay are the true owners, is unenforcible in most instances. I have worked out the legislation that will be necessary, to implement this last recommendation, but I will not detail it here in the interest of brevity.

I need not make any recommendations regarding fire hazards. Due to the dedication and determination of our commission, John Carroll, Massachusetts, has set the highest standards for construction of fire-resistant nursing homes in the entire United States.

Although many other recommendations for legislation should be considered—I have presented to you those recommendations which I feel will make the greatest and the most beneficial impact in the upgrading process for nursing homes in Massachusetts.

Two of our commissioners have requested that the commission hold regular monthly meetings on the same day, same hour, same place—every month. In view of the fact that there is so much to do and so little time left before the expiration date of the commission—which is January 1965, this seems a very progressive suggestion.

Would the third Thursday of every month at 10 a.m. be a suitable time for monthly meetings?

The commissioners and the members of the commission feel strongly that this work has not been and cannot be completed before the expiration date of the commission.

Therefore they urge that a resolve extending the life of the commission be filed with the general court as soon as possible.

May I take this opportunity to offer you my congratulations on your new post, and wish you great success and the best of luck.

Sincerely yours,

GERTRUDE K. WEINER,
Counsel to the Special Commission to Study Convalescent or Nursing Homes.

QUINCY-SOUTH SHORE CHAMBER OF COMMERCE, INC.,
Quincy, Mass., August 9, 1965.

Subject: Special hearing in Boston concerning care of the elderly, conducted by special Senate subcommittee, of which Senator Edward M. Kennedy is a member.

Mr. LARRY LOUGHLIN,
Office of Senator Edward M. Kennedy,
Boston, Mass.

DEAR LARRY: We telephoned Mr. Constantine who was in charge of setting up the public hearing in Boston.

Inasmuch as the Quincy-South Shore Chamber of Commerce has taken an active part in this sphere of activity in Quincy, I was interested in testifying. We would have been the only chamber that apparently expressed interest. It was impossible, according to Mr. Constantine, to include me in the list of witnesses.

In am enclosing a copy of an outline of my proposed talk. I expected to inject more details during the presentation. The remarks, however, do indicate some interest on our part.

We would appreciate your forwarding the testimony through Senator Kennedy to the subcommittee.

Sincerely,

WILLIAM A. O'CONNELL,
Executive Vice President.

PROPOSED TESTIMONY BEFORE THE SENATE SUBCOMMITTEE ON CARE OF THE ELDERLY, HELD IN BOSTON, AUGUST 9, 1965

My name is William A. O'Connell, and I am executive vice president of the Quincy-South Shore Chamber of Commerce.

I realize that it may seem somewhat strange to the professionals that a chamber of commerce should participate in a discussion concerning the care of the elderly.

The number of elderly people is significantly increasing, and the elderly are playing an increasingly important role in the cultural, economic, and civic life of the community.

To quote Max Lerner in "America as a Civilization":

"In 1900 there were 3 million Americans who were 65 and over, forming 4 percent of the population; in 1955 they had grown to 14 million, forming 8½ percent; the Census Bureau estimates for 1975 were almost 21 million, forming more than 10 percent of the population. Thus the old people constitute the most rapidly growing portion of the American population. During the half century since 1900, when the total population doubled, the number of people 65 years and over nearly quadrupled. Much of this increase is due not only to the new techniques for prolonging life in the old years but to the drastic cutting down of mortality at birth and in infancy. The current American emphasis on medical and

psychological advances in 'gerontology' promises to prolong the lifespan further, thus intensifying the trends and problems of an aging population."

According to the Quincy monograph, prepared by the Massachusetts Department of Commerce and Development, and based on U.S. Census statistics, there are 9,921 people over 65 in our city. This figure represents 11.3 percent of the population. The percentage of the total Boston metropolitan area is 10.9.

The Quincy-South Shore Chamber of Commerce has a number of retired businessmen on its board—men who are providing vigorous leadership in the community. Just one outstanding example is George L. Anderson, a director of the Massachusetts Bay Transportation Authority, who is 81 years of age.

