TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FIRST CONGRESS

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Part 1. Trends in Long-Term Care, Washington, D.C., July 30, 1969
Part 2. Trends in Long-Term Care, St. Petersburg, Fla., January 9, 1970
Part 3. Trends in Long-Term Care, Hartford, Conn., January 15, 1970
Part 4. Trends in Long-Term Care, Washington, D.C., February 9, 1970 (Marietta Fire)
Part 5. Trends in Long-Term Care, Washington, D.C., February 10, 1970 (Marietta Fire)
Part 6. Trends in Long-Term Care, San Francisco, Calif., February 12, 1970
Part 7. Trends in Long-Term Care, Salt Lake City, Utah, February 13, 1970
Part 8. Trends in Long-Term Care, Washington, D.C., May 7, 1970
Part 9. Trends in Long-Term Care, Washington, D.C., August 19, 1970 (Salmonella)
Part 10. Trends in Long-Term Care, Washington, D.C., December 14, 1970 (Salmonella)
Part 11. Trends in Long-Term Care, Washington, D.C., December 17, 1970

CONTENTS

TRENDS IN LONG-TERM CARE
(Hartford, Conn.)

THURSDAY, JANUARY 15, 1970

U.S. Senate,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Hartford, Conn.

The subcommittee met at 9:45 a.m., pursuant to call, in the north courtroom of the Federal Building, 450 Main Street, Hartford, Conn., Senator Frank E. Moss, chairman, presiding.

Present: Senator Moss.

Staff members present: Val Halamandaris, professional staff member; John Guy Miller, minority staff director; and Margaret Wright, clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. Ladies and gentlemen, the hearing will come to order.

We are here today to take testimony on the trends in long-term care. This is a subcommittee of the Senate Special Committee on Aging. We have been holding these hearings in several places. Last week we were in Florida, and I can give you a clue that it was almost as cold in Florida as it is up here in Connecticut.

We were delighted to be in Florida. We received a good bit of testimony that helps us with our record. Florida, as you know, has an unusually large concentration of nursing homes, homes for the elderly. I do not want to be too harsh on Florida; I have read since that they have broken the 30-year record with the recent spell of cold weather. By reason of their having a large number of homes and facilities for elderly people, we were able to get a good deal of information that we wanted in Florida.

Connecticut certainly does not have as many facilities or as large a concentration of elderly people, but it is one of the most progressive States that we have, as far as our information goes, in the licensing and regulation and maintenance of nursing homes or homes for the elderly. So we look forward to receiving an assessment here of the progress that has been made and suggestions of improvements yet to be made in providing adequate facilities for our elderly people.

We have a list of very distinguished witnesses who will appear before us this morning. We hope that we can proceed with dispatch to get the testimony in the record, and that is the purpose for being here, to establish a record which will be studied by the full committee as we determine what further steps, if any, need to be taken from the Federal level.

We think that we have come a long way already in providing more adequate facilities for our elderly people to accommodate their needs and to enable them to live full and satisfying lives. We recognize we still have a long way to go, there are many things that are yet to be accomplished, and that is what we want to talk about—not so much how far we have come but how far we have yet to go and what we need to do in order to accommodate and provide for this segment of our population which has been woefully neglected in years past.

Now I don't want to make a speech or start philosophizing about the changes in our ways of living and the fact that the older people have borne the brunt of this change. That can be done by the witnesses.

Before I call on Senator Marcus I do want to recognize Mother Bernadette, whom I have known and admired for a long time and who is a great leader in this field. I would ask Mother Bernadette if she would come forward at this time and let me greet her again and tell her that we appreciate her presence. If she has any communication to give us, we will be pleased indeed.

Mother Bernadette. [Applause.]

STATEMENT OF MOTHER M. BERNADETTE O. CARM, ST. JOSEPH'S MANOR, TRUMBULL, CONN.

Mother BERNADETTE. Senator Moss, it is indeed a profound pleasure and a privilege for me as chairman of the Governor's Council on Aging for the State of Connecticut to welcome you to Hartford today.

May I tell you, Senator, that I bring you a very warm welcome from Governor Dempsey who personally asked me to tell you how pleased he is that you have chosen Hartford to conduct hearings on trends in long-term care. The Governor has expressed deep concern for all the needs of the older person—economic, medical, social, employment, day center programs, housing and living arrangements with varying degrees of service and care so that the older individual may have the opportunity to choose the kind and degree of service that would most adequately suit his individual requirements.

Senator, it is the hope of the Governor and the members of the Council on Aging that your presence here and the testimony you will receive from the authoritative witnesses in the field of aging will stimulate national and State interest, and thus provoke interest in the promotion of services and programs which will enrich the lives of the older citizens of our country and the State of Connecticut.

COMMUNITY PARTICIPATION ENCOURAGED

May I, in passing, as administrator of St. Joseph's Manor, tell you that we are not only interested in providing various programs in which the residents may participate at the home but that we are encouraging the more active residents to participate in the life of the community away from St. Joseph's Manor in such activities as giving talks on choosing a career, conducting art classes, planning and giving parties for children, and offering to tutor children who need special help. In the spring, some of our residents will be at the Kennedy Center, in Bridgeport, to assist retarded children in reading compre-

hension in underprivileged neighborhoods where they will benefit from the assistance.

Senator, since I do not wish to take time from those who are scheduled to testify here today, may I ask if this is permissible: that you might include in the record the 1969 health services report of St. Joseph's Manor which we plan to present at our annual medical staff meeting tonight. It will provide you with factual information on the multiplicity of services that can be made available to older people in a progressive multiservice facility.

Such a plan is economically feasible as the older individual, his family or third party pay only for the amount of service needed by the older person. Such a facility with varying levels of care assures the older person and his family of the kind of security he needs. As his health needs change, plans would not have to be made for transfer to another facility, there would be no duplication of costly equipment and professional services. These specialized departmental services would be available to all persons, either in residence at the different facilities or as members of the nonresident day center program.

Thank you very much, Senator, for the opportunity and the pleasure of talking with you on a subject that is of deep interest to you and to me.

Senator Moss. Thank you, Mother Bernadette. We will be pleased to have the report that you intend to make tonight on St. Joseph's Manor and it will be made part of the record. We have known of your very excellent facility at St. Joseph's Manor for a long time and consider it one of the outstanding examples of what can be done in this field. On previous occasions I have referred to St. Joseph's Manor as a good example of the kind of extended care facility for older people that we ought to try to duplicate across the country. So it should be very revealing to us to have your report.

(See appendix 1, item 6, p. 339.)

We are pleased indeed that you came to testify this morning and to get us off to a good start here in Hartford.

Thank you, Mother Bernadette.

Mother BERNADETTE. Thank you, Senator, very much. I am a collector and in my collection I happen to have the State bird of Connecticut, a sculpture by our famous American artist. I would like to leave this for you as a souvenir of your visit to Hartford.

Senator Moss. Well, how very sweet of you. Thank you so much, Mother Bernadette.

A sculpture of the State bird of Connecticut. I am pleased and touched that this gift has been given to me here.

We will now proceed with our witness list. Our first witness is Senator Ed Marcus who is the majority leader of the Connecticut State Senate. We are pleased to have Senator Marcus.

I might identify to you the gentlemen who are seated at the table with me. This is Mr. Val Halamandaris on my immediate right and Mr. John Guy Miller, who are members of the staff of the Senate Special Committee on Aging. They will sit with me and, on occasion, I will ask them if they have any particular questions that they wish to ask because they are going to be responsible for all of the myriad of duties that fall on the staff in organizing and analyzing the material and helping us as we proceed with the work of the full committee.

Senator Marcus, we are glad to have you, sir. We will hear from you now.

STATEMENT OF HON. EDWARD L. MARCUS, SENATE MAJORITY LEADER, CONNECTICUT STATE SENATE

Mr. MARCUS. Thank you, Senator.

I want to indicate that I am deeply appreciative of your giving me the opportunity to appear this morning. I know your schedule is a full one. I know your schedule was already made out and I know you are on a very tight schedule, as I am, but I am really here this morning because I feel strongly about this issue.

Also I feel strongly that on your list of witnesses there failed to appear the name of any elected public official in the State. Now I cannot say that I speak for the people of the State but I think that there is a certain feeling, as you know, that somebody who runs for public office, that an elected public official does get a certain feedback, a certain reaction. I think really that it is important that someone like myself be here this morning to relate to you what I really feel the people are thinking and what I think they are saying through me.

Senator, I am also aware, as you are well aware, of the fact that it is kind of a very cold way to make a presentation by reading but I do not know of any other way to really get on the record what has to be said.

MEDICARE PROGRAM REDUCTIONS

I wish to vehemently protest the cutbacks in the Medicare program which affect the health and welfare of so many of our over-65 citizens. At least 40 percent of the over-65 patients presently served under the Medicare program will no longer have their expenses paid by the Federal Government.

Senator, to get off the prepared statement for a moment, when you indicated before that we are moving ahead in this area, I kind of doubt it.

This policy, I would submit, is contrary to the overriding philosophy of the Medicare Act. Nursing homes in Connecticut are refusing, on a day-by-day basis, to take Medicare patients because of the recent cutbacks in coverage ordered by the Nixon administration. Cutbacks are jeopardizing the entire nursing home program as well as home health service, such as the home nursing program and public health nursing programs.

The Nixon administration—and I think you can get a feel that I don't think they are really doing the job—is depriving our over-65 citizens who desperately need nursing home care and/or home nursing services to sustain their very existence as the result of a newly imposed, arbitrary, stringent policy refusing payment for these services to those who cannot prove, beyond a shadow of a doubt, that they have positive rehabilitative potential. This means that someone with a terminal illness—I think we have to face as a fact that this is the way of all flesh and eventually this comes to all of us—someone who is dying, is left to their own devices. What average Connecticut family can afford to support a sick parent, an elderly relative, affected by a catastrophic illness?

Senator, Connecticut may be No. 2 in nursing home care. Maybe it is not as warm here usually as it is in Florida, but I submit to you

that it is probably even more expensive in many areas of Connecticut to live than it is in Florida. What is to happen with the vast numbers of people who can now no longer look to the Government for a helping hand?

The burden of the cost of care of these patients has already begun to fall heavily on their families. I can tell you that as I speak around the State, and I spoke last night in the 113th town of 169 towns in the State of Connecticut within the past 6 months—I can tell you that the feedback is one of desperation on the part of the people who now have to pay the bill and find they don't have the dollars with which to give the elderly the care that they are entitled to receive. I believe that we will soon see a sharp increase in welfare costs in the State of Connecticut as the limited resources of our over-65 citizens is exhausted.

The Congress must act, and I believe act now, to restore the full meaning of Medicare. Denial of the rights of our over-65 citizens to adequate medical care is making a mockery of the law.

The full impact of the Nixon administration cutbacks is yet to be felt by many of our elderly and their families. It is cruel and deceitful to destroy hope and the chance to live one's golden years in security and dignity. I think without any question one of the greatest programs ever passed by Congress, certainly from a philosophical point of view, was the Medicare Act. We cannot afford to fail those for whom it was written. America cannot permit the Nixon administration to pervert the intent of the American people to provide vital health care assistance to its citizens.

The present deplorable state of affairs highlights the unmet health needs of all of our citizens. Until a meaningful, workable national health insurance program tying in Government and private industry is enacted, the American people will not be able to surmount the financial barriers that keep us from achieving our intrinsic right to good health care.

Most importantly, on an immediate basis, it is urgent that Congress force the Department of Health, Education, and Welfare to revise its existing discriminatory regulations.

Senator, that of course is my prepared statement. I have to confess to you that I really do not like to read prepared statements. I think that I can say to you probably in 60 seconds what I really think the the issue is.

Inflationary Costs

I think essentially we have to come to grips with the fact that the elderly, and I think particularly the elderly in the State of Connecticut, have the unique problem of being faced with inflationary, rising, escalating hospitalization costs; additional costs in the area of convalescent homes and at home nursing. All of us have to go down the path at some time or another of terminal illness. To say to the people of this State that they can no longer receive Medicare help in the situation of an elderly person except in that case where the elderly person can be rehabilitated and is not subject to a terminal illness I think is to deprive the elderly of any opportunity of living out their final days with any kind of feeling of serenity, dignity, or security.

I think equally important is the impact that this change in regulation has on the families of the elderly. I am not a fan of Mr. Nixon's,

but I think it is about time that we did start doing some thinking about the guy in the middle, the forgotten man, the man who receives nothing from Government, tries to struggle to pay his bills. I would submit to you that the change in this regulation is about to drive many of these people into a situation of financial oblivion and I do not think that this country can afford to see this happen.

Third, and maybe most important, I kind of get a feeling that the Federal Government is becoming an adversary, that the Federal Congress to some extent—I think most of the Members of Congress on both sides of the aisle are very sincere but I get the feeling that they are becoming an adversary of really the unmet needs of the American people.

I really think that we owe you a debt of gratitude for coming to Connecticut and for trying to develop how the people feel about this issue. I would hope, Senator, that when you complete the hearing in Connecticut, when you complete your tour around the country, that this just is not going to be another one of those congressional subcommittees that makes a record, that really does a fine job maybe to some extent politically for the people that participate in it and then goes back and sits on their hands, writes a beautiful report that gets tossed in the wastebasket and does nothing really to face up to the issue.

I would hope that something productive and meaningful is going to come out of this. I would hope it is not going to happen in 1972, 1973, or 1974 but I would hope that it is going to happen this year because I think the need is that desperate.

Senator Moss. Thank you, Senator Marcus, for your statement. Certainly you have underlined one of the great problems that we are grappling with now, the inflationary trend in all costs but particularly as centered in hospitalization and medical services, nursing services. We have not kept pace, I am sure, in providing those services and you have put your finger on a very crucial issue that we must face up to.

I hope with you that we can get action and not just have a hearing to lay out the facts. There is no use getting them all laid out unless we act upon them in an intelligent way. I know that this is a very serious problem in all areas of our country, and surely in Connecticut, too. Medicare payments are inadequate to meet the costs of elderly people who go to nursing homes and that, as a consequence, some are being turned away.

Now this choosing among them as to whether or not they are rehabilitatable or not, certainly is one of the cruelest kinds of classifications that we could have, and I am sure that something needs to be done. Your broader statement is that the Congress and the administration, all of us have to face up to the priorities that we have to meet.

I think your criticism in good part is justified since Congress and the administration when faced with limited resources, do get our priorities scrambled a little bit, in an effort to cut down and economize. This is one of the issues we are trying to come to grips with at the present time so I cannot quarrel with your statement. I am glad you made it and I am glad you are on the record to help reinforce what I believe that we simply must move forward in our financing of this problem.

Now by saying we have come a long way, I meant that we are now building better nursing homes, we are getting better nursing services, but as you say there is one area where we have been slipping back a bit. We must make better provision for our citizens who must rely on Medicare bearing the brunt of their costs. So I thank you, Senator Marcus. I appreciate it.

Mr. MARCUS. Thank you.

Senator MOSS. Our next witness will be Dr. Franklin M. Foote who is director of the State Department of Health in Connecticut. We are glad to have you, Dr. Foote.

STATEMENT OF FRANKLIN M. FOOTE, M.D. COMMISSIONER CONNECTICUT STATE DEPARTMENT OF HEALTH

Dr. FOOTE. Thank you, Senator Moss.

Senator Moss, it is indeed a pleasure to welcome you to Connecticut and to know that you have invited several experienced and able persons to present statements this morning. We are proud of the fact that Connecticut has an excellent supply of extended-care facilities and nursing homes and that when the Medicare program started, our State had the highest proportion of licensed nursing homes that were approved as extended-care facilities.

NURSING HOME CLASSIFICATION SYSTEM

One of the truly unique things that Connecticut has done was to institute a point system of classifying nursing homes in 1961, for purposes of welfare payments. In this classification which was worked out with representatives of the nursing homes and Medical Society and other interested groups interested in the aging, plus points were awarded for providing services that exceeded those required by our State laws and regulations. These added points were provided, for example, for nursing services, medical services, physical and occupational therapy, laboratory, X-ray, recreational therapy, dietary, and so forth. Through this point system it has been possible to upgrade significantly the standards of care provided.

Appended to my formal statement is an article which was published in the October 23 issue of the Journal of the American Medical Association that recounts the progress we made here and gives an outline of how this unusual point system works.

(See app. 1, item 1, p. 313.)

The same system, I might say, provides for demerits or minus points for minor infractions of regulations and minor problems that they have. So we give both plus points and minus points. Depending upon the scores the nursing homes achieve, they are classified A, B, C, D, and E. Most of them today are in A and B, a large number in A. The payments from the welfare department, for example, and from other State agencies are pegged to this, and since 60 percent of the patients in our extended-care facilities and nursing homes are welfare recipients that has been very important.

Now also appended to my formal statement is a copy of an article prepared by Dr. John O. Pastore, the son of one of your distinguished colleagues from Rhode Island, who happens to be a resident of Connecticut and who is a member of the faculty of the Yale University of

Medicine today. He prepared an article with others which was published in the New England Journal of Medicine in July of 1968 which is appended.

(See app. 1, item 2, p. 317.)

I am not going to take the time to tell you the fine things that we are doing in Connecticut other than what I have mentioned already. I would like to spend the time, as Mr. Halamandaris requested, on some of the problems that I see. I shall wind up and Mr. Arthur J. Jarvis, director of our Division which deals with certification for Medicare and licensing and inspection, will also suggest some solutions as we have seen them working very close to the problem day after day, week after week in Connecticut.

Senator Moss. Thank you. The two very fine articles you have appended will be printed in the record.

Results of Nursing Home Studies

Dr. Foote. In Connecticut, the State department of health has been the licensing and inspection agency for long-term care facilities and hospitals for many years. Among our major concerns has been the feeling that fundamental to good care in nursing homes is the provision of a careful medical disgnosis of the patient's problems together with frequent continuing medical supervision of the patient. Over the years we have strengthened requirements in a number of ways, among them placing more responsibility on the medical director or medical consultant of the nursing home, requiring admission medical history and physical examinations within 24 hours of admission, encouraging transfer of information from hospitals and encouraging various diagnostic tests and frequent supervision.

In order to accomplish these objectives we make studies from time to time of the kind of care provided in the nursing home. We were chagrined to learn in 1966, in a study made of 35 nursing homes in south central Connecticut, that there still were a number of problems that had not been resolved. For example, we discovered that the two largest hospitals in the area, both of which are highly regarded as training centers for interns and resident physicians in many medical specialties, were failing to transmit any information at all about the patient's condition in from one-third to 40 percent of the patients they sent to the nursing homes. This failure has been brought to the attention of all of the hospitals in the State and we believe that the situation has improved since then and plan to repeat the study in the near future to determine what the benchmark is today.

In the same survey we discovered that there were failures on the part of the attending physicians to give adequate information in the patient's chart concerning the basis for the medical diagnosis and the nature of the changes in the patient's condition while in the nursing home. Lack of such information makes it impossible for a utilization review committee under either title 18 or title 19 to make meaningful review of the necessity for nursing home care and also of course of the quality.

We found further that tests which we felt essential were not being done in about 40 percent of the patients. We learned that 37 percent of patients taking such cardiovascular drugs as digitalis had not had blood pressure recorded for more than a year before the survey date.

We learned that 35 percent of nursing home patients taking drugs which might lower the blood pressure markedly had not had a blood pressure determination recorded during the past year. We found patients getting digitalis who had no record of any heart abnormality and patients getting insulin who had no record of the diagnosis of diabetes. All of these deficiencies have been brought to the attention of the physicians involved and we plan to make a resurvey in the near future in order to learn to what extent these problems have been overcome.

As the State licensing agency that has to enforce State laws and regulations we have also held hearings with regard to several nursing homes where we felt there were significant deficiencies in the kind of care rendered. Licenses have been revoked for what we felt was neglect of patients on the part of the staff of the nursing home. I think this is done by all aggressive and concerned State licensing and inspecting agencies. In one instance in the Middletown area where a seriously ill patient was seen only relatively infrequently by the attending physician, a hearing was held for 2 days and a reprimand issued to the medical director. In another instance in recent months a nursing home license was revoked because of failure to provide proper activities for the patients in the facility. I cite these to show that we have been alert to take action to overcome deficiencies that have been found.

However, these findings emphasize the need for careful monitoring and surveillance of all of the activities in the nursing home. It cannot be taken for granted that because a licensed health care practitioner or nurse is on duty that everything that needs to be done is being done for the patient. In this regard our hopes that title 18 and 19 of the Social Security Act would permit a comprehensive, stepped up surveillance program have been frustrated by the manner in which these objectives have been implemented.

The duty of surveillance has been divided in the case of title 18 between the fiscal intermediary who is, of course, primarily interested in financial aspects of the program and the responsible State agency which is primarily interested in the necessity and quality of care rendered. Directives from Washington clarifying the respective roles of each of these agencies have not been helpful. In addition an entirely separate Federal agency administers implementation of title 19 and has promulgated a different set of standards for surveillance.

There appears to be a tendency for the Federal agency involved when they provide financial assistance to the responsible State agency to have the surveillance activities for title 18 or title 19 performed by individuals who have no responsibility at all for the other program or for licensing and inspection. Such a desire means that if followed, different individuals would be going into the same nursing home to check the same patients to see how the nursing home meets different requirements with resulting inefficiency for the programs and confusion to the nursing home staff and the State agency staff who are trying to enforce the various standards.

So far we have largely tried to keep these monitoring activities and certification activities in the hands of generalized individuals, reporting to the Federal agencies involved the portion of their time devoted to the activities financed by the Federal agency. However, we would welcome the support of your committee in continuing to try to merge certification and monitoring activities for both titles 18 and 19 along

with the ongoing licensure and inspection activity of the State agency so that efficient coordinated monitoring of these activities can be achieved. In addition I would urge that the role of State health departments in these programs be strengthened rather than dividing monitoring activities for utilization review as is now done with the fiscal intermediary.

To be specific about something that happened about 6 months ago, the interim regulations describing standards for skilled nursing homes under Medicaid issued by the Department of Health, Education, and Welfare last summer which become effective July 1, 1970, I feel are a step backward. Although the new standards are called realistic, actually it is ridiculous to permit a single partially trained licensed practical nurse to be responsible for as many as 300 patients on the afternoon or night shift.

Here in Connecticut we have labored with the problem of nursing coverage and now require that an extended care facility or nursing home with 30 beds or more shall have a nursing director who is a registered nurse. On the afternoon shift we require a licensed nurse for at least every 45 patients and on the night shift a licensed nurse for at least every 60 patients or fraction thereof.

Although there are occasional difficulties in meeting these standards, on the whole they have been accepted by the people who operate the nursing homes. Concerned nursing home administrators recognize that even minimum patient care cannot be given without these standards. It seems most unfortunate that Federal standards are so low when we would like to look to the Federal agencies for leadership in improving good nursing home care.

There is one other point I would like to mention. Mother Bernadette mentioned the perfectly marvelous work they were doing at St. Joseph's Manor and at a great majority of the nursing homes around Connecticut. Patients in nursing homes are men and women with genuine social, emotional and spiritual needs which require attention in addition to such basic needs as medical and nursing care and dietary services.

We have placed great emphasis on requiring nursing homes to meet the recreational, social, spiritual and occupational therapy needs of their patients. Many of these men and women may need only 2 or 3 hours of nursing and medical care each day but they cannot spend the remaining of the 24 hours confined to a bed or wheelchair staring vacantly into space or watching television. In this particular field most of the extended care facilities in Connecticut have made tremendous strides forward. I do wish we had time to speak of that more. Such patient activity programs need further encouragement in the future to provide care for these patients.

That is the end of my formal statement. I will be happy to answer any questions.

Senator Moss. Thank you very much, Dr. Foote, for a very fine statement and for bringing these two articles which will be helpful in our record.

May I first say that I applaud your criticism of the regulations that have been issued on the standards of nursing care. We on this committee and in the Congress feel that the Department has not issued regulations consistent with the objectives of the amendment to the

Social Security Act which we passed in order to upgrade nursing services in nursing homes.

We heard the criticisms, too, of those saying, "Well, you are going to drive certain homes out of business" and "After all, a practical nurse can look after it." But it was our congressional intent, I am sure, to insist that the services there be upgraded and be under the supervision of a registered nurse at all times assisted by practical nurses. In fact, we have held some hearings on that and we will keep after it congressionally.

Financial Incentive of Rating Program

On this point system, which is a very interesting and excellent idea providing some incentive for a nursing home administrator to upgrade his services, do I understand that the welfare payments from the State respond to the point system so that there actually is a financial bonus?

Dr. Foote. Yes, that is right. The ones at the upper level in grade A, for example, will get 50 cents to a dollar a day more than for grade B, and grade B gets more than grade C and so on. This provides a real financial incentive.

Now this is not a static system at all; it has been revised from time to time and we are making plans to revise the point system still further to respond to the experience we have had with it. I think everything in our society cannot be done merely by fiat or by issuing laws and regulations; some of it can be done on an incentive basis. Of course for both nonprofit and proprietary homes the financial incentive has been tremendously helpful in upgrading standards of care here.

Senator Moss. I am glad to have that description of it. As you say, just laying down the fiat and then trying to enforce it is not nearly as flexible nor as acceptable to the party regulated as to have some sort of an incentive that gives him a reward for upgrading his services for doing a better job.

Availability of Patient Records

I also was concerned when you spoke of the faliure of the hospitals to pass on its records to nursing homes or extended care facilities when patients left the hospital. Is that a fault of the hospital or the physician, or is it a fault of the nursing home for not demanding such care?

Dr. Foote. The nursing homes do demand it, I am sure of that. They telephone and they try to get it, but unfortunately the larger the hospital and the more the hospital is divided into specialized services, the more difficult it sometimes is to get in the hospital.

I think there is an administrative problem here. The administrator needs to recognize this as part of his administrative responsibility to see that this is done. Secondly, there is a deficiency on the part of the attending physician. Here again in a very large hospital care will be given a patient by a number of different physicians. There are resident physicians, specialized consultants and attending physicians who practice in the community and come in and see the patients relatively briefly while the residents are providing a lot of the care.

The difficulty in the hospitals has been that often there is not just a single physician who recognizes it as his responsibility to transmit this information. Curiously enough, in the smaller hospitals this is much easier done, everybody knows each other. If a patient goes into a nursing home, a doctor or nurse in the nursing home can get the record without too much difficulty. It is in larger hospitals where one would expect better standards of care that we find this lack of a sense of responsibility in the continuity of adequate care for the patients for whom they are providing excellent care while they are in the big hospital.

Senator Moss. Do you require a standardized sort of recordkeeping in the nursing home so it is compatible with hospital records?

Dr. FOOTE. Not necessarily, Senator Moss, we simply ask that there be records kept. We do recommend one or two types of records which we suggest both for the transfer of information from the hospital to the nursing home and for the private record to be kept within the nursing home. This can be improved upon. Many nursing homes use different types of records. Any of these are acceptable.

Senator Moss. I wanted to ask one additional question about the paper work required on the fee system that is charged. I have heard in some other hearings that the requirements which I guess come primarily through the intermediary that the amount of paper work required is very burdensome and has a retarding effect on the care that could be given because of the time required in keeping up the paper work. Do you have any comment on that?

Dr. FOOTE. I would prefer to let Mr. Dellafera and Mr. De Preaux who will be speaking later and perhaps others comment on that, Senator Moss. I am not as familiar with that as I should be perhaps.

Senator Moss. All right. I appreciate it.

John Guy Miller.

PROFESSIONAL PERSONNEL

Mr. MILLER. Dr. Foote, as Senator Moss has observed, Connecticut has long been looked at by the rest of the Nation as a model in this whole area of convalescent care and nursing home care. Apparently Connecticut has done a very good job in solving the problems relating to the supply of the nurses and other personnel necessary to maintain the standards that you have attained here.

From your experience in Connecticut do you have any suggestions that might be helpful to the other States where such a favorable situation does not exist as toho w they can meet this problem of supply of professional personnel?

Dr. FOOTE. Well, first of all we still have a problem here, we need more nurses in Connecticut. We may have one of the higher proprotions of nurses to the population but we still have a need for nurses here.

About half of the hospitals in Connecticut operate nurse training programs. The State Department of Education in Connecticut and the State Nurses Examining Board for a number of years have been encouraging setting up licensed practical nurse programs as well as other training programs. In addition we have had groups encouraging the recruiting of young women to go into nursing. We have done all of the things that I think a person would normally do to try to encourage this.

Other things that have been done have been that the groups that I have already mentioned as well as the State health department have also conducted some in-service training programs. Particularly since Medicare came in in 1966 we put another person on our staff to help in-service training programs so that the directors of nursing in the nursing homes are in charge, of a particular part of a nursing unit and also the nurses aides. All of them could be better prepared to do their job.

There have been three discussions about the changing roles of these various people and how you can best utilize the particular skills of each of these people—registered nurses, licensed practical nurses, and nurses aides. I don't feel that we have resolved the problem at all but we have certainly worked hard at it, Mr. Miller.

Mr. HALAMANDARIS. Dr. Foote, I have one brief comment. In answer to the question of why Connecticut homes are so good you mentioned the point system. I would like the record to reflect the fact that the point system is called the Foote Point System and is largely your creation.

Dr. FOOTE. Well, there is no one person responsible for it, Mr. Halamandaris. A large number of people have worked on it. As a matter of fact, I think the people from the nursing homes themselves who put the legislation through in 1961 deserve the greatest credit for this. It has been my role simply to work with them, and I have had the opportunity to work with some wonderful people.

Senator Moss. Thank you, Dr. Foote, for your very fine testimony. We appreciate your coming here today to be with us.

Dr. FOOTE. Thank you.

Senator Moss. Our next witness will be Mr. Francis P. Dellafera who is the administrator of the Crestfield Convalescent Hospital and president of the Connecticut Association of Extended Care Facilities.

STATEMENT OF FRANCIS P. DELLAFERA, ADMINISTRATOR, CRESTFIELD CONVALESCENT HOSPITAL, AND PRESIDENT, CONNECTICUT ASSOCIATION OF EXTENDED CARE FACILITIES

Mr. DELLAFERA. It is nice to be here, Senator.

Senator Moss. Would you introduce your associate.

Mr. DELLAFERA. Yes, sir. I would like you to meet Capt. Forrest Dressler who is on loan from the U.S. military service to the Yale School of Medicine where he is going to get his master in public health. He is doing some work on utilization for better distribution of nursing services and nursing homes in Connecticut. When that report is ready, and I will refer to it, I think you will be pleased to receive and review it.

Senator Moss. We will be most happy to have the report.

We welcome you, Captain Dressler, and are happy that you are here today.

Mr. DELLAFERA. Mr. Chairman, my name is Francis Dellafera of Manchester, Conn. I am currently serving my fifth consecutive 2-year term as president of the 172 member Connecticut Association of Extended Health Care Facilities. I am a member of the State of Connecticut Council of Hospitals, a member of the advisory committee to the State of Connecticut Welfare Department, a member of

several planning commissions and I have been the administrator of Crestfield Convalescent Hospital in Manchester, Conn., for the past 12 years.

I will read this and then you can ask me any questions you think I might be able to supply information on to this hearing.

Senator Moss. You may proceed that way, sir.

Mr. DELLAFERA. Thank you, sir.

Senator Moss, I am delighted that you could come to Connecticut to conduct these hearings regarding long-term care, which embraces not only care of our aged in the present but all age persons in the future if we are ever to find ways to contain the ever increasing cost of the delivery of medical and nursing services. We are exceptionally proud of the progress we have made in Connecticut during the last decade in partnership with the hospital and medical division of the State health and the welfare departments, and I assure you that it is our intention to continue to improve Connecticut's health delivery systems on behalf of the patients in our institutions.

Upon passage of the Social Security Amendments of 1968 (1902, secs. 26 and 30), our association in collaboration with the State departments of health and welfare instituted a study by the School of Public Health of Yale University to assess patient care in extended health care facilities, to investigate the provision of delivery of total institutional health care to all citizens of this State. It is anticipated that this report will be completed and available on or about February 1, 1970. Findings of this study will assist us immeasurably in development of patient care review which would achieve placement of patients in the proper extended health care setting to receive nursing care at the appropriate time and to the degree necessary. Assuming this posture, in our judgment, will be in the best interest of the patient, the community and the third party. This should result in maximum utilization of all health care resources. Our posture is in agreement with the preliminary report of the Secretary's "Task Force on Medicaid and Related Programs."

It is interesting to note when nursing homes were certified for Medicare (title XVIII) in 1967, Connecticut led the Nation in the percentage of homes which were certified under the conditions of participation. It is further noteworthy to observe that our public health code standards, augmented by a classification system to which Dr. Foote referred, permitted rates of reimbursement to be established on a level of care plan, provided a base which exceeded in practically all aspects those requirements for certification resulting in the large numbers qualified to admit title XVIII patients.

Eight years ago only 14 nursing homes received maximum qualification, whereas in 1969 over 50 percent of some 262 licensed nursing homes representing 15,000 beds in Connecticut received the highest classification. We would be unequivocally opposed to any regulations which would permit depreciation of standards, particularly when adequately supervised nursing services are concerned, regardless of whether the patient's status is medicare, medicaid or private pay.

Reducing standards as planned in the interim regulations issued by the Department of Health, Education, and Welfare solely for the purpose of reducing the total cost of the program is a subterfuge that is completely unacceptable. It would be more preferable if other states would adopt regulations similar to those in Connecticut to

insure uniformly high medical and nursing standards throughout the country. However, it is recognized that this may not be immediately achievable in all segments of the country since we are fortunate in having a high ratio of skilled personnel to patients. The higher standards should be so implemented as to provide for orderly transition in those areas where there is a critical shortage of qualified personnel.

Minority Group in Nursing Homes

I will just speak briefly on access of minority groups to nursing homes. In regard to the title VI program, with the exception of one isolated incident, there have been no problems in admission policies of Connecticut nursing homes. Patients are admitted without reference to race, color or creed.

Expansion Programs

As in many areas, Connecticut has experienced an unprecedented growth in the construction of nursing homes because investors have been attracted to the field by what was an apparent bonanza promising lucrative returns on dollar investments following national legislation of Medicare. The number of beds have tripled in the past several years providing needed beds, but there were many adverse conditions manifested. Probably the greatest problem is the inability of the work force to provide adequate numbers of skilled personnel, particularly graduate registered nurses and State-approved licensed practical nurses. The latter program in Connecticut has been expanded by 500 percent. Nevertheless, the program lags behind the demand.

The 1969 General Assembly in Connecticut legislated a licensing law for nursing home administrators and our association has collaborated with the University of Connecticut and the health department to plan and implement approved 200 numbered courses in administration. By June of 1970 some 200 administrators will have completed a course in preparation for a licensing examination.

To properly control the promiscuous construction of nursing home beds, this same general assembly legislated new acts establishing a "Council of Hospitals" which will permit construction only if there is a "demonstrable need." Proper planning will be implemented as a result of this legislation.

In addition the council is charged with reviewing the cost structure of all medical facilities. The institutions, including nursing homes, must refer their request for increase in charges to the council and the council will consider the validity of these charges in the face of preventing duplication of services, for instance, and to regulate this cost of delivery of medical service.

Medicare Denials

The recent actions of the SSA and HEW to judiciously prosecute a complete reversal of policy through its fiscal intermediary serves to deny fiscally covered care of the patient in extended care facilities and is most discouraging. It is amazing that the intent of the national Congress has been so perverted by this change in policy in so short a time after the implementation of the title XVIII program. The new

approach is to insist that only those patients who have rehabilitation potential are covered under the program and that all others are to be considered custodial without regard to the degree of difficulty in nursing care necessary to care for the patient.

Pressures by SSA on the fiscal intermediary have reduced their prerogative of judgment to practically nothing and the claim personnel caught up in the spirit of rejections, have drastically reduced the numbers of patients whose care is covered. SSA and fiscal intermediary officials deny this; however, the statistics and case studies of my testimony refute those claims.

The most direct adverse conditions as a result of this new position has been to increase the length of stay in expensive general hospital beds where the daily per diem charge is three to four times that of the extended care facilities. Physicians whose medical judgments have been completely abrogated have become most reluctant to transfer patients from the general hospital to the ECF with the threat of "no covered care" hanging over the patient. Additionally, patients are being discharged to home from the general hospital and are being readmitted shortly thereafter when their conditions had worsened because they were denied further convalescense in the ECF.

This area of apparent conflict in responsibilities under the Medicare program should be thoroughly examined by the Social Security Administration and resolved one way or another. While the controversy apparently exists between the fiscal intermediary and the physicians, it must not be overlooked that it is the patient who is ultimately caught up in the shuffle. Many physicians serving in these capacities in Connecticut ECF's feel greatly put upon by the utilization review function as presently operating and object violently to having their judgmental authority (which is legally imposed) usurped by the fiscal intermediary's staff personnel.

Recently we have conducted research regarding the intake of admissions to Connecticut's ECF's and the disposition of claims which were filed with the fiscal intermediary during the months of September, October, and November of 1969 with the following data compiled:

Number patients admitted to the ECF's from general hospitals	1, 826
Approved for covered care	Percent--893 or 49
Denied from date of admission	Percent--383 or 21
Denied on information from ECF	Percent-- 171 or 9
Denied on technical error	Percent-- 58 or 3
Denied pending clarification	Percent--321 or 18

We have yet to collect and collate the data regarding approved cases. Generally these approvals were for 1–30 days pending changes in the patient's condition. In some cases they were approved pending review by the Utilization Review Committee of the ECF. Most significantly 30 percent were denied benefits with the probability of an additional 12 percent being denied coverage retroactively to the date of admission.

Admission to ECF's in Connecticut for the 3-month period in the fall of 1969 were 1,826 patients admitted as compared to 2,328 in the same period of 1968.

In our judgment, the admission rate to the ECF should have been increased removing patients from costly general hospital beds more rapidly, especially when the following figures are considered.

Administrative costs for Medicare:	
1967	$62, 000, 000
1968	104, 000, 000
1969 (9 months)	102, 000, 000
Admissions for 33-month period from July 1, 1966:	
General hospitals	13, 000, 000
Outpatients	1, 000, 000
Home health	860, 000
ECF's	1, 690, 000
Cost for Patient Care 31 months from July 1, 1966:	
General hospitals	$7, 191, 000, 000
Outpatients	12, 000, 000
Home health	60, 000, 000
ECF's	550, 000, 000
Expended in general hospitals:	
1968	$3, 300, 000, 000
Expended for physicians services:	
1968	2, 100, 000, 000
Expended in ECF's:	
1968	330, 000, 000

Taken from hearings of the Senate Finance Committee July 1969.

I would like to point out to you that these cost figures for 1968, $3, 300 million was expended in the general hospitals and only $300 million in ECF's. Now I don't mean to say that I think we ought to spend more money for the sake of spending more money but I think we can get more patient days for less cost than we can in the general hospital.

Cost for Services

We are all concerned with the increasing costs in the delivery of medical and nursing services. It is a relatively simple thing to examine and justify reasons as to why costs have risen, particularly when one considers the sharp increase of labor during the past several years and the fact that labor costs represent some 68 to 70 percent of all costs of operation. Because the wage scales in nursing and its supportive forces have historially been low, it is fair to assume that these increases were largely overdue, especially if we were to attract competent personnel to care for patients in our institutions.

Nevertheless, it behooves us to examine our cost structure and to develop ways to reduce the cost wherever possible. We must deliver the best care possible within our fiscal capability. It is readily apparent that the Medicare load will decrease while the Medicaid (title XIX) load will increase. Currently some 74 percent of all patients in Connecticut's nursing homes are Medicaid patients, forecasting a rise to 80–85 percent in the next few years. It is also readily apparent that the greatest cost to the Federal and State governments in the long-term area will be in regard to patients in skilled nursing homes, rest homes with nursing supervision and homes for the aged.

We would do well to examine the nature and conditions of the patients who are in our institutions regarding the level of care needed to meet their needs. It is impractical to pay a charge, for example, of $20 per day when the patient actually requires maintenance services at $10 per day.

The implementation of a level of care system with distinct parts in an institution would provide areas wherein operations could be geared to give adequate care based on the patient's needs. There is really no problem to set this system up with many beneficial results.

For example, nursing staffs could be reduced in those distinct parts designated as custodial with less need for registered graduate nurses and LPN's.

Financing this system, recognizing that proprietary interests can do this job, is the bone of contention. It should be further recognized that there can be a good marriage between the provider of nursing care service and a fair reimbursement schedule. It should be realized finally that the private sector is willing to invest considerable capital of its own and that the balance of capital borrowed for mortgages is a risk venture of the highest degree.

It has been my contention for some time that services should be paid for on a fee commensurate with the services provided with the establishment of a fee for the operational phase paying in accordance with service level needed and on a plant basis with an imputed rental schedule. The rental schedule would be based on type of construction, age of construction, geographical location, and on appraisal by competent and qualified appraisers.

We would eliminate all other factors such as depreciation and interest on loans making payment on an individual basis. I am confident that if we were to implement such a program, beds could be easily found to care for patients on a level of care determination. The following chart based on three 100-bed institutions would illustrate my point. The plan merits consideration.

	Patients	Daily patient charge	Total daily charge	Annual cost (charge)
Institution:				
A	100	$18	$1,800	$657,000
B	100	20	2,000	730,000
C	100	25	2,500	912,000

Note.—Assume 100 percent occupancy, fixed charge for all patients regardless of level of care needed.

Patients	Charge for patient care	Total daily charge	Daily imputed rental	Annual cost (charge)
50	50×8.00	$400.00		
50	50×14.00	700.00		
Charges		1,100.00		
Total charges and costs		+275.00=	$1,375	$491,875

Institution	A	B	C
Rental	$657,000	$730,000	$912,520
Annual cost	491,875	491,875	491,875
Cost reduction	165,125	238,125	420,625

Note.—1. Assume 25,000 square feet × $4.00 per foot rental; assume 36,000 patient days—$2.75 per day per patient.
2. Reduction of cost in each system $165,125 to $420,625.

Wage Control by SSA

Mr. Chairman, it has come to my attention just last week that SSA will impose a wage control directive through fiscal intermediaries on a regional basis retroactively to January 1, 1967. These directives will require intermediaries to review by survey and other means the salary scales paid to all employees of ECF's with particular emphasis on the

salary allowance for administrators. The wage and salary allowances which were scheduled by the Travelers Insurance Co. auditors were considered by them to be extremely conservative; however, it appears the proposed allowances will be a mockery of the professional posture that is demanded by the conditions of participation for Medicare (title XVIII) and more recently the licensing of nursing home administrators law. Salary ranges for administrators as proposed will be below those paid to truckdrivers, electricians, plumbers, carpenters, and probably equal to that of a laborer.

If it is the intention of SSA and HEW to eliminate the ECF as an integral part of the medical and nursing care delivery system, the imposition of these limitations of wages will most certainly be a crushing enough blow to effect the withdrawal of many providers of services from the program. Currently, because of the additional burdens placed on nursing homes because of the reduction in admissions of patients to Connecticut ECF's from general hospitals, some 40 ECF's have either volunatrily decertified or have started proceedings to withdraw from the program, with others indicating a consideration to withdraw.

I can predict with a reasonable amount of certainty that many more ECF's will withdraw from the program if SSA and HEW continue to apply these pressures making it financially impossible to continue. It would be most difficult for administrators to reconcile the increasing wage scales for employees with these new policies now being implemented. We are very much concerned with this latest development which will have a very severe effect on our ability to provide adequate nursing services on behalf of the patient, and we ask that you use your good office to investigate and consider these latest developments.

Thank you, Senator. That ends the formal part of this testimony. I will be glad to answer any questions you may have.

Senator Moss. Thank you very much, Mr. Dellafera. Just this last part of your testimony is enough to shock us into insisting that we go ahead out of this survey of the trends to get some reversal of policy. To be told that some 40 extended care facilities have either decertified or started proceedings to withdraw from the program is startling and, of course, most depressing. Your prediction that there will be others would indicate that we have started to unravel the very fine system that you have here in Connecticut. We have praised Connecticut for being very advanced and one of the leaders, and now the pressures that have been applied are causing severe problems for many of these facilities.

I also was startled by your figure that some 30 percent of the hospital patients that were leaving the hospital were denied admission to nursing homes under the classification that has now been applied by Social Security through the intermediaries, and this is bad but even worse are these retroactive denials. I can see the hardship on the patients themselves, but their families face a real dilemma when denials come retroactive to a time when they first entered, and I can think of nothing worse than that. This is very disturbing. One thing that I agree with, we must study very seriously with the other side of the Congress and with HEW so that we lay down clearly what the congressional policy is and then require strict observance.

The other part of your testimony was very heartening about the training of administrators, particularly. I think that this is one area in which we need more personnel. We know that we are short of nurses; we never can have enough of those. Sometimes we tend to overlook the fact that the fellow that has to be in charge of the whole operation is the administrator and he should be a professional skilled in knowing how to perform his function. Too often in many States there really is no attention given to that, somebody just simply takes on the job and begins to do it. Some of them do very well and some do very poorly—there is no professional standardization. So hopefully you are doing as much as you can in Connecticut to train administrators to handle this job with your nursing homes.

Cost-of-Care Level

In monetary figures, have you any determination of just how far short we are falling in meeting the fiscal requirements on care of a patient? Do you have any standard amount that you could say is perhaps the lowest level at which you could provide extended care?

Mr. Dellafera. Yes, Senator. In the State of Connecticut it is in the neighborhood of $16 to $17 per day currently. Now with the inroads of unions in the next year or two I am sure that this is going to be considerably higher. The minimal wage that is being negotiated in nursing homes where union contracts have been signed are quite in excess of the standards of the Federal Government. I am sure that this is going to raise the costs in the next year $2 or $2.50 or $3 for the per diem because of the increase in labor cost.

Senator Moss. So it would be something over $20 a day that you think——

Mr. Dellafera. I am afraid it is going to approach that; yes, sir.

Senator Moss. Of course, you must face up to the fact that in order to compete for competent personnel the wages paid for nursing home employees must be equivalent with that of the other occupations in the community of similar length of hours and requirement of responsibility and so on. So the problem will not go away by simply saying we will hold the line. It has to find its level, does it not, competing in the labor market?

Mr. Dellafera. That is correct, sir.

Senator Moss. As soon as we recognize that, then we can see what we must do on the financing side.

Amount of Recordkeeping

I was going to ask this question about the amount of paperwork required to computing the fees on patients. Can you give me a word or two on that?

Mr. Dellafera. Yes, sir. First I would like to say my good friend Dr. Foote passed the buck very well.

Senator Moss. I thought that was a good hand off.

Mr. Dellafera. I think he has done a good job.

Well, in regard to the paperwork, the fiscal part of it I don't think is any chore at all. I think that in completing the forms which will first provide the eligibility for care and then filling these out to receive remuneration from the intermediary is a simple thing. If each

institution would do this on a regularly scheduled basis, there would be no problem.

Now the Travelers Insurance Co., which is our fiscal intermediary in Connecticut, does a very fine job of getting out the checks to cover payment for the services which have been rendered. As a matter of fact, at one time it has been within 3 days on receipt of the form from the nursing home in their home office. They did a real good job on that. I think it slowed down a little bit now because there has been this switch to determining whether care is covered or not. Now the bulk of paperwork, I think, comes in all of the other records—utilization review, staff meeeings, social work and all of these things. I don't think that you can classify this as too much paperwork because I think that these records are most important if we are going to give adequate care to the patient. I think we have to equate good records to it so that one person who may come in at another time who is not familiar with the case certainly can, by reading the record, know what the story is all about. So I cannot say that there is too much paperwork.

FISCAL ITEMIZATION

Senator Moss. Even with regard to the fiscal itemization?

Mr. DELLAFERA. Yes, sir.

Senator Moss. I have heard some people complain there must be a notation of every medication administered and so on recorded in great detail.

Mr. DELLAFERA. One of the things we did in Connecticut with our association was to try to educate our administrators. We had them bring in their accountants, their bookkeepers, and we conducted seminars and we literally taught them step by step how to complete these items and the best way to do it. I think we worked out a pretty fair system so that it is not much of a problem. I know in our office we can complete the paperwork for some 25 or 30 medicare patients at one time in requesting payment and do this all within 6 or 7 hours of one work day, no problem at all.

Senator Moss. I am glad to have you give that account because I have been a little bit concerned upon hearing about this problem from other witnesses.

Any questions?

Mr. Miller.

Mr. MILLER. On page 9 of your statement you say:

> The implementation of a level of care system with distinct parts in an institution would provide areas wherein operations could be geared to give adequate care based on the patient's needs.

How large an institution would be required to have this provision?

Mr. DELLAFERA. I think this can be adequately done in 90 to 100 beds and do a good job. Anything below that, Mr. Miller, would be difficult.

I might say, if I may, just one more thing: that it has been my hope that rather than to build many, many more new nursing homes of 60, 90 or 100 beds, that we might use those already existing as a base and in proper planning increase the size of those with these various functions and then we would not have to distribute our workload all over the lot. I think we could start right there.

Mr. MILLER. In this sense you are using the term "nursing home" to include both the home or the aged?

Mr. DELLAFERA. Absolutely. Yes, sir.

Senator MOSS. Thank you very much. We appreciate, Captain, your being here also.

Thank you for your testimony.

Mr. DELLAFERA. Thank you, sir.

Senator MOSS. Our next witness will be Mr. Paul de Preaux, administrator of the Avery Nursing Home and president of the Connecticut Association of Nonprofit Hospitals and Homes for the Aged.

Mr. de Preaux, we are glad to have you, sir. Glad to see you again.

STATEMENT OF PAUL de PREAUX, ADMINISTRATOR, AVERY NURSING HOME, AND PRESIDENT, CONNECTICUT ASSOCIATION OF NONPROFIT HOSPITALS AND HOMES FOR THE AGED

Mr. DE PREAUX. Glad to see you, sir.

I would like to state before I start that after this morning I hope that we can prevail upon Senator Marcus to lead the fight next year in per diem reimbursement for title 19.

I would also like to state that I agree with Mr. Dellafera on the title 18 legislation because in my personal opinion it was probably the most overpublicized, least explained bit of legislation that has ever been foisted on the older American. In every booklet that I have ever seen explaining Medicare to the older person I find that after a 3-day hospital stay they are either entitled to or eligible for up to 100 days of care in an ECF but no where does it say, not even in the small print, only if they meet the stringent requirements now called for by computers, and I find this is a little ridiculous.

I will say nothing about title 19 because I think you already know my position on that.

RECENT CONGRESSIONAL ACTION

Congress recently enacted legislation authorizing $150 million for continuation of the No. 202 program and authorized FHA mortgage insurance of intermediate care facilities. Both proprietary and nonprofit institutions would be eligible for mortgage insurance. On the face of it, this would appear to be of tremendous benefit to the problem of housing for the elderly but, in my opinion, it is not.

My basic reason for opposition to these amendments is that,while there is great need for each of them, there seems to be no apparent attempt to coordinate or consolidate the planning of housing programs for maximum efficiency. When I speak of housing programs I speak of four phases: apartments, congregate living areas, nursing homes, and intermediate care facilities.

For reasons unknown to me and many others, some Government officials believe that the answer to every problem is a massive input of funds unaccompanied by comprehensve planning. Lack of comprehensive planning usually results in inefficiency, ineffectiveness, deterioration of the goals of the program, and a waste of the taxpayer's money.

The present public housing for the elderly programs fall far short of their announced goals because each plan seems to be based on a separate premise of need. Anyone knowledgeable in the field of the aging realizes that there is a multiplicity of overlapping needs within each program which affect every other program. These needs are individual, personal, and cannot be computed in generalized premises. In fact, one of our greatest problems is the retention of the human element in Federal programs for older persons. Programs initiated because of concern become homogenized and computerized into financial and mathematical equations from which concern has been eliminated. In my opinion, public housing for the elderly is an excellent example of this. I could name others, but I do not wish to digress.

Consolidation of Aims

It is my belief that Government must cease attacking the problems of housing for the elderly on myriad plateaus and consolidate its planning into one effective package to answer this multiplicity of needs. In other words, Government must replace its construction programs with one program of concern.

In caring for the older person, we find four main phases of care are necessary. They are:

1. Independent living: Apartments.
2. Semi-independent living: Communal or congregate living areas.
3. Intermediate care facilities: Rest homes with nursing supervision.
4. Intensive nursing care: Extended care facilities or nursing homes.

An important adjunct to the above is the Senior Citizens' Community Center which is primarily for those persons still residing in their homes in the community.

I know that the Congress and State governments have become involved to some extent with all the above phases of care except one, but, as yet, I have seen no evidence of any attempt to merge or consolidate these areas of care under one master plan.

Campuses for Older Persons

It is my opinion that campuses for older persons is the logical answer and the great need of the future.

Each campus should contain separate facilities for the four main phases of care and a community center. This would give the older person the one item which none of the existent Federal programs do, a permanent home. Under the present system of comprehensive nonplanning, the aforementioned facilities are constructed many miles apart and have no connection, one with the other. The ultimate result is the older person being transferred from one to the other, from town to town because of changes in his physical or mental condition. In other words, he becomes a "vagabond of the system." Under the campus plan, he would have a home and, though he might be transferred from one facility to another for reasons of illness or personal desire, he would remain in the same locale with his friends nearby.

I believe that the facilities for the four main phases of care can be constructed in the same area and arranged as a campus with a community center for use by the residents of said facilities and older persons in the community. The latter is most important, for the

campus must remain a part of the community and never become an "isolation area" for the older persons.

The community center should consist of a program area (auditorium, recreation and occupational therapy area), kitchen, dining room, and office spaces for administration, women's auxiliaries and volunteers. It should also contain an area for staff social workers who would assist both the residents of the campus and the older residents in the immediate adjacent community. In fact, the center should serve as the main artery between the heart of the community and the individual residents of the campus.

I stress involvement with the community because the benefit derived from such an involvement flows both ways.

1. The community would gain a greater understanding of the needs of older persons and really be made cognizant of the usable talents still available in the old people.

2. As an adjunct to this hot meals on wheels could be served to older persons in the communiy for a nominal fee, and this would insure them some degree of adequate nutritional intake. Too many of our patients are admitted with diagnoses of malnutrition, anemia or nutritional deficiency.

3. Older persons in the community could become acquainted with the benefits and advantages of campus living, thereby easing the psychological shock which usually occurs when they find they must leave their homes for an institution.

4. The residents of the campus could reestablish their individual identities in the community, thereby escaping the generalized classifications usually applied to older persons.

5. Both residents of the campus and members of the community could become involved together in some of the newer innovative programs such as the adopted grandparents plan for retarded children. This is only one, there are many others.

6. Involvement such as I have described would act as a stimulus to the mental and physical well-being of both groups. They would feel that they are still needed and have not been cast aside by society.

I can imagine, in the future, clinics on each campus solely for the care of the older person. I can visualize their utilization as centers for research programs dealing with the programs of older persons on all levels: physical, psychological, medical, mental and social. I can see all of this developing from the campus idea, and I feel that it is time the government realized it must commence a concerted effort to care for the total person. It must research all the above areas of care and have answers before they become unsolvable problems because of lack of time.

There are three available courses of action that can be taken immediately to insure a start of the campus idea.

1. Build public housing adjacent to nonprofit extended care facilities or intermediate care facilities and assign their management to the religious or fraternal order which manages the original facility. Plan to start construction of the other necessary facilities as soon as possible.

2. Build public housing in an area with sufficient acreage available for the construction of the other facilities in the very near future.

3. Combine all the Federal programs applicable and start projects of the campus idea in toto in various parts of the country. Revise

present plans and in the future construct only this type of multiple facility. Congress could authorize FHA mortgage insurance available to any group, proprietary or nonprofit, for this specific purpose.

As I have said before, before you, Senator, the older persons I speak of are no ephemeral group, but 20 million of our citizens—10 percent of our population and, I might add, a much higher percentage of our eligible voters. We owe them the concern that we ourselves will be seeking in a few years. We cannot answer their problems with cliches because in their years they have heard them all. It is our duty to coordinate the multiple programs of the various governmental agencies under one plan which will attempt to answer all their needs.

I also believe— and I think I have many backers in this—that there should be one section in the Department of Health, Education, and Welfare which should administer every program relating to older persons, including housing, Medicare, Medicaid, research programs—everything. I further believe that there should be in this section experts in every field concerned with the care of the older person ranging from architects to registered nurses. It should draw from the vast reservoir of available talent the best minds to deal with this great need. Perhaps, in this way, we could take that first step to replace random construction with specific concern.

Thank you.

Senator Moss. Thank you, Mr. de Preaux, for a stimulating and well thought out bit of testimony. I like the last part especially because one of my pet peeves is this fragmented administration that we get so often, not only with programs for the elderly but other things that the Federal Government becomes involved in. I suppose the disease goes on down to State governments, too.

What you say has occurred of course a great deal within HEW and in HUD dealing with problems that are centered on the aging, and how much better it would be if we could have all of those functions brought together and the administration could then look at the whole picture.

Now your idea of campus living certainly has a great deal to recommend it, it is the best idea I have heard in a long time for trying to pull together some of these problems. It seems obvious to me, that an older person might not have too much trouble in moving to the campus in the first instance and then staying there. But how would older people react to the fact that there would be different kinds of care there and to the fact that he is sort of progressing from one to the other? Would that have an inhibiting, psychological effect on him?

Psychological Effect

Mr. de Preaux. Psychologically we ran into this at Avery and it is a terrible thing to try to overcome at first because for some reason or other the elderly look upon the hospital as the elephant's graveyard, the last place to go. The basic function that must be performed by a nursing home or ECF, even in the campus, regardless of where it is—and this State I think is an excellent example of it—is the fact that the basic intent must be to rehabilitate.

Therefore, if you can take people from their apartment or cottages or the congregate living area and get them into the hospital section or the nursing wing and transfer them back, then psychologically this

becomes their hospital, not the elephant's graveyard. This is something that has to be overcome but it has to be done on an individual basis within the unit because you cannot tell them about Avery or Crestfield or any other place, they have to be there to see it themselves.

Senator Moss. If I understand what you are saying, it is that these people that are living in this campus area observe others of their friends who are able to come out of the hospital and go back to their public housing or whatever they are able to return to and then have a feeling that hospitalization is simply to get over some malady that they have and that they will be coming back and therefore they are not depressed by this idea of going into the hospital.

Mr. DE PREAUX. Yes, sir. We must instill in every patient the minute he is admitted he is not there to stay, he is there to get better. If you cannot instill this incentive to leave, then there is very little you can do for them.

There is a pilot program similar to this campus idea and the only two functions not in it at the moment are the rest home with nursing supervision and the senior citizens community center which we are attempting to, shall I say, garner funds for. There is a problem of getting the funds but there is a pilot program. I think it can work and I think it can work on both levels, proprietary and nonprofit. This covers the whole field. There have to be experts.

In answer to your remark about the fragmentation of the various departments, I was talking the day before yesterday to a gentleman in the department of community affairs who is waiting for a call from a colleague of yours, Senator Ribicoff.

Now I would expect that anyone who would call the Senator had something really important to discuss. He did. He wanted to find out what department in Washington handles specific housing information that he was trying to find. Now this is how fragmented you really are down there.

Senator Moss. We are fragmented. [Laughter.]

Well, I appreciate your testimony because it reinforces the feeling that I have had for such a long time that first of all we had to overcome this idea of people when they go into a nursing home that they are just going to spend the rest of their life there and die there and therefore they are depressed mentally and psychologically. This has its effect, of course, on them physically. The second part is this idea of having your campus or whatever it is closely integrated with the community because I also think it is very depressing to older people to see nothing but older people.

Mr. DE PREAUX. Yes, sir.

Senator Moss. They enjoy having children and seeing them around—they maybe cannot put up with them as long as younger and more vigorous people but this is part of life. After all, you don't just cross a certain age barrier and then withdraw from society and live only with older people from then on. A person ought to have some contact with the whole mainstream of living which includes children and younger folks and all the activities that go on in our communities besides the facility that is adapted to the particular needs of older people. They do have to have more convenient housing, they have to have more access to medical care. They have periods of illness and hospitalization where they have to have added care as

they get older but these should just be incidentals, they should still be in this mainstream of living.

Mr. DE PREAUX. Yes, sir.

Senator Moss. Your philosophy is very well expressed here in your testimony.

Any questions?

Thank you very much, Mr. de Preaux.

Mr. DE PREAUX. Thank you.

Senator Moss. As always, your testimony was very good.

Mr. DE PREAUX. Thank you, sir.

(See app. 1, p. 326, for additional information.)

Senator Moss. Mr. Art Jarvis of the State department of health, will be our next witness.

Glad to have you, Mr. Jarvis. We look forward to hearing from you.

STATEMENT OF ARTHUR J. JARVIS, DIRECTOR, DIVISION OF HOSPITAL AND MEDICAL CARE, CONNECTICUT STATE DEPARTMENT OF HEALTH

Mr. JARVIS. Thank you, Senator.

My name is Arthur J. Jarvis. I am the director of the division of hospital and medical care of the Connecticut State Department of Health. I am a professional hospital administrator by virtue of some 19 years of work experience in the hospital field, as well as the recipient of a master of science degree in hospital administration from Columbia University, having received my baccalaureate degree from Trinity College here in Hartford.

The division of hospital and medical care is the designated organizational component of the State department of health for three programs. First, we are the responsible State agency for title XVIII, that is, medicare; secondly, we are the designated State agency for the Hill-Burton program; and, thirdly, we are the licensing authority under State statutes for the licensing of all general and chronic disease hospitals, nursing homes, rest homes, homes for the aged, clinics and rehabilitation centers.

MEDICAL PROGRAM BACKGROUND

The thrust and intent of the remarks that I shall make to you in the time allotted to me will be to try and highlight why Medicare as a program has failed in some respects in its public mandate. It has become a program increasingly misunderstood by the beneficiaries and, by virtue of less and less coverage, has proven to be a bitter disappointment to the very people we had hoped to serve.

In the days of 1965 and 1966, American citizens over the age of 65 were rightfully jubilant that Medicare was now law. Any of us who were responsive to the national mood of our elderly citizens at that time, It am sure, share with me the almost impossibility of describing how joyfully the aged reacted to the news that "their" health law was now a reality. After all, the aged then, as now, use the hospitals and nursing homes twice as often and twice as long as the rest of the population.

Small wonder that they thought that as they proceeded into their advancing years their greatest concern, which was health care cost,

was now being met with a program that would give them quality of service that they could accept with a sense of self-dignity and self-respect. They were told that they were now entitled to their hospital costs, all of their nursing home costs met up to 100 days, as well as being entitled to 100 visits by a nurse from a home health agency.

The original organizational framework for the implementation of Medicare was a troika composed of the Bureau of Health Insurance of the Social Security Administration at the Federal level, through whose regional offices would see to the business of administrative and policy supervision of the other two parts of the troika, mainly the fiscal intermediary and the State agency.

Nonetheless, the realities of passing such a controversial piece of legislation had to go through the legislative process of both Houses of Congress which necessitated the compromise and the judgment of all the lawmakers involved such that the law as finally written has presented statutory requirements for administration and implementation that have presented some problems for the program over the last 3 years. If there was ever a time for review and reassessment of these administrative and statutory regulations, it is now, so that we can more effectively implement the program and better serve the beneficiaries that the law was originally enacted to serve.

In January of 1966, I attended a week long training session conducted by the U.S. Public Health Service and the Social Security Administration in New Haven for the purposes of orienting State agency personnel from regions I and II to their new State agency Medicare responsibilities. They talked in those days of the three C's of State agency responsibility; namely, certification, consultation and coordination. There is not time to go into the course content of that session, but suffice it to say that I and the other health professionals who attended that workshop recognized by the end of the week that, with this new survey mechanism, coupled with statutorily required consultation, "plus" the possibility of enforceable coordination of all components of the health delivery system, this program of Medicare promised to be the most significant step of the 20th century in the improvement of health care to the American public.

The euphoria for the State agency health professionals lasted but a short time. Connecticut, like the majority of States in the country, assigned the Medicare State agency responsibility to its existing licensing component. Licensing standards from State to State vary greatly with some States having excellent licensure codes and others not nearly adequate to do the job of protecting the health consumer. Now, with medicare, we had a model—or a guideline, if you will—which could have had a far-reaching effect on upgrading the quality and coordination of hospital, nursing home and home health services to our people, as well as providing meaningful and effective standards to insure high quality of health care which, in my opinion, is the right of every American.

You know, Government control has never been a comfortable phrase in our American society; and I certainly need not tell you that it is an even less comfortable phrase with the voluntary hospital and physician sector of our health delivery system, to say nothing of the proprietary sector of that system.

In a nutshell, what has happened is that the authority and responsibility originally assigned State agencies to maintain adequate

surveillance and provide effective consultation for the protection of the health consumer has not been fully realized and thereby, in my opinion, the original intent of Congress has been thwarted in this regard.

For example, when Medicare first started, the State agency was charged with the specific responsibility for surveillance and consultation to see to the proper functioning of the utilization review committees called for in Public Law 89–97. For the first time in the history of the American health care system, it was now possible for a Government agency to go into a hospital or a nursing home and test for the effectiveness of the medical and surgical self-audit performed by the medical staffs of hospitals accredited by the Joint Commission on Accreditation for Hospitals. These self-audit committees take several forms but operate in much the same manner; namely, the medical record of a discharged patient is reviewed by a peer group of physicians appointed to that committee by the chairman of the medical staff.

The scope of the review is essentially to match up the diagnosis made by the attending physician with what prediagnostic examinations he ordered and, following confirmation of diagnosis, what drugs and treatment he ordered. Included in this of course, the committee evaluates the effectiveness of the treatment ordered and the attempt here is to adjudge that this particular patient received the proper care and achieved the amount of "cure" possible in relationship to the patient's diagnosis and prognosis.

While medical peer group, self-audit committees go back to the teens and the twenties of this century, the inclusion of these medical self-regulatory committees as a common practice in community hospitals began in the early fifties with the requirements of the Joint Commission on Accreditation for Hospitals. In order for a hospital to be accredited by that commission, these self-audit committees had to be organized and functioning. (Preeminent among these committees, of course, was the tissue committee which reviewed all surgical cases to insure that only diseased tissue was removed for defensible clinical reasons.)

However, these committees did, and still have, the built-in weakness of a subjective, if not honest, difference of opinion between a physician on an audit committee reviewing the medical record of another physician. In other words, physician A who is reviewing the chart may make the decision that such and such a decision, or procedure, was not the appropriate treatment or service that should have been ordered in view of the diagnosis.

On the other hand, physician B, the attending physician responsible for the medical record and his patient, may disagree and say, "I am sorry, but in my judgment this was the best way to handle the case." Thus it is that while we in the hospital field and our colleagues in the physician community have been able to take pride that such peer group self-evaluation is going on, and has been for some years, the problem of medically subjective disagreement between the "reviewer" and the "reviewed" has been a recognized weakness in this audit program from its inception.

I give you this background because it leads us directly into the heart of the quality of care problems that surround the significant public protection that the utilization review committees "can"—

and should—provide to our Medicare beneficiaries. Section 1861(k) of Public Law 89–97 states that a hospital or an extended care facility must have a utilization review committee. The purpose of this committee is "(1) For the review, on a sample or other basis, of admission to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services and (B) for the purpose of promoting the most efficient use of available health facilities and services."

Since I am not here representing a provider of service, my concerns in this testimony will not be with rates of reimbursement, plus-or-minus. Since I am not here representing a fiscal intermediary, my testimony will not concern itself with costs or determination of levels of care. But since I am representing a State agency, my primary concern is surveillance of the quality of care provided in this program.

"Quality of Care"

The phrase "quality of care" has loomed as probably one of the greatest imponderables for the health care community for as long as I can remember. After all, what constitutes good "quality of care"? How can the health field define good quality of care in the face of a system which places the subjective opinion of one physician against the subjective opinion of another? This leads very naturally to the age-old argument as to whether or not the practice of medicine is an art or a science. Surely, prior to World War II, the practice of medicine was much more of an art where sensitive hands, indeed all the five senses of the physician, were the major diagnostic tools in the treatment of disease. In the absence of antibiotics and other miracle drugs the use of medicaments and powders constituted the combined art, of the physician and pharmacist.

However, it is now 1970. Medicine has become a technological science with sophisticated computerized, diagnostic procedures and a proliferation of available drugs and treatments unknown in the history of man. It is my opinion that to suggest that the practice of medicine today is 80 to 90 percent a subjective art rather than a definable predictable science is tantamount to saying that man will never go to the moon.

Thus it is that if the American public is to get the quality of care and treatment that it has a right to, then there must be enforceable legislative mechanisms by which the responsible State agency can insure that the subjectivity is taken out of audit committees of medical staffs and replaced by a system whereby the review of these committees can be tested for their objectivity and scientific integrity.

At the present time, by virtue of administrative regulation of the Social Security Administration, the State agency is limited to requesting from the providor of service a description of the plan by which the utilization review committee is to function. At the time of our certification survey we are to review the minutes of their meetings to test whether or not the committee is, in fact, functioning within the written plan they submitted to us.

If, following review of these minutes, we discover patterns of care which indicate that the care being rendered "in general" is of below average quality, we may then take the facility to task and, if neces-

sary, recommend termination of that facility's participation in the Medicare program. However, on the basis of the utilization review committee minutes, we are strictly prohibited from reviewing any individual chart to compare it with the findings of the utilization review committee. While it is true we may review any and all charts for their administrative content and compliance with medical records requirements, at no time may the chart be reviewed as to the effectiveness and quality of the job being done by the utilization review committee.

I emphasize all of this because of the quote I read you earlier wherein the law very specifically states that the utilization review committee will review cases for the "medical necessity" of services provided, including drugs and biologicals. Well, ladies and gentlemen, there is only one way to determine whether a given diagnostic examination, or drug or treatment, was medically necessary unless the person, or persons, reviewing these records first ask themselves the question. "What is accepted good care in a case with this diagnosis?"

Faced with the subjective disagreement between physicians, and faced with the prohibition of an outside objective source to review such records, how can we guarantee that, in fact, our beneficaries are receiving the quality of care they are entitled to and for which the American public is spending a significant amount of money? Why should there be this absence of an effective objective audit of health in our hospitals, nursing homes, and other deliverers of health care?

We audit banks, corporations, and other businesses. Even hospitals and other voluntary health and welfare organizations are subject to annual financial audit to insure that the public trust placed with these institutions has not been improperly mishandled. If we as a society do this to protect our money investment, then why in the name of all that's holy can't we as a society develop an objective audit mechanism to insure that we are receiving the best possible health care by those who promise to deliver it when our very lives are at stake?

I think that such an objective system is possible and I shall attempt to outline a possible system in the remaining paragraphs of this statement. I hasten to add that this is but one such system and is suggested because it best fits in with the medicare program as presently constituted. There are others which with research and study might and could be adopted nationwide to insure high quality of care for all Americans.

Be that as it may, approximately a year and a half ago the Social Security Administration assigned certain consultative responsibilities to the fiscal intermediaries and the utilization review committees served by those intermediaries. However, their role in this area is not quality of care but rather merely a determination of level of care. Forms provided by the intermediary are submitted to the home office and personnel of the company make a determination as to whether or not the patient's diagnosis and treatment meet the level of care justifiable for reimbursement and the Medicare beneficiary may or may not be covered. They make no determination as to the quality of care rendered.

One major plea I would make here is that the fiscal intermediaries share utilization and clinical data of their beneficiaries with the State agencies so that certain areas relating to quality of care, such as the length of stay and services used, can be pinpointed for subsequent

follow up by the State agency and hopefully result in the protection of all patients concerned. Since the early days of 1966, we in Connecticut as a State agency have taken steps to sit and talk with the intermediaries in our State and have been successful in working out operational problems on a cooperative basis. But even in a State like Connecticut where our day-to-day relationships with the fiscal intermediaries are strong in comparison to other States, yet even here we do not receive the kinds and the amount of data we need to exercise the kind of quality of care surveillance that I think our beneficiaries have a right to expect.

I said earlier that medicine was upwards to 80 to 90 percent an art prior to World War II. I would now submit that in 1970 medicine is upwards to 80 to 85 percent of a predictable, definable science ere 90 percent of the common diagnoses. The proof of the pudding here is that objective criteria for given diagnoses have already been developed, most notably by the Professional Audit System of Michigan, the guideline criteria developed by New Jersey Blue Cross, the utilization guideline criteria developed in the Alleghany project and many others.

National Criteria Guideline

Accordingly, I should like to recommend that a national criteria guideline be developed, by diagnosis, relating itself to prediagnostic examinations, accuracy of diagnostic nomenclature, and treatment and services appropriate to that diagnosis. In addition, these guidelines should address themselves to utilization if inpatient facilities in relationship to both diagnosis and prognosis. Therefore, backed with these criteria, it would be possible for our qualified physicians from the State agency to make meaningful judgments as to the adequacy and efficacy of this peer group self-audit mechanism known as the utilization review committee by virtue of comparison of review of individual charts and the minutes of the committee's meetings. Thus, the consumer would at last be represented by an objective source of review as to the scientific integrity with which his health services are being overviewed and evaluated by their physician community on which the health of all of us depend.

Needless to say, I am not suggesting that these guidelines be hard and fast rules and regulations for the treatment of the sick but should have an amount of flexibility so long as that flexibility does not overstep basically adequate patient care for a given diagnosis, Secondly. these guidelines should be reviewed and revised annually. These standards should not be cut in stone for eternity. Certainly a great advantage of such review and revision would be to reflect the benefits of the massive amounts of American dollars being spent in medical research. Who knows? This might be the first step in destroying the existing research gap between the highly sophisticated university teaching centers, on the one hand, and the community practicing physicians on the other.

Thus, it is as the amount of care provided under Medicare decreases because of denial and the cost of care rises we have a significant job ahead of us. The vast majority of nursing homes and extended-care facilities are proprietary, either by single ownership, stock corporation, or national syndicate. The overbuilding of nursing home beds is ap-

proaching national proportions and we have little or no overall planning in order to insure that these facilities are working in a coordinated manner with general hospitals. Surely on this last point there can be no doubt that the relationship of the general hospital and the nursing home must be strengthened significantly in order to assure a continuum of care and effective utilization of all of the components of our health delivery system.

Finally, let me make an urgent plea that as title XIX and Medicaid is now in its infancy that the legislative and executive branch of the Federal Government make every effort to insure that high standards of patient care are promulgated with mechanisms that will make it possible for the State agency to enforce high standards of care so that the American dream of good health for all can be realized. In many ways, Medicaid is as important, if not more important, than Medicare since all too often Medicare beneficiaries, because of spell-of-illness restrictions, find themselves outside the system all too soon and, therefore, must revert to the public assistance roles; namely, title XIX. As Mr. Dellafera stated, these persons will soon be 85 percent of the nursing home inpatient population.

Most of all, Medicare and Medicaid should have uniform standards of care and effective means of meaningful enforceability by State agencies because both programs address themselves to the health needs of those Americans who need health care the most and can afford it the least.

There are many, many more problems of an administrative and technical nature that are hamstringing our attempts to bring total and effective health care to all Americans irrespective of race, color, or socioeconomic status. Let us hope that future hearings and similar reviews will further examine these technical problems so that ultimate health care can be delivered to all of our citizens.

This past September, in Denver, a National Association of Program Directors of Licensure and Certification Authorities was formed as an official affiliate organization of the Association of State and Territorial Health Officers. This affiliate organization is composed of people like me who on a day-to-day basis, working for a State mental health commissioner or his counterpart, faced a problem of enforcing standards of high-quality patient care, be it for licensure or Medicaid certification. This organization is a vital and significant resource that should be used on the national level to insure the standards as set by Federal decisionmakers are both realistic and enforceable and that they represent the best interests of the sick.

Regrettably, it appears to me that the decisionmakers at the Federal level have listened only to the counsel of every other component of the health delivery system, be it voluntary, proprietary, or the insurance interests. They have then set down rules and regulations and issued them to program State agency directors like myself who have had no say in their formulation but are required to implement them with all deliberate speed. I would submit that I and my 49 other counterparts in the country could and should be a valuable resource in the formulation of policy, rules, and regulations at the Federal level. This expertise should be utilized across the boards to insure that in all such programs all facets of the health care team, nationally, are heard from prior to establishment of health regulations that affect all Americans.

I, perhaps, can leave you with two quotes that I like to think reflect the spirit and the intent within which this statement has been prepared. The first is from Abraham Lincoln who has said, "The dogmas of the peaceful past are no longer appropriate for the stormy present." Well, our present is, indeed, stormy and the health needs of our society are significant, indeed. Remember, it was no less a person than Henry Ford III who said, "Anything, I do not care what it is, can be done better than it is now."

Therefore, let us learn our lessons from the great experiment in medicare since 1966 and evaluate and strengthen the strong points of what we have learned and eliminate those weak points where we, as public decisionmakers, have failed to bring ultimate health to every citizen of the United States as we so boldly promised them when we first said that there would even be anything like a title XVIII, Medicare, and a title XIX, Medicaid.

If the background and recommendations that I have made in this testimony can contribute to the improvement of health care for not only our aged population but for all Americans, then I am gratified for this opportunity to speak and I have accomplished what I was invited to do.

Thank you very much.

Senator Moss. Thank you, Mr. Jarvis. That certainly is a well prepared and thoughtful statement, and coming as it does from a man with your background and your responsibilities it is very impressive for us to have.

I listened with a great deal of interest to your discussion of the fact that the practice of medicine just in our lifetime, and, in fact, very recently has shifted largely from being a healing art to a healing science, and that is a good way to put it because all of us just observing it know that the sophisticated and advanced systems we have now of diagnosis and then of regular procedures for dealing with diagnosis have standardized in great measure the practice of medicine.

Now there is always going to remain that little percentage. Of course, it does depend on other factors, but the main procedures that are followed, I think, certainly can be determined. I think those of us who are of the older generation still tend to think the other way, we just have not stopped to analyze the system as you have expressed it here.

I think this is a good addition to our record. Certainly you have made some suggestions that ought to be very seriously considered at once by our executive administrators and by the Congress, itself, as to how we can upgrade the health delivery system that we have, rather than more or less floundering along as we are doing largely now in the programs we initiated.

Mr. Jarvis. Thank you.

Senator Moss. I agree with you we started off with the highest of hopes and have found that they have sort of crumbled a bit as we have begun to live under Medicare and Medicaid but this still remains the greatest forward step we ever made and now it is time that we improved it, shored it up so that it will be useful to all of our citizens but especially to our elder citizens with whom we are particularly concerned.

I don't have specific questions to ask you. I am very much impressed with your testimony and I am going to do a lot of thinking about it

as we go on with this series of hearings and then get back into the committee.

Any staff questions?

Thank you very much.

Mr. JARVIS. Thank you very much.

Senator Moss. Our next witness is Dr. Otto Goldkamp, president of the Connecticut Society of Physical Medicine and Rehabilitation. We are very glad to have you, Dr. Goldkamp, and we look forward to hearing from you.

STATEMENT OF OTTO GOLDKAMP, M.D., PRESIDENT, CONNECTICUT SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION, HARTFORD HOSPITAL

Dr. GOLDKAMP. Senator Moss, I want to add my welcome to those here and also express my appreciation of your concern for the growing social problems of the aging population. I think, as I listen to all of these people presenting various problems, that they become somewhat simplified when I consider they are not addressed solely to the situation of the elderly but that I am considering a disposition for myself.

As an anchor man on this group of panelists, so to speak, I have two difficulties and some benefits. One of the benefits, of course, is that you learn a great deal from what has gone before, and one of the difficulties is that you may end up repeating, somewhat, what others have said. Also, to rival some of the speakers I have just heard will be quite difficult. Nevertheless, it is interesting that as I looked at the remarks I have prepared without any cooperation between the previous speakers, I, as a physician, have arrived at very similar conclusions in almost all instances though perhaps carrying them out may be somewhat difficult.

As a physician directly involved in the care, the management and the rehabilitation of older individuals, my experience as a consultant in physical medicine and rehabilitation at various hospitals and extended-care facilities has led to certain observations relevant to the problems so far encountered in provision of medical service to the senior citizens. I list them as follows.

UTILIZATION OF FACILITIES AND SERVICES

At the present time Medicare coverage in an extended-care facility can be legitimately extended to only those patients who upon discharge from the hospital are in need of special nursing care or procedures not otherwise available. Yet any conscionable physician quite properly feels his patient's needs take priority over the interests of insurance companies or carriers and acts accordingly. Consider, if you will, elderly individuals in the following situations:

(1) Post-surgical healing period for fracture of the hip but independent with walker and no weight bearing.

(2) Stabilized stroke in which patient can perform all functions but is aphasic.

(3) Stroke in which patient needs help—only minimal help—in toileting or cannot prepare food or serve herself.

(4) Cerebral vascular disease with normal motor activity and control but lapses of memory and judgment.

(5) Reduced cardiac reserve but stable and without complaint at graded activity.

(6) Post-surgical recovery period from major surgery without complication but reduced work capacity for self-care.

(7) Post-operative leg amputation, wheelchair bound or marginal crutch performance.

None of the above disabilities would qualify for extended care because none would need skilled nursing, physical therapy, or any other medical services except for occasional visits by a visiting nurse and physician. Yet, none of these individuals can function alone sufficiently to take care of his basic needs, and, yet, such individuals probably comprise conservatively one-third of nursing home populations the country over. No worthy physician will return a patient to an environment conducive to recurrent trauma or disease until that patient is capable of protecting himself. Hence, the nursing home in such situations must serve as a temporary or permanent protective environment.

However, we look at the above patients, statistically, as medical problems when in reality they are social problems created by sickness or trauma. Many of our social problems consequently masquarade as medical problems in nursing homes and elsewhere because the social needs are more easily fulfilled by the medical budget and in the medical environment. Yet, we could reduce our medical costs considerably if we had more boarding homes with competent domestics and management rather than more nursing homes with expensive medical standards. Furthermore, such boarding homes, while providing in a sense a protective custody, can permit greater freedom and means of recreation than most nursing homes where medical procedure must take precedence over social needs.

Here I certainly heartily endorse the suggestion made by Mr. Dellafera that a survey of the occupants of the nursing homes, appropriately oriented, might well give us the knowledge that we need for future planning in our communities concerning services that are actually necessary.

Utilization of Services in Extended Care Facilities

Currently there are efforts to bring nursing home standards closer to those of general hospitals in the belief that the ECF should be an extended arm of the hospital capable of providing almost all of the services rendered in a hospital short of surgery. As beneficial as this might appear, when it seems undesirable to return an occasional acutely ill patient to the hospital, the disadvantages would far outweigh the gain. Such a reorganization would of necessity siphon off skilled personnel from the general hospitals already in short supply. Requirements for X-ray, electrocardiograms, oxygen therapy, pharmacy, physical therapy, occupational therapy, on a regular basis would demand full-time and regular part-time services of skilled people not now available as well as inflate the cost of service.

It must still be the judgment of the physician that determines when and how much of medical services are required for his patient and, therefore, whether hospitalization rather than extended care is indicated. Duplication of expensive equipment and personnel would undoubtedly soon move the cost of nursing homes up to that of

hospitals. Furthermore, today, almost all services are available through readmission to a hospital, or the use of portable equipment and reliable local or mail order laboratories as needed.

Utilization of Rehabilitation Services

Since World War II, physicians and public alike, have become rehabilitation conscious, for its appeal has been great. Even though every form of medical treatment has as its ultimate goal, rehabilitation, popular concepts for many years now have identified with physical rehabilitation. Such treatment involves the restoration of limited, or total function, through the utilization of the techniques of rehabilitation medicine which incorporates the use of prosthetic and supportive devices, physical therapy, and occupational therapy with support from other special paramedical services and facilities. Commonly such services are employed where other medical or surgical procedures have been unsuccessful in adequate functional restoration or in conjunction with them to facilitate recovery of function.

Unfortunately, it must be acknowledged that despite much publicity and numerous rehabilitation centers throughout the country and departments of rehabilitation medicine in most large hospitals, and many smaller hospitals, only a small percentage of practicing physicians have a functional knowledge of physical therapy or rehabilitation procedures. Consequently, in many places physicians freely admit their deficit and defer to the physical therapist. Yet, the law requires that physical therapy is to be rendered only upon a physician's prescription which, in this situation, becomes a meaningless technicality. In such a situation the hopes of the physician and the patient are often frustrated by the physician's ignorance of the limitations of physical therapy, and the therapist's efforts come to naught or worse because of his lack of medical knowledge concerning the pathology and associated disorders of the patient.

Consequently, costly hours and months of physical therapy and rehabilitative training are wasted because of lack of understanding on most physicians' parts of the indications for, and the limitations of physical therapy and rehabilitative training. Such considerations can be, and are ignored, under the pressure to do something for the patient even if it is ineffective, provided it is not harmful—so at least is the rationalization. Further rationalization provides indications such as "giving the patient hope," "relieving boredom," or qualifying them for Medicare in an ECF.

Unfortunately, such innocent and well-meaning abuse of utilization is generating an administrative backlash that could deprive medicare and other third-party beneficiaries of one of medicine's most valuable services. Physical therapists are already avoiding Medicare patients for a number of reasons, and lack of medical direction is a major contributing cause. Another cause is, incidentally, that physical therapists' claims are being processed by well-motivated but nonclinical personnel, which many therapists believe unqualified to judge the merit of the claims, and hence, they commonly and in error, reject reasonable and professionally established practices as unjustified even though the physician has prescribed or otherwise requested or sanctioned treatment.

Recommendations for Corrections of Abuse of Utilization

Medical schools must include sufficient instruction in the principles and procedures of rehabilitation medicine to make all physicians at least aware of its potentials and its limitations. In all probability such courses would have to be required as to most young candidates the chronic disability and the ravages of aging have never been able to compete with the more dramatic moments of diagnostic methods, chemotherapy, or surgery.

In addition greater effort must be made to recruit more physical therapists and consider their potential as a type of physician assistant which, of course, would require modification and changes in their present undergraduate curriculum or establish a need for a post-graduate period. However, any serious consideration of this idea would take considerable thought and study in close association with the medical profession and possibly even changes in the law.

Better utilization control of rehabilitation services must be organized in ECF's in which knowledgeable—and I emphasize this (and I think this is somewhat confirmatory to Dr. Javits' remarks)—physicians regularly review patients, or lists of patients, receiving such treatment. With such a small number of such physicians now available for these services, possibly courses could be offered to semiretired and other physicians in order to qualify them for making such reviews at modest compensation.

A system of providing rehabilitative services and physical therapy in ECF's must be devised which prevents unethical therapists and physicians from exploiting, actually within the law, Medicare and other third parties but retains sufficient incentive to encourage the provision of services. The present system of individual fees for each patient seen provides incentive but at times minimal selection and often great temptations.

Employment of rehabilitation services must have specific and reasonable objectives that will significantly improve the patient's independence or relieve his pathology within a reasonable period of time.

Motivation

Now there is another point, and that is the patients motivation which perhaps does not fall in a particular category, but in sickness as in health, there must be some promise of reward for our efforts or our existence becomes meaningless and we become depressed and ineffective. This is particularly true among the elderly population of nursing homes who would have no place to go even in good health. Consequently, it would seem that our society should begin thinking in terms of more rewarding activities, responsibilities, and pleasures to reduce the boredom of forced retirement and the reduced socialization opportunities for the later years.

Related to this quite specifically is the expense and difficulty that older persons experience in obtaining appropriate transportation. For many, a trip to the doctor once a month by taxicab is their only source of pleasure and contact with the outside world.

I believe that a special transportation corps with adequate conveyances and reliable schedules as well as minimum cost could be a key to better out-patient medical care for the aged and to more rewarding social experiences.

Medically I believe we have been successful in prolonging the "rabbits" of life, to speak metaphorically, but socially we seem to have neglected the "carrot."

If there are any questions, I would be glad to answer them.

Senator Moss. Thank you, Dr. Goldkamp. I appreciate your testimony.

I particularly liked that last part when you talked about motivation or something to be presented to older people that would give them the incentive to want to prolong their life and want to be ambulatory and want to continue to be concerned about other people in the life stream generally, and a transportation corps as one possibility is a good suggestion.

When you talked of utilization of the services in extended care facilities I was a little concerned when you indicated what you thought were the disadvantages of extended care facilities, that they would take over hospital patients and would drain off supply of personnel for general hospitals. Are not patients presently being kept in an acute care hospital much longer than need be and at much higher expense?

Dr. Goldkamp. No, I don't believe so. I think that most of the physicians are well aware as to what is necessary as far as acute medical care is concerned. There are times certainly in the general hospital when we just do not feel that it is feasible to transfer a patient. If we try to duplicate all the hospital facilities in the extended care unit, as I indicated, the costs would go up so that you might as well keep the patient in the hospital. Our means of transportation, our means of obtaining medical services, and our means of communication are such that it is not advisable. Certainly we want more than merely minimum nursing care in the real nursing home; but to try to equal a hospital requirements of a certain percentage of services, facilities and such is not realistic and not really necessary. Many of these patients if they were being cared for at home—and many of them could be (as I also tried to indicate if there were help)—would not be seeing a physician except when he was called or perhaps on a regular infrequent basis. There is no feeling now that these people should have next door to them all the facilities of the hospital.

Senator Moss. Well, of course I would have to agree with you if you were duplicating all of the services of a hospital it would not make sense. Some of the figures that we have received in other hearings have indicated that since this rather selective process of determining who are entitled to go into extended care facilities has been put into effect that there has been a considerable rise in the length of stay in the hospital. Patients have been kept in the hospital much longer because of the peril of not being able to get into the extended care facility. I just wondered from your testimony if your viewpoint did not tend toward that same problem.

Dr. Goldkamp. It does because in that case you would have the same problem of the doctors which I mentioned in the beginning. Most doctors caring personally about their patients are not reluctant to show some indifference to the third parties regardless of who they are if they feel it is the welfare of their patient at stake. As you know, there are various ways to point out that certain needs are required, be they in a hospital or an extended care facility, at whatever level,

providing they serve to qualify the patient for medically legitimate benefits.

Senator Moss. So if we have a better standard care in the extended care facility, the doctor will be much more likely to discharge his patient from the hospital and enter him in the extended care facility.

Dr. GOLDKAMP. If medicare or the other agencies can qualify him, and of course there will be no advantage to it if the cost of the extended care facilities are not significantly lower than they are in the general hospital.

Senator Moss. Well, I agree to that but at least as of now they are considerably lower than the hospital.

Dr. GOLDKAMP. Yes.

Senator Moss. Any staff questions?

Thank you very much, Dr. Goldkamp. We do appreciate your testimony, it was fine.

Dr. GOLDKAMP. Thank you.

(See appendix 1, p. 325, for additional information.)

Senator Moss. Mr. Walter Adams, president of the Connecticut Chapter National Council of Senior Citizens, and Mr. Harry Fiorillo, the United Auto Workers senior citizen representative in Connecticut.

Very pleased to have you, gentlemen.

STATEMENT OF WALTER ADAMS, PRESIDENT, CONNECTICUT CHAPTER, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY HARRY FIORILLO, SENIOR CITIZEN REPRESENTATIVE IN CONNECTICUT OF THE UNITED AUTO WORKERS CAP COUNCIL, NEW BRITAIN, CONN.

Mr. ADAMS. Senator Moss, we are laymen, we are not professionals, so our testimony is going to be rather elementary in sounding. Speaking on behalf of the Connecticut UAW CAP Council and the senior citizens from the State of Connecticut we would like to present some of our observations.

Senator Moss. Very good. We are pleased to have it.

Mr. ADAMS. I am Walter A. Adams and alongside me I have my associate from the CAP Council, Mr. Harry Fiorillo. Very simply and briefly we are going to give you just our observations and I hope in summary that they will be helpful to this testimony that is being given here today. We are only going to take about 5 minutes totally and I am going to read them as I have them prepared here:

(1) Unnecessary services required by Medicare when not needed.

(2) Of course we do not have enough convalescent hospitals. Those that are available are beyond the reach of our senior citizens once their medicare has expired.

(3) There are some convalescent hospitals that have three services; namely, a private section, another for Medicare patients and a third for the welfare patient. Three types of meals; one for the private patient, second type meals for the Medicare patient and the third type meals for welfare patients.

(4) Connecticut, we must admit, is one of the first States to have a recreation program in the convalescent hospitals. We want to note here that we are keen observers of what is being done by our important medical profession.

(5) We also feel that a larger reserve than $1,200 be set aside for burial when a senior patient is put on welfare, even if it must be labeled as this account.

(6) Standardized doctors' fees for medicare or private patients so when a patient is in need of special care the family need not shop around for a doctor with a lower fee.

(7) People fear convalescent hospitals because of financial drain.

(8) Unnecessary paperwork for convalescent hospitals under the Medicare program. From our observance trained personnel are required to do much paper work whereas they could be giving nursing care.

That is it, sir.

Senator Moss. Thank you very much, Mr. Adams. What you say about the paperwork is the thing I have been asking off and on here, as you know, during the hearing. This is the complaint that we hear, and obviously there is a problem at least in some places.

Your recital of the fact that there are three kinds of services, even to three kinds of meals, is considered terribly disturbing. This is segregation on another standard of the care in nursing homes, and if this exists why of course I think it constitutes an intolerable distinction within that nursing home that would be noticeable to the patients and degrading to the patients. I would think there should not be a different standard within the nursing home.

What you say, of course, strikes the most sympathetic note of talking about standardization of costs, particularly standardization of fees. The thing that we have tried to do in getting to Medicare and then Medicaid is to relieve our elderly citizens and their families from this great specter that hung over us and still hangs over us, but hung particularly over the older people who at the time of life they reached were usually living on a very small pension or social security or some very modest income and yet at a time of life when they are most prone to have sicknesses and to need hospitalization and had nowhere to turn and it was ruinous to their families and relatives to try to take care of them. Now, if we cannot make Medicare or Medicaid work to relieve this, we have not made the great advance that we thought we made when we passed the medicare statute in the Congress.

Is it your opinion that care is already deteriorated very seriously for our older people or are we still quite a little bit better off than we were before we had medicare?

Mr. Adams. Well, of course we cannot disagree with Medicare as it is. We must admit that there is room for improvement. Of course we really just started in this thing so as we go along we see where these improvements are necessary.

Of course this standardization of doctor fees, I don't know. This is a Nation of free enterprise, but still if a person has to shop around—and sometimes when you have an elderly person and you have got to get a doctor and you know for a special job he charges $75 and you know that if you could have had maybe 4 or 5 hours more you could have got another doctor, as I happen to know you could, for $45, it is better if you can shop around.

Senator Moss. Well, there is some background for that standardization. In health care policies many of them have written right in there how much is allowable for various medical procedures. Now

although that does not bind the doctor, it usually turns out that that is the fee that will be charged for that particular medical procedure.

I don't know whether the resistance would be so complete among the medical profession that this could not be accomplished. I recognize that there is a great desire to resist it because of the desire for freedom. Of course some procedure might turn out to be routine and another might have complications that make it much more difficult, and consequently the doctor's time would be involved and he would feel that he ought to have a higher fee perhaps for performing it. I think this is fine.

Do you have anything you want to add, Mr. Fiorillo?

Mr. FIORILLO. I think my associate covered it pretty well.

Senator MOSS. We are glad to have both of you gentlemen. You started off with a sort of an apology about being laymen. I think you are good practicing laymen in this field of care for the elderly. I am most pleased that you came here to testify today for us. After all, you are viewing it from the eyes of the people most concerned of all, those who are already in the age group that you are speaking for.

Mr. ADAMS. Thank you, Senator.

Mr. FIORILLO. Thank you.

Senator MOSS. Dr. Michael B. Miller, medical director of the White Plains Center for Nursing Care, is our next witness.

STATEMENT OF MICHAEL B. MILLER, M.D., MEDICAL DIRECTOR, WHITE PLAINS CENTER FOR NURSING CARE

Dr. MILLER. Senator Moss, thank you for permitting me to come before you. I come before you as a practicing physician to make a plea since we have an immediate problem in caring for the aged. Also, I thank the audience for having patiently waited this long.

As the last speaker I presume I do have certain advantages. I have heard comments by previous colleagues, many of which I agree with. There were certain cliches that appeared in their presentations that concern me greatly. I hear daily the anathema of institutional living. It is a hazardous cliche. All patients cannot go home. They don't all have homes, they don't all have families, or they are too sick to be cared for at home. Patients who are institutionalized are really not there unless there is significant need for such protective care.

They often come from homes that are very sick homes. They come from homes that in effect are nursing homes, but these are essentially bad nursing homes. I have yet to see in my travels all over this great country a licensed, approved functioning ECF that is as bad as the homes I see patients come from.

I believe society had better come to grips with itself in recognizing the disabilities of the patient population covered under the medicare law. For patients whom I see who average 83 years of age, many of whom have had one, two, three, four, five strokes with advanced heart disease and diabetes who can't see, who can't hear, who can't walk, who can't talk, et cetera, there is no noninstitutional environment to meet their needs. If they are ever to achieve a meaningful functioning level of everyday life, it can only be in a skilled protective environment.

Some patients can go home. In our experience less than 20 percent of patients can go home. Even those that do go home go home with acute and chronic illness. We have yet to discover what these patients

do to people in their home and what do the people at home do to these patients. We have discharged patients from our ECF still requiring maximum nursing care and all other ancillary services. They do step out into a social vacuum, we don't know where they go or what happens to them.

Merely discharging a patient is a meaningless statistic unless you define for me who that patient is, what are his needs; what are his disabilities, what is the status of the home or environment you are discharging him to.

Now who am I? I am a practicing physician of internal medicine, and fellow of the American College of Physicians. In 1947 I spotted the problem we are dealing with today in a hospital in New York City. I ran the department of rehabilitation and physical medicine of that hospital for 10 years. I spent 10 years as an assistant clinical professor in rehabilitation medicine and walked into a wasteland of caring for the aged. In my presentation today, I shall try to bring to you certain pressing problems that I have not heard my colleagues yet discuss.

Submerged in Paperwork

With respect to paperwork, which has nothing to do with clinical material—we are submerged with it; we are overloaded with it. I really believe that sooner or later we will have a problem in storing it. Twenty percent of my practicing day is spent in reviewing charts merely rebutting the fiscal intermediary. Something is wrong with that. Our social workers are wrapped up in rebuttals with the fiscal intermediary. We have an office staff wrapped up in this mountain of paperwork. There can hardly be a question about its meaning or its uselessness, but we are wrapped up in it.

Mr. Dellafera mentioned that 30 percent of his patients on admission to an ECF are rejected for medicare benefits. I think he is missing the remainder of the iceberg.

Patients, families, doctors, and hospitals, feel they know who can qualify under the new stringent regulations so they don't even apply for benefits under the Medicare program. There is a selection process outside the ECF, thus the 30 percent number is not meaningful.

In order not to embarrass patients and their families financially we conduct a very meaningful, thoroughgoing social work evaluation. We eliminate many patients for admission to avoid embarrassment. So the 30 percent number is not valid on the basis of our experience. The number is not 30 percent, it is really much more than that. Very many sick people are leaving the hospital to go home to flounder. That was not the meaning or intent of the medicare law. We are caught up in that. I am here protesting.

Our Medicare experience was 40 percent 1 year ago. Now we are down to 5 percent and getting out of it. The decline in Medicare admissions has been deliberate. We don't want to get out of it. We truly don't wish to withdraw from this program, however we have little choice.

These patients have a right to be serviced. Receipt of Medicare benefits is not a privilege as social security thinks it is, it is not a privilege asset that the insurance company thinks it is. These benefits are a right. The elderly have paid for insurance; they are entitled to it by law. It is a right, and all of us are defensive trying to prove that

these poor disabled people have a right to their rights. How can you not be moved by the dilemma we are in?

Now it may be that in Connecticut I am a stranger. I am here at your invitation, however. I do not believe a meaningful, comprehensive rehab program can be run at $16 and $17 a day.

In New York, if a really meaningful program is to be obtained, the level of care must be first-rate wherever provided—the hospital, the ECF or the nursing home. If a second-rate level of care is expected in the ECF, then nothing will be gained in attempting to raise the level of care for the aged. There cannot be two levels of medicine. We must perform at the same level as my colleagues here in medicine, not less, and you cannot do it at $16 a day unless that patient does not require much or you are removing something from a first-rate program.

A comment about working with hospitals. I have been all over this country in the past year. I do not know of any ECF that would not open its doors for immediate communication with hospital colleagues. Has the ECF been dragging its heels? The hospitals from some perverted sense of social status have closed their doors to communication.

There is a strange dilemma and prejudice in this great country with respect to nonprofit agencies. The Federal Government, however, is in partnership with Boeing in developing airplanes, with no great outcry from society of this proprietary subsidy.

The hospital because of its nonprofit status maintains a "holier than thou" attitude toward the proprietary institution, there is something wrong with this. Because of these values, Senator, a barrier has existed between these two important welfare facilities, thus, there is poor communication, and believe me, the patient must suffer thereby.

The hospital discharges patients into a social vacuum—where do those patients go? If one talks about comprehensive care, it is the hospital's responsibility to know where their patients are going, even if it means following that patient in the ECF. I hope you can agree with me. The moment you have a vacuum in the health-care chain, at that point you have a serious break at the level of health care.

I hope you can understand this is completely impromptu. This was not part of my presentation, I am reacting to what I heard this morning.

I would like to discuss what has caused the dilemma we are focusing on this morning, because I have heard it over and over again. Why is this system breaking down and how did it happen?

The public health law and the Medicare law is a good law; it is a step in the right direction. It set out to help the people that need help. But there are certain deficits in the law. What is the public interest? Who are they, what are their needs? Who are the providers, what are their needs? How does one work out a meaningful and better program for all of these separate needs? They are not really separate, they are coordinate. Without hysteria triggered by costs, I think we can solve the dilemma.

Public Health Law 89–97 (Medicare) as promulgated by Congress is a good law and is in the best interest of our chronically ill-aged population. The intent of Congress was to provide continuous skilled nursing services, restorative nursing services, as well as the total complex of comprehensive rehabilitation techniques to the ill aged. That was the intent.

As might be anticipated during the developmental phase of new medical and social legislation, problems relating to the equitable application of the law, the determination of who are the chronic ill aged and the nature of the needs of the ill aged certainly can be expected to arise, particularly during a period of national spiraling inflation.

The spiraling costs of care, however, provide no reasonable basis for the hysterical reaction of the Social Security Administration in Washington. While spiraling costs of medical, as well as other services provided by our Government is of major concern to the Government and to our Nation as a whole, there are other concerns which are of equal import; namely, Are the people getting what they need and deserve?

The Social Security Administration, in an attempt to curb rising costs, has over reacted by invading the vacuum of definition of "skilled care" provided by Congress. They have instituted self-concocted definitions which in effect invalidate the medicare law as promulgated by Congress and the expressed wishes of the people of this country. By instituting restrictive definitions of skilled care, which will be developed during my testimony, and by altering the conditions of participation, extended-care facilities, as defined in the Federal Health Insurance for the Aged pamphlet HIR-11-2-68, the Social Security Administration is effectively placing a stranglehold on the effective development of a meaningful medicare program in this country.

One year ago the medicare patient population of our two extended-care facilities in White Plains, N.Y., was approximately 40 percent of the total patient census. Today it is 5 percent of the total patient population and is in effect in the process of being phased out entirely. Many ill aged do indeed require the help Congress intended under the Medicare provisions. These people, however, are currently being denied their rights under the insurance program that constitutes Medicare. Denial of their rights is being accomplished by capricious, arbitrary, medically indefensible definitions of "skilled care" which deserve public study.

I would like, therefore, to address myself to the following items at the pleasure of your committee:

1. Definitions of skilled nursing care and the application of those definitions by the fiscal intermediary, in this instance Aetna Life and Casualty, as described in Medicare Bulletin ECF No. 144, May 22, 1969, make a mockery of clinical medicine and clinical professional nursing and reveals a surprising lack of understanding of the practices as described.

Let me make it clear. The people at Aetna are simply wonderful people, but untrained and unskilled. They have been working out medical and accident rates for 20 or 30 years. What has this got to do with old sick people? They will never solve the problem in an insurance office, it will never happen there. They must get out in the field. I am talking about doctors and nurses. They must come out where the sick people are. They must learn our problems. Otherwise, no matter what you put on paper it will not work.

The Social Security Administration definitions of "custodial care" as applied to skilled or covered services are sufficiently obscure to place the deserving patient at a total disadvantage and deny him his rights for care under the medicare law.

I have heard this morning the words "maintenance care." Senator, it has always frightened me. I don't know what you mean by maintaining sick people. I don't think you are talking about skilled negligence but are talking about unskilled negligence.

The people whom I see have had one or more strokes with brain disease and many are psychiatrically ill. As a matter of fact, we have begun to learn some of the ramifications of what senility is. We are finding at least a third of the patients we call senile were mentally ill people 30 or 40 years ago. With superimposed strokes we place them in one basket and label it "senility," and then we consider them custodial and not needing specialized skilled care.

Ladies and gentlemen, this is the most pressing problem in our country in terms of health care. It requires more skill than most of us have. Our present skills scarcely meet the needs of these people. As to their maintenance, we put them in a boarding house with an untrained woman of 60 or 70 years of age as the house mother. How do you transmit information to her? Please believe me, I have heard this here; I have heard it all over.

There is no need for me to reproduce what Mr. Jarvis said about the utilization of the law which says "utilization review" is composed of doctors and other professionals who are to determine the needs of a patient at the local level.

The rights of people are being determined 100 miles away from charts poorly written by doctors who just don't know how to describe their patients, and poorly written notes by nurses. The average nurse today, ladies and gentlemen, is a high school graduate; she did not write well 20 years ago and she does not write much better today.

Now this is not funny, this is serious because when the intermediary reviews charts, these patients are being denied what is rightfully theirs. This is a real problem, but it is remedial. I think you better get the facts. I am not so sure that the doctors and nurses of the fiscal intermediary are better able to evaluate the facts.

Now for specifics. (P. 6 of ECF Bulletin No. 144.) Last spring social security issued a new definition of skilled nursing care. They have no relation to reality. Now I will attempt to show you how and why they don't.

Let's discuss what they think a skilled nurse might be responsible for. Certainly drug management. However, the SSA has a peculiar suspicion or rejection about drugs given by mouth; if they are given by mouth, it is not skilled care. If it is given by injection, it is a skilled service. You can help people by providing medications via injections, you can help them by providing medications orally; you can kill them both ways, too.

Feeding a Patient

We have just conducted a survey to be published in a medical journal; 20 or 30 percent of our patients lose a very significant amount of weight. These patients are severely handicapped patients with brain disease, with and without other concomitant organic diseases.

Am I taking too much time?

Senator Moss. No; go ahead.

Trained Nurses

Dr. Miller. We try to find out why. I assumed all nurses knew how to feed patients; they don't. Doctors don't know how to feed patients either, we were never taught. I conducted surveys in two nursing homes. Certain nurses can feed certain patients. There is an interrelationship in the feeding process, I don't know what it is. I know that we have seen patients lose 40 percent of their body weight in our institution. I can only conclude we don't know how to feed patients.

It is as fundamental as that and I don't know of any study being done on how to feed a patient. There are studies on calories, minerals, and vitamins. But how do you get it in? I don't know. If a patient wants to die at the age of 80 or 90, they frequently die by not eating. Do we have a commitment to save them? If we do have a commitment to save them, we certainly should learn how to feed them. A patient who dies on the basis of starvation is surely a result of lack of professional care.

I expect a nurse to understand diagnosis. Maybe she is not held responsible for the specific diagnosis, but she has got to know what is going on, and that is a skilled service.

Management of bowel movements, to my colleagues in rehabilitation medicine, is not an unskilled service. The importance of whether or not a patient can hold his bowels at all and how it mimics one disease (intestinal obstruction, et cetera), is indeed significant. I cannot see any part of this as being a nonskilled service unless you are prepared to accept a second and third rate level of care.

Certainly nurses should be trained in rehabilitation nursing and all that it implies. Unless I am wrong, less than 10 percent of nurses over the age of 35 have had such an exposure. The nurses who work in nursing homes are not usually young nurses; they are the old nurses who have returned to nursing after raising a family—they are essentially untrained. Many hospitals also do not teach nursing rehabilitation. However, it is a skilled service.

Family Counseling

In the acute hospital, gentlemen, you can get away without knowing the family; the patient is only there 9 or 10 days. For chronic care the patients remain a long period, the family is sick along with the patient—sometimes sicker. If one is going to institute a meaningful program of patient rehabilitation, you must begin family therapy as well. So few professionals have been trained in family counseling, which is a skilled service.

Psychotherapy

What is more important in the art of nursing than relating to the patient and vice versa? Everything will fail—drug management, rehabilitation nursing, family counseling, everything—unless the nurse is able to relate to that patient and provide the necessary nursing leadership. This is not called skilled care by the SSA. They almost permit a void between doctors and nurses with respect to the patients.

Finally, the ability to coordinate a meaningful nursing program with all the ancillary services; namely, speech therapy, physical

therapy, recreational therapy, et cetera, and not the least of all, working with the doctor. These are the skilled services.

The SSA states that if a patient is treated only orally it is a nonskilled service. I feel offended. Doctors for years have been trying to be released from parental orientation in the administration of drugs. For years we have looked forward to oral medication such as insulin and oral diuretics drugs, and they are simply washing that out by saying, treat your patient orally. It is a dilemma that must be remedied now.

It also says on the last page, Senator, if you use restraints it is nonskilled care, but it does not say on whom. Who needs restraints? The most handicapped patients possible, disturbed patients who are unsafe, patients with fractures, arthritis, and amputees. To the educated person the use of restraint is an admission of failure of the nursing process. It means we do not have better techniques, but it is not a nonskilled service. This restriction must be removed immediately, because when the "fiscal intermediary" sees "restraints" ordered on the chart your patient is finished.

The law says you must be in the hospital for 3 days before you go to an ECF. If the "fiscal intermediary" sees the patient was in the hospital only 3 days, there is an assumption of fraud and benefits are denied.

It also says if you stay in the hospital for 60 days there is an assumption—not a bona fide service. That also excludes your patient. Something is wrong with this, seriously wrong.

For instance, if a severely ill patient is given weekend privilege to go home he is not considered in need of skilled care. If you want to find out whether a patient can develop a rapport with his family members, permitting him to go home on weekends is an important theraputic device.

I am attempting to reveal monkey wrenches that were thrown into the program.

The use of the urethral catheter. The catheter is an instrument put in the bladder to maintain an open urinary flow. I don't have to go through the details. It is used often, it is an important lifesaving tool of care, at the same time it is a life-threatening process. All of us know that within 2 to 3 days every patient is uniformly infected by a foreign body in his bladder. We all know this, it has been documented any number of times. An improperly managed urinary reservoir, such as raising it above the level of the patient's bladder, guarantees an infectious process, many times with shock and death ensuing. It is that important.

The Social Security Administration says the following: When you put the catheter in it is a skilled service; when you leave it in it is a nonskilled service.

Aren't you offended by that?

Please believe me that every pateint subjected to the long term catheter is infected. I have rarely seen the patient with a long term catheter who does not have repeated episodes of fever and chills. In our aged patients with preexisting brain disease, the incidents of coma associated with urinary track infections is extremely high. They call this a nonskilled service and it is placed in the hands of untrained people. I am absolutely mortified with it. You must help us.

Colostomy

They say here that colostomy after surgery is skilled care. However, colostomy on a long term basis is a nonskilled service. A man with a colostomy can be taught to care for his colostomy in 1 or 2 weeks, granted. A lady of 80 or 90 who has a colostomy is confused and throws the stools against the wall. She is utterly incapable of managing the colostomy.

These rules were written by nonclinicians. The management of a colostomy in the hands of a patient who is frightened, depressed, and confused is indeed a great nursing skill. The rules must be changed.

They also say on page 2, section 3, "If changing the patient's position is the only regular and frequent service provided, it would not be a skilled service."

To you who are involved in long term care of the ill aged, you must ask yourself what else is wrong with that patient. You will rarely see an 80- or 90-year-old patient that requires 24-hour, long term care who does not have brain disease, heart disease, spinal cord disease, or severe arthritis, who is not eating, who does not need urinary tract care. It is the total patient that makes this a skilled service, not just the changing of positions. This knocks out an awful lot of our patients.

Please believe me, they are being cared for, but under tremendous financial load. The Congress in its intent was to spare them that load. We should not in good conscience permit a distortion by Congress of the will of the people. The fiscal intermediaries are doing the best they can, they are simply uninformed.

Physical Therapy Services

There is one more bombshell that came in this week. That is ECF No. 173, related to physical therapy services, section B, restorative nursing care, it says: "Restorative nursing care would include such measures as maintaining good body alinement and proper positioning of bedfast patients, keeping patients active and out of aged in accordance with physicians' orders, and developing patients' independence in activities of daily living by teaching self-care, transfer, and ambulation activities. In addition, nursing personnel should assist patients in adjusting to their disabilities, in practicing the use of prosthetic devices, and in carrying out prescribed physical therapy exercises between visits of the physical therapist."

This bulletin eliminates professional physical therapy. What the fiscal intermediary and the Social Security Administration are now saying is that physical therapy should now be carried out by a nursing staff already overloaded and untrained in physical therapy. Guess who is going to do this kind of physical therapy—the RN? The LPN is scarcely oriented. Your nursing aide is going to be doing this.

Who are the nursing aides? Please believe me we are devoted to them, we appreciate their willingness to help old sick people. Usually nurses aides are working people one step above literacy—well intentioned but untrained and uninformed people. We want to put into their hands the most sophisticated, the most sensitive treatment programs for the aged that took 20 years for rehabilitation medicine to establish. We will have nurses aides training patients in prosthetic uses. Something is seriously wrong.

I close my presentation. I came to make a plea, I have made one. I know of your long interest, Senator, in health care for the aged. I bring to you a clinician's problems, his experience, his great concern for the future of medicine and a sense of our own conscience of what we owe these people.

I want to thank you for listening to me. I appreciate your patience.

Thank you. [Applause.]

Senator Moss. Thank you, Dr. Miller. The response of the audience indicates the impact of what you had to say. You have done it very eloquently and certainly you have been specific and pointed to the very things that you think are causing a great deal of the problem we are having with the system. I am glad to have it. In fact, you did not read all of the documents that you referred to but I will order that they be placed in the record so that we have them there in full and can study them in full.

(See appendix 1, item 5, p. 332.)

Senator Moss. I appreciate what you say. The burden of your plea as I get it, is that extended-care facilities are indeed in need of the highest degree of care, and that rather than downgrade them as we tend to do with the intermediary's rules, and with others, that we should be upgrading them, that they should be equal in the sense with the hospital. I did not appreciate that fully at first but I can see your point, that it does require care.

Now a hospital perhaps deals more with acute cases in that you have surgery performed there and things of that sort, but what you are saying is, it is no more skilled care than is required for other services that are not perhaps as complicated, let's say, as the full surgical procedure, just as necessary for the health of the patient and needed as the acute care.

Do you have something to add to that.

Dr. MILLER. The American hospital is functioning under a myth, it is not a curative institution. All over this country 40 percent of patients are under medicare coverage. If one took the chronic care patients out of the acute general hospital, you would have no limited need of hospitals.

The hospital today is facing the dilemma of its own oreintation. My colleagues think they are dealing with acute illness, they could not make a living on it. Our colleagues are really involved in chronic care but have not shifted their sights to understand its implications. That is a serious problem.

I don't want to go on but there is an acute phase of the hospital, but it is a small part of their total problem. An acute heart attack, is acute only the first time. How about the second, third, and fourth? Is it really acute or is it chronic?

I think my doctor colleagues and society had better take a long perspective of the problems they are confronted with. I don't think they have yet.

Senator Moss. Well, thank you very much, Dr. Miller. I certainly appreciate your coming here and giving us this insight from one who is deeply involved in practicing every day in this area. You have been most helpful to us, and it does give us some guidance into what we might do, and ought to do, in order to make the system responsive.

Thank you.

Now before we adjourn I want to acknowledge the presence of Mr. Berkeley Bennett who represents the National Council of Health Care Services. We appreciate your being here with us. We hope we will have an opportunity to hear from you at some subsequent hearing. Unfortunately, we don't have time to do it today.

In fact, I had a 1 o'clock deadline and it looks like I am just about going to make it in finishing the hearing.

Let me say that I appreciate so many of you who have stayed through the whole proceedings. We had an overflow audience to begin with and we still have a fairly large audience, indicating the concern that all of you feel with the problems that we are examining, hoping to find the answer or at least factual matters that will help us get the answers to some of the problems we have.

I think I can truthfully say that this is one of the most fruitful hearings that I have had the opportunity to sit through or to conduct during the time that I have served on the Special Committee on Aging which has been quite a number of years now. The witnesses have been excellent; they have spoken to the point, they have had specific things to discuss, weaknesses to point out, remedies to suggest.

We have not fully agreed and that is the way it should be because we want every point of view. We probably have been overweighted a little perhaps on the medical side but I guess we can expect that when we are dealing with the problem of health care for the elderly. I think we have heard from the administrators and the licensing side, the medical, and those who were concerned with the problems generally of the aging.

As Mr. Adams said, the laymen, the biggest group of all, and their representation we surely need. So I want to thank you all for your attention and, especially, the witnesses for the contribution they have made.

I might say this about the record. Everything we have done here of course is to make a record. If any of you who were witnesses, or in fact if there are others of you who would like to submit to us in writing, if it is concise, and if it is to the point, and represents a point of view that you have, you may forward it to me, to the U.S. Senate or to the Special Committee on Aging of the U.S. Senate and if we receive it within 30 days we can include that in the record, too. It may be that in listening you have had some disagreement with something that was said and you would like to put down a different point of view or you may have something to add that you think was overlooked here. If it contributes to our general consideration of this whole problem, and no matter which side of the argument you are on, we would be very glad to have your contribution to this record that will then be presented to the full committee. It will assist us in that regard.

So I suggest that be done, any of you who want to submit a written statement. In the end, after we have held the hearings that we have scheduled, this record will be printed up. When the transcript is printed, you may secure a copy by writing to the Special Committee on Aging or, if you want, to the Government Printing Office, but we will be happy to furnish it to you. Those who have been witnesses will receive a copy automatically but the others may secure it by writing and asking for a copy.

So let me thank you all.

The hearing is now in adjournment.

(Whereupon, at 1:03 p.m., the subcommittee adjourned, subject to the call of the Chair.)

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. PROGRESS IN NURSING HOME CARE, BY FRANKLIN M. FOOTE, MD, DrPH

(Reprinted from the Journal of the American Medical Association, October 23, 1967, Vol. 202.)

By classifying nursing homes in five categories by services and resources available and by tying payment for state patients to rates set in relation to this classification, one state has greatly improved the quality of care provided. Nursing, dietary, and medical services have been upgraded, and many more homes are providing other rehabilitative and therapeutic services. Now, after five years, there are more than five times as many beds in homes in the highest class and only one-fifth as many beds in the lowest category.

Because Connecticut is among the states with the highest proportion of licensed nursing homes approved as extended-care facilities under Medicare (171 of 256), an account of statewide efforts to improve services available and quality of care rendered may be of interest to others concerned about convalescent care and long-term rehabilitation of the disabled person.

The state health department has been responsible for licensing nursing homes since 1928. With legislative authorization of specific regulations, it makes inspections and issues, denies, suspends, and revokes licenses. Over the years, both the Connecticut Association of Extended Care Facilities and the Association of Non-Profit Homes have helped in raising standards through workshops, institutes, and courses. The state medical society and the Connecticut Health League (composed of various voluntary health agencies and professional societies) also have had a keen interest in this field of work.

About six years ago in Connecticut all nursing homes were receiving a reimbursement of $7 per day for welfare patients regardless of the kind of services provided. This rate, set by a state commission, caused general dissatisfaction because nursing homes varied greatly with regard to services facilities, and resulting care.

Efforts were initiated to work out a classification system. The association representing nursing homes operated for profit sponsored legislation requiring such a classification in 1961. The legislation was adopted by the general assembly. With the objective of encouraging quality care, a system was developed in cooperation with nursing home leaders and interested physicians. The aim of the classification was to emphasize preventive and restorative services by encouraging (1) activities to keep patients mobile; (2) provision of services by dentists, dietitians, physical therapists, podiatrists, and other therapeutic personnel in addition to the minimum services required by nursing home laws; (3) rehabilitation as an integral component in nursing home care and giving an incentive to those nursing homes that provided added services.

In planning for the classification, the Connecticut State Department of Health sought to provide financial rewards for activities that might help in early diagnosis and treatment of a disease process or might help to avoid further disability or restriction of the patient's usual life pattern.

Existing licensing regulations already required licensed nurses on duty around the clock, provided for a safe and sanitary environment, and required appointment of either a medical director or consultant who would be available in emergencies and would make rounds in the home at least once a month to check on nursing services rendered, diets, and medical care needed. Each patient was required to have a personal physician. A history, medical examination, diagnosis, and medical orders were required within 24 hours after admission. Such a medical evaluation and prescription of care is basic to service and therapy appropriate to the patient's specific needs.

Among Connecticut's 252 nursing homes, 6 are operated by municipalities, 6 by churches or religious orders, 14 by other nonprofit organizations, and 226 by persons or corporations operating for profit. Sizes range from 5 to 275 beds. The average at present is 46 beds.

AWARD OF PLUS POINTS

The kinds of facilities and services for which plus points are given under our classification may be summarized as follows: administration, physical plant, and equipment, 12½; nursing services, 29; medical services, 10; dental care, 5; podiatry service, 2; speech therapy service, 2; laboratory facilities and services, 6½; x-ray department, 5; prescribed physical therapy, 5; dietary department, 8; recreational, spiritual, and occupational therapy, 17. A wide range of services is needed for patients in nursing homes, and sound overall administration is of fundamental importance.

A nursing home receives one plus point when the administrator devotes his entire time to it, another point when he is a college graduate, and two more points if he has a master's degree in hospital administration. Each of these qualifications makes him better prepared to develop and operate a good program. Other examples of points given are as follows: provision of an emergency power supply that is adequate for light, heat, food storage and preparation; preemployment medical examinations that include chest roentgenograms or tuberculin tests; and handrails on both sides of corridors and bathrooms. Additional points are given for having more nurses or nurses' aides than meet the minimum requirements of our regulations. In medical services, points are given for having an organized medical staff and for having regular medical rounds for all patients at least twice weekly.

If there is a program director for recreational, spiritual, and occupational therapy, points are given depending upon the amount of time spent on this work and the training of the program director. Points are given with regard to craft programs, religious services, special entertainment, and regular scheduling of volunteers.

It is our belief that all of these plus points stimulate better assessment of the patients' medical condition, early recognition of conditions requiring therapy, prevention of deterioration, and help to rehabilitate those who can benefit from such a program.

Patient Activity Programs

In the early days of this classification system the greatest misunderstanding arose concerning the points given for the recreational, spiritual, and occupational-therapy programs. It is difficult to judge whether such opposition arose primarily from a feeling that anything that might be pleasant was inherently sinful or from a belief that such services were frills that state agencies ought not to encourage.

Listless, apathetic men and women lying in bed or sitting dejectedly in chairs do not produce a therapeutic environment. Such conduct contributes to physiological changes with which prolonged inactivity is known to be associated: interference with optimum carbohydrate utilization, loss of appetite, anemia, loss of muscle tonicity, and absorption of calcium from the bones. The emotional state of healthy persons can adversely affect their physical condition. We thought that this effect was even more serious for disabled and chronically ill persons.

For these reasons we insisted that strong encouragement be given to programs that would motivate patients to take part in activities in their own rooms, even in bed, as well as in group activities. We encourage the use of volunteer aides in proprietary as well as nonprofit nursing homes. Everything possible must be done to get the patients interested and to reawaken their meaningful participation in the world about them. As a result of our efforts, nearly half of the nursing homes in Connecticut now have trained recreation program directors and carry on a fairly

complete round of patient activities. Most of the remaining homes have made real efforts to carry out at least a portion of these programs.

DEMERITS

Some of the problems faced by those responsible for licensing and inspection are the occasional violations of regulations which are not of a quality or magnitude to warrant legal action that would lead to revoking the nursing home license. The classification system provides demerits or minus points for such violations (Table 1).

TABLE 1.—*Examples of demerits (minus points)*

Nature of failure:	*Demerits*
Patient in nursing home 24 hours without medical orders	5
Inadequate identification record	5
Inadequate medical admission history and physical examination	10
Inadequate medical progress notes	10
Failure to report accidents	3
Failure to report change of supervising physician	3
Less than equivalent of 4 ounces orange juice per day	6
Less than equivalent of 5 ounces meat per day	6
Stained, cracked, chipped, or unclean dishes, trays, glasses	2
Improper storage or care of food	5

In setting up the classification, we consulted with interested physicians and worked closely with officers representing both the proprietary and the nonprofit nursing home groups. The classification represents a compromise between what might be considered ideal and what turned out to be a practical system for our state. Some thought was given to requiring minimum standards for each of the four classes above class E (Table 2), but this idea was strongly resisted by the nursing home representatives and was not included. We have modified the classification over the years, adding certain items and deleting others.

TABLE 2.—1966–67 CLASSES AND WELFARE RATES

Class	Points	Welfare per diem rate
A	45 or more	$10.50
B	35 to 44½	9.85
C	23 to 34½	9.05
D	13 to 22½	7.80
E	0 to 12½	7.60

CLASSIFICATION NOT PARALLEL WITH SEVERITY OF ILLNESS

Connecticut's classification system does not necessarily indicate where the most handicapped, incontinent, bedridden, or senile patients are to be found. There has been a tendency on the part of both welfare department and hospital social service workers to refer patients requiring the greatest amount of nursing and other care to the A and B homes, but these homes cannot carry on a quality program if they accept only this kind of patient. Most nursing home administrators prefer to have a wide variety of patients, including those who are ambulatory, feeling that this makes their institution a more agreeable place both for their staff and for the convalescent or chronically ill persons whom they serve. Also, in some of the semiambulatory patients complications develop which make them more dependent. Rather then transfer such persons, most administrators consider these patients part of their family and try to continue to give them care even after their disabilities advance. Therefore, one finds both very disabled and only mildly ill persons in Class A homes as well as in Class D and E homes.

Table 2 shows the current classes and welfare rates paid under our classification system. One of the results of the classification system is that the accountants who serve the rate-fixing commission now receive detailed financial reports from most of the nursing homes. These reports are used in determining reasonable rates to be paid for state and local welfare patients in these classes of nursing homes. The rates paid are of considerable importance because more than 60% of the patients are on welfare.

The incentive to reduce violations of nursing home regulations is reflected in demerits given in 1966 as contrasted with those given in 1961 (Table 3). Table 4

shows improvements in some of the services and facilities receiving at least 50% of the possible plus points that could be given under the categories listed. We are indeed pleased with the obvious improvements that were effected.

TABLE 3.—DEMERITS GIVEN, 1961 AND 1966

	Number of homes		Number of beds	
	1961	1966	1961	1966
Nursing service	30	7	1,117	365
Dietary service	10	2	636	142
Medical service	14	0	683	0

TABLE 4.—HOMES AWARDED 50 PERCENT OR MORE PLUS POINTS IN 1961 AND 1966

	Number of homes		Number of beds	
	1961	1966	1961	1966
Nursing service	23	184	5,055	9,025
Medical service	4	122	376	6,677
Recreational and occupational therapy	18	110	1,405	6,987
Physical therapy	8	52	969	509

Table 5 shows the comparison of ratings for 1961 and 1966 in Connecticut nursing homes. The differential payments in these homes has helped tremendously in bringing about improvements. Although not all improvements can be attributed solely to the classification system and the payments resulting from it, we are convinced that relatively little would have been done had it not been made possible for nursing home administrators to finance the services required for good patient care.

TABLE 5.—COMPARISON OF RATINGS, 1961 AND 1966

Class	Number of nursing homes		Number of beds in nursing homes	
	1961	1966	1961	1966
A	14	103	1,261	6,690
B	27	63	1,139	2,430
C	88	67	2,603	1,851
D	78	10	2,191	213
E	22	4	531	100
Totals	229	247	7,725	11,284

Conclusion

The Commission on Chronic Illness in its report, *Care of the Long-Term Patient*,[1] stated: "Since the people it serves are so much at its mercy, the institution which cares for long-term patients must go to great lengths to serve them in accordance with their needs." Quality of care in nursing homes is affected by both administrative and professional interests. In our award of demerits for violations of accepted minimum standards and in the giving of plus points for providing desirable services, we have helped to make it possible for conscientious nursing home administrators in Connecticut to improve considerably the kind of care which convalescent and chronically ill men and women receive in these facilities.

[1] *Chronic Illness in the United States: Care of the Long-Term Patient*, Commission on Chronic Illness, Cambridge, Mass.: Harvard University Press, 1956, vol. 2.

ITEM 2. CHARACTERISTICS OF PATIENTS AND MEDICAL CARE IN NEW HAVEN AREA NURSING HOMES

(John O. Pastore, M.D., Frederick B. Winston, M.D., Harold S. Barrett, M.D., and Franklin M. Foote, M.D.)

[Reprinted from the *New England Journal of Medicine* 279: 130-136 (July 18), 1968]

There is widespread ignorance in the medical community today concerning nursing homes—their patients, their potentialities and their special problems. Moreover, it is only in the last 15 years that anything resembling a real effort has been undertaken to lessen this ignorance. The reasons for this situation have been many and varied.

First of all, nursing homes have flourished only since 1935, when the Social Security Act made available substantial public-assistance funds for the aged. Recently published data indicate that 700,000 persons reside in "nursing homes and related facilities."[1] Another factor has been the opinion of medical personnel that nursing homes are capable of providing only shoddy care, as a consequence of this attitude patients are often inappropriately referred to homes unsuited to their needs, or are referred without adequate medical information. A third reason has been the unwillingness of nearly all medical investigators to evaluate the performance of other doctors in these homes. Thus, Haughton [2] exercised originality and courage in studying the apparent apathy of some New York doctors toward crucial laboratory information provided them free of charge on their nursing-home patients.

The main purpose of this study was to answer basic but inadequately resolved questions: What kinds of patients are cared for in nursing homes? What sort of care are they receiving? How can the homes be helped to improve their health-care services? We attempted to evaluate the interaction between the medical community (including both hospital staff and private physicians) on the one hand and the nursing homes and their patients on the other hand.

COLLECTION OF DATA

The Connecticut State Department of Health licenses 250 chronic and convalescent nursing homes that house approximately 12,000 patients. Homes are required to provide adequate nursing personnel and services as well as to see that each patient is cared for regularly by a physician. For the past seven years nursing homes have been awarded points for services available and classified on an A through E scale, with A homes receiving more money per welfare patient per day than B homes and so forth. Sixty per cent of patients in nursing homes are recipients of public assistance.

There are a total of 100 points that a nuring home may earn. Twenty-five are devoted to the nursing service and to the qualifications of registered nurses and licensed practical nurses and the ratio of nurses to patients. Seventeen points pertain to the provisions for recreational and spiritual activities and qualified directors. Thirteen points are devoted to administration, physical plant and equipment, and organized medical staff and dietary services account for eight and six points respectively. The remaining 31 points are divided among laboratory, speech-therapy, x-ray, physical-therapy, occupational-therapy and dental services. Within this point system approximately 30 per cent of the points pertain to space and equipment, including apparatus for x-ray study and electrocardiography and physical and occupational therapy, Foley catheter, intravenous sets and television and film sets. To receive an "A" rating a nursing home must earn 45 points; a "B" rating requires 35 points, and C, D, and E ratings require 23, 13 and 0 points respectively.[3]

The present study, which was undertaken during the summer of 1966, was an attempt to learn something of the medical as opposed to the administrative and nursing aspects of these homes. A 10 per cent sample of the State's nursing homes was selected—that is, 35 facilities in the New Haven area. We had the opportunity to study the medical records kept on each of the 1,422 patients in these homes. In addition, the charge nurse on each patient's floor was consulted for further information on the patient. Not every nursing home in the selected towns was included. But each patient's chart in each selected home was surveyed.

The following items used in our survey form required further elaboration:

Admitted from own home.—Most nursing homes do not record whether the patient came from his private domicile, from a rented hotel room or a boarding

References appear at end of article.

house or from some other place. We decided to include under "own home" all nonmedical institutions or habitations that served as sources of patients.

Dates transfer information received.—Only one nursing home out of the 35 recorded the date this information was *received* from the referring facility. At all other homes, we therefore had to be content with finding the date the transfer data were sent (that is, the date appearing on the transcript). Unquestionably, in many cases this date reflected the time of dictation rather than the time of mailing, but we had no way of determining the latter, more important date.

Transfer history.—Hospitals rarely send histories composed of sections on present illness, review of systems and so forth. No extended-care facilities do. We therefore accepted as a minimal transfer history a mere diagnosis. Even so, as indicated below, this low standard was not always met.

Transfer physical examination.—We accepted nearly any evidence that the patient's body had been inspected at the referring facility as a transfer physical examination. However, something besides a vital sign (usually blood pressure) had to be recorded. For example, the statements "BP-210/90, rest negative," or "heart normal" would have been acceptable. In most cases the information, where present at all, was somewhat more detailed than these samples.

Date of admission history.—The same criteria as for transfer history applied.

Date of admission physical examination.—An adequate physical examination by our definition, which was partially determined by the realities we found, had to include at least the following: a recorded blood pressure or other vital sign; mention of the head, eyes, ear *or* mouth (in some cases all were mentioned, but in most recorded adequate physical examinations, only one or two of these were noted); and mention of the heart, lungs, abdomen *and* extremities.

Current diagnosis.—The primary diagnosis was defined as the reason the patient had been admitted to the nursing home. Thus, a patient with a known cancer and a recent hip fracture would be admitted for the latter but be expected to succumb because of the former. The hip fracture would be his primary diagnosis.

Only one primary diagnosis was recorded for each patient, all his other diagnoses being recorded as secondary. Many of the doctors who see patients in these homes record their diagnoses according to highly individualized systems of nomenclature so that broad groups rather than an international classification system were used.

THE FINDINGS

Vital statistics

Although many modern homes consider themselves rehabilitation centers, they still service an almost exclusively geriatric population. The mean age of all patients was 79 years, and only 1 per cent were younger than 45. The nonwhite population was 3.3 per cent, which compares favorably with the ratio of whites to nonwhites in the older age groups in Connecticut. Two-thirds of the patients were female, and 85 per cent without a marital partner.

The average patient had been in his nursing home two years and four months at the time the survey was done. Table 1 compares our findings on length of stay with those of Solon[4] in 1954. The most striking change in Connecticut has been a doubling of the percentage of patients who have spent five or more years in their nursing homes.

TABLE 1.—DURATION OF NURSING-HOME STAY AS REPORTED BY SOLON[4] COMPARED WITH THE DURATION IN THE PRESENT STUDY

[In percent]

Year of study	Period (years) in nursing homes			
	<½	½ to 2	2 to 5	5 or more
1954 (Solon[4])	31	37	25	7
1966 (present report)	26	33	26	15

References appear at end of article.

TABLE 2.—SOURCE OF NURSING HOME PATIENTS

Class of home	Number of patients	Percentage of patients				
		Home	General hospital	Other nursing home	Mental hospital	Chronic-disease hospital
All	1,422	49.3	33.1	8.7	7.2	1.7
A	871	48.5	34.6	8.7	6.3	1.9
B	321	48.3	34.6	6.9	9.0	1.2
C	178	59.1	27.0	8.4	5.5	
D and E	52	32.8	21.1	21.1	17.3	7.7

Sources of Patients and Transfer Data

Table 2 indicates the sources of patients. Much information was gathered on the extent of transfer information sent with the patients. The nursing homes are obliged by the State to have each patient examined within 24 hours of admission unless he is referred by a medical facility that sends transfer data with him.[5] In addition, each patient is supposed to have an annual hemoglobin count and urinalysis. Many homes, when questioned about the absence of admission and laboratory data, pointed out that many of their patients were referred from general hospitals where this work and more had presumably been done. However, as demonstrated in Table 3, much of this information was never received by the nursing home.

TABLE 3.—TYPES OF TRANSFER INFORMATION AND PERCENTAGE OF PATIENTS FOR WHOM INFORMATION WAS RECEIVED, ACCORDING TO CLASS OF NURSING HOME.

Class of home	Number of patients referred from medical facility	Percentage of patients with information received by nursing home				
		History	Physical examination	Course of illness and treatment in hospital	Laboratory data	No information
A	449	64.1	16.7	59.3	19.4	34.1
B	166	72.9	19.3	74.7	18.7	23.5
C	73	58.8	27.4	57.5	27.4	35.6
D and E	35	62.9	0	60.0	0	37.1

Table 4 shows how several individual referring facilities treated nursing homes in regard to transfer information. Hospitals A and B, for instance, sent more than one third of their nursing-home referrals without any transfer data of any kind. The usual reason given for this practice was that hospitals have no control over what private physicians send with their patients. However, many patients who had been cared for by the hospital house staff only were also referred without these data. Many were taking digitalis and other potent medication, and yet no treatment orders accompanied them. In many cases new physicians were called to see the patient for the first time and could not gather from the nursing-home chart what the work-up had entailed.

TABLE 4.—TRANSFER INFORMATION SENT BY MEDICAL INSTITUTIONS TO 35 NURSING HOMES (1966)

Institution	Number of patients sent	Percentage of patients with no transfer data
A [1]	217	33
B [1]	143	40
C [2]	13	8
D [2]	17	18
E [2]	16	6
F [2]	21	24
G [3]	19	5
H [4]	94	15
K [5]	59	34
L [6]	124	44
Total transferred	723	

[1] Large general hospitals.
[2] Smaller general hospitals.
[3] Chronic-disease hospital.
[4] State mental institution.
[5] Other hospitals.
[6] Other nursing homes.

References appear at end of article.

Admission diagnoses

The admission diagnoses most frequently made were heart disease (of various kinds), senility and peripheral vascular disease (Table 5). Of these, senility was most often the reason given for the patient's being placed in the nursing home; in other words, it was the most frequent *primary* diagnosis. Stroke, with its complications, when recorded, also was often the primary diagnosis. This was not true of heart disease. Hip fractures (83 percent of which occurred in women) were not among the most frequent diagnoses made on admission, but when made, they had usually figured heavily in the decision to send patients for nursing-home care. Conversely, diabetes was present and charted in 10.9 percent of all patients but had been the main factor in the admission of only 2.2 percent. Even more striking was the fact that hypertension, although diagnosed in 12.7 percent of all patients, was the primary diagnosis in only 1.9 percent.

TABLE 5. *Most Common Diagnoses among the Nursing-Home Patients in the Present Sample*

Percentage of patients with disease as primary diagnosis:	
Senility	22.9
CVA or hemiplegia (or both)	13.2
Heart disease	12.0
Peripheral vascular disease	6.3
Hip fractures	6.1
Neoplasms	4.4
Arthritis	3.6
Psychosis	3.2
Percentage of patients with disease:	
Heart disease	34.2
Senility	33.5
Peripheral vascular disease	30.4
CVA or hemiplegia (or both)	17.7
Hypertension	12.7
Diabetes	10.9
Arthritis	9.7
Pulmonary disease	9.5

Condition of the patients

Unlike most of the preceding data, the figures given here on the condition of the patients are the result of interviews with nurses involved in the care of each patient and do not necessarily reflect the quantity or quality of information available in the medical records.

For the most part, the opinions of the charge or other nurses were accepted, and no concerted attempt was made to check their reliability. Patients were not interviewed by the investigator in any planned manner. The nurses interviewed were usually registered nurses, some with extensive general-hospital experience, and seemed to know their patients exceptionally well. Only questions concerning patients' teeth and eyeglasses seemed a serious challenge to their funds of knowledge on the large number of patients for whom each nurse was responsible.

Table 6 indicates the walking status, bed status, mental status and degree of continence among the patients in the study.

TABLE 6.—TYPES OF DISABILITY

Condition of patient	Percentage distribution				
	All homes	Class A homes	Class B homes	Class C homes	Class D and E homes
Walking status:					
Alone or with cane	44.0	45.2	40.8	39.3	59.7
With walker	10.3	12.7	7.2	3.9	11.5
Only with attendant	21.9	20.7	23.4	23.6	26.9
Does not walk	23.8	21.4	28.7	18.4	1.9
Bed status:					
Out of bed	78.2	77.5	77.6	80.5	88.4
In bed part of time	5.8	6.9	3.7	5.0	2.0
In bed most of time	16.0	15.6	18.7	14.6	9.6
Mental condition:					
Always clear	37.3	38.6	37.4	33.7	33.3
Confused part of time	27.7	27.6	27.7	28.7	26.7
Confused most of time	34.6	33.1	34.9	38.2	40.0
Unknown	.4	.7			
Continence:					
Continent	66.0	78.6	43.9	48.3	50.0
Incontinent of feces only	1.0	1.1	.9	0	2.0
Incontinent of urine only	7.4	6.8	8.4	7.3	11.5
Incontinent of both	25.6	13.4	46.7	44.4	37.5

Eighty-one percent of patients live in homes that have organized recreational activities, and half these patients (40 percent of the entire sample) participate to some extent. The majority have recreational directors, who are aided by civic-minded groups that regularly visit the homes. Programs are varied and original; the most popular include bingo and arts and crafts.

Nursing notes and services

Connecticut's nursing homes are required by the State Health Department to have the services of registered or licensed practical nurses available to the patients at all times. The Public Health Code regulates the minimum number of nurses that homes of varying size may employ. For instance, one regular or licensed practical nurse must be available for every 30 patients during the day and for every 60 patients during the early morning hours. Most of the homes in this survey employed both registered and licensed practical nurses, but it was not unusual to find only the latter at small homes.

These nurses are also required to keep their own notes on each patient. Although encouraged to do so, they are not required to record their notes every day. It was found that most homes do keep daily, and often thrice daily, nurses' notes on each patient in his chart. However, one large Class A nursing home keeps its nurses' notes on all patients chronologically in a single notebook and only records "significant" happenings. Following a patient's course over a month at this home, if the nurses' notes are used, requires searching for his name among the several listed on each of 30 to 50 pages. A very few homes keep the most recent nurses' notes in loose-leaf binders, with a page for each patient. When full, these are alphabetically arranged, taken out of the binder and placed on the corresponding patient's chart. Minor variations on these three basic methods, even among only 35 homes, are numerous.

Again, the information on nursing services was not gathered from nurses' notes but orally from each patient's nurse or nurses. A breakdown of the data according to class of nursing home is provided, and the following points are salient:

Only 7.8 per cent of patients in D and E homes received help in feeding whereas 31.2 per cent of those in B and 26.4 per cent of those in A homes received such help. The same trend holds for most other nursing services.

It is not true that a higher proportion of patients in A homes receive more nursing services than those in B homes. Indeed, except for injections, enemas, and tub baths, the reverse is nearly always the case.

It is not known how many patients in all classes of homes actually need these services, or how much each patient needs them.

An overwhelming majority of patients in each class receive medications. This point is considered in detail in the following section.

Medical care and its recording

In this study we were particularly interested in determining the extent and, as much as possible, the quality of medical care received by these nursing-home

patients. Rather than interview doctors or nurses or examine their patients, it was decided to depend on the physician's progress notes in each patient's chart.

It is apparent that the variability in methods of charting extends to physicians' admission write-up's and subsequent notes. Most homes ask that physicians use a form supplied to the nursing homes by the State Health Department. When our data indicate missing physicals, histories, or laboratory work on admission, it can generally be assumed that parts of the admission form, on which a single check is sufficient to indicate normal findings, were not completed by the admitting physician.

According to Health Department regulations, nursing-home patients should be seen by a physician within 24 hours of admission unless accompanied by transfer data from another medical facility. Because this regulation is not scrupulously adhered to, we considered, quite arbitrarily, that a history, physical examination and so on had been done on admission if it did not follow actual admission of the patient to the nursing home by more than a few months. If the work had not been done by this time, it was usually done later. "Admission history," "admission physical" and similar points are defined above.

Table 7 shows the scope of admission work-up's. For the most part, the urine studies done were determinations of protein or glucose and ketones or urine cultures. Few patients had both on admission or subsequently, and fewer still had a more detailed urinalysis (that is, microscopical examination of the sediment).

TABLE 7.—PERCENTAGES OF PATIENTS RECEIVING THE VARIOUS ELEMENTS OR A WORK-UP ON ADMISSION TO THE NURSING HOME

Elements of work-up	Percentage of patients				
	All homes	Class A homes	Class B homes	Class C homes	Class D and E homes
History	73.4	73.6	79.4	59.0	85.4
Physical examination	66.5	67.0	58.9	70.8	88.6
Urine study	30.7	33.0	21.2	37.6	24.7
Hemoglobin or hematocrit	27.4	33.8	17.4	18.0	13.8

Most patients (61.4 per cent) had been seen within the month before the survey by a physician who recorded his visit in the patient's progress notes. Thirty-two per cent had had their last recorded physician visit between one and six months before the survey. A substantial number of patients (6.6 per cent) had had no recorded visit by a physician in the last six months. However, in the event of acute illness physicians were available to see their patients.

Perusal of all available progress notes on each of these 1422 patients made it clear that the content and quality of the notes were more closely related to the custom of the physician than to the debility of the patient. Thus, one physician recorded a complete physical examination (including examination of head, eyes, ears, nose, throat, lungs, heart, abdomen and nervous system) for each of his patients—even those whose only diagnosis is senility. Another physician who (like most of these physicians) had several patients with congestive heart failure and other serious maladies, never wrote anything more than "condition unchanged" or an occasional recording of blood pressure. It was also apparent from a study of these records that the frequency of physicians' visits bore no relation to the degrees of illness of the patients. For the most part, a physician's patients were seen only on the day of his regular visit to the home (emergencies excepted), and most patients who were senile only were seen as often as much sicker, though not emergency, patients.

The State also encourages nursing homes to perform annual hemoglobin determinations and urinalyses on all patients. Well under 40 per cent of all patients had these tests recorded annually. Well under 30 per cent had had an adequate physical examination in the year before the survey.

Both nurses' and physicians' notes were searched for recorded blood-pressure measurements, since it was found that few nursing homes had nurses regularly check patients' blood pressures as is done in most general hospitals. Most nurses reported that the absence of a blood-pressure reading in the chart indicated, besides the fact that the doctor had not recorded one himself, that they had not been asked by the physician to monitor a patient's blood pressure. It is of interest, then, that 37 per cent of all patients taking cardiovascular drugs (digitalis or diuretics or both) had not had a blood pressure recorded in the year before the

survey date. Twenty per cent of all nursing-home patients surveyed were taking phenothiazines, and three fourths of these had not had a blood pressure recorded in the month before the survey. Indeed, 35 per cent of patients taking phenothiazines had not had a blood pressure recorded in the past year. A substantial number of patients were receiving two and, in one case, three different phenothiazines on a regular basis. Prochlorperazine (Compazine), nearly always given for its antiemetic effect, was