Last week the chamber held a small luncheon for the dean of the Quincy City Council in recognition of his 80th birthday.

The chamber, however, appreciates that concern for the elderly must be all-inclusive—that this concern should involve the entire community—all the people and institutions that comprise the social fabric of the community—that this is a social development which is a result of the process of natural growth.

This has occurred in Quincy, Mass., and the chamber has played an important part in the vision and foresight that has brought it about.

Recognition of the aging, and awareness of the need for their care—economic, physical, and spiritual—is an accepted part of Quincy's social structure * * * the American way of life, so to speak.

Concerning nursing homes, the chamber has encouraged their construction in Quincy. It has conferred with Dr. Samuel Levey, seeking his advice and counsel. The chamber has appeared before the city council soliciting municipal support where it has been necessary. Businessmen, clergymen, as well as hospital and municipal officials have been invited to visit and inspect new nursing homes.

In Quincy an eight-story home for the elderly is being built under Public Law 88–372. The chamber enthusiastically supported it. This was the second such facility in Massachusetts at the time.

There are other examples that I could cite.

I just want to mention in closing that the business and civic interests also have a part in the care of the elderly, and in Quincy, Mass., these interests are functioning together for the overall good of our increasing elderly population.

SPRINGFIELD, MASS., *August 5, 1965*.

Senator FRANK E. MOSS,
Hearing On Nursing Homes,
Boston, Mass.

DEAR SIR: I sincerely hope that your hearing on nursing homes will result in better care for the people who have to be patients in such homes.

My parents entered Spruce Manor Nursing Home on March 2, 1965. This is a very new building in a good central location. The rooms are large, attractive and clean looking. The food is good some of the time, but pretty ghastly at other times—mashed potatoes with creamed dried beef and creamed corn on the same plate.

Most of the nurses are dedicated and kind, but there are not enough of them. Recently there was 1 RN nurse and 1 aid to care for 22 patients, about one-half of them bedridden.

There are no bell pulls to ring for a nurse within reach of a patient who is able to sit up in a chair. Bedsides are not always put up and broken ones left unrepaired.

Personal cleanliness and care are not particularly good—hair is not combed or brushed, nails uncut and uncleaned, men not shaved. There is very little physical therapy and no occupational therapy.

I realize it is difficult to get and keep nurses and other help, but patients should not be accepted if the care for them is not going to be adequate.

My parents and many others at Spruce Manor cannot really do anything for themselves and they do need lots of help. Certainly none of these people want to be in such a condition. It is a sad way to end a good life and they should have good care.

Very truly yours,

VIRGINIA A. BUMP.

STATEMENT OF CHARLES C. O'DONNELL, NATIONAL AND STATE PRESIDENT OF THE SENIOR CITIZENS & ASSOCIATES OF AMERICA, LYNN, MASS.

This statement to be filed with other information obtained at the hearing of the Subcommittee on Nursing Homes held Monday, August 9, 1965, at the New England Life Hall, Boston, Mass.[1]

The number of nursing homes has consistently grown and there has been considerable misleading information that there was a chance of receiving substantial returns on a nursing home investment which many an inexperienced operator has found to be untrue.

The average patient on medical assistance goes into a nursing home and because of his financial circumstances is forced to give up his home or room with the result that it is like a life sentence to him. A very small percent are physically able to return during their normal life unless they have some relative who is able to care for them. A visit to these homes will find that the vast majority are there just waiting for the good Lord to call them to their reward.

I am a trustee at the Cushing Hospital in Framingham which is a nursing home, and out of 600 patients we do not discharge more than 6 a month to return to their homes. The cost of maintaining a patient there is a little over $12 a day. The Federal Government pays 50 percent, the State two-thirds of the balance and the city or town one-third. Any resources they have are deducted from the $12 cost.

An item that I believe should be corrected is the amount of money allowed for food. We have taken this matter up on several occasions and I understand that they only allow $0.82 a day per patient and many of the homes spend less; some of course, spend more. We have asked for at least $1 a day along with proper diet requirements.

Massachusetts allows the patients $15 a month for their own personal use. I secured permission to give this to the patients from a trip I took to Washington with a committee representing the House Ways and Means Committee, the Commissioner of Public Welfare and also a representative of the Massachusetts Tax Payers Association. I found the committee representing the Health, Education, and Welfare Department very cooperative and upon our return to Massachusetts, we were able to get our legislature to accept the full benefits of the Kerr-Mills bill. Our State saved at least $10 million on the first year of its adoption.

I recommend the following: that there be established a strictly nursing home which is equipped to give 24-hour nursing care if needed; that there be provided equipment to teach those to walk whose illness is involved in the temporary loss of use of their limbs; and that upon being able to leave this type of home they be sent to a convalescent home and with increased progress, that they go to a rest home.

Rest homes are really giving extended medical care and should be reclassified in order that they come under the new medicare bill. I have asked for this on many occasions and made a trip to Washington in this connection and found that it is simply a matter of finding a way of reclassifying them. Patients in these homes are all ambulatory but require supervision and medication. This type of home is only allowed $4.25 a day which is way below what they should receive in order to maintain the standard required by the State.

I do not find the nonprofit homes any better than the proprietary homes. The smaller homes where it is run as a family venture by a man and his wife or a widow and her daughter offer the patient a lot of love and tenderness, but I regret to say they are usually forced to go out of business. The bigger homes become institutionalized and the white shoes, uniforms, and picturesque surroundings do not take the place of gentle care. In order for a proprietor to conduct his home properly, it is almost a 7-day job and they are never really off duty. The whole question of the conduct of a home depends to a large extent upon the superintendent or proprietor who must be possessed of not only medical knowledge and commonsense, but must have the milk of human kindness in his heart.

I feel confident that this would be a good project for the Peace Corps to undertake and they would find my past experience valuable to them. My services are at your command, and I would be only too happy to assume the responsibility of taking on a project of this type. Many other volunteers could be secured from the various churches and clubs not only from my State but throughout the Nation who would take a personal interest in the patients who have been neglected by their relatives or those who have no one left. These volunteers could see to it that in States where the patients are allowed to have a personal spending allowance that

[1] The material referred to is contained in the files of the subcommittee.

this money is either saved for them or spent in their behalf. I am sure that the honest nursing homes would be only too happy to be relieved of this responsibility. Considerable money could be saved by the taxpayers by the program mentioned in this letter, and at the same time the patients would be receiving better service.

It is not a very pleasant situation for a patient who is on the way to recovery to be in a bed next to someone who is passing away or moaning and groaning. For those who are able, occupational therapy would be very beneficial. I spent 16 months in the Veterans' Administration hospital and I found that this service was a big contribution toward my recovery.

At a recent hearing of the Committee on Pensions and Old Age Assistance on legislation regarding the aged, I was in the hospital and the chairman of the committee sent a State car out to the hospital so I would be able to attend the hearing; the second hearing I was able to attend on my own. All this experience throughout the years representing the elderly people has been of value to me in carrying out my work.

Do not depend on the State, cities or towns to carry out a welfare program. There are a few that will, but the vast majority as the records will show, have a very low budget for old-age assistance and have not fully accepted the benefits of the Kerr-Mills bill. We must bear in mind that the proprietary home pays taxes whereas the nonprofit home does not and our State and Nation are dependent upon its tax revenue.

I would further suggest that you do not leave the obtaining of your information to the professional groups alone. Send somebody out to these homes to talk to the patients as that is how I gained my information.

My remarks are based on over 38 years' experience serving as president of the Senior Citizens & Associates of America, legislative agent, and legislative council. Our society was organized in 1926, 4 years before the first old-age assistance bill was adopted in our State, and years before the Social Security Act became effective.

Your committee is to be congratulated on the work it is engaged in and there is no question that there will be improved conditions throughout the Nation in caring for our elderly people as a result of this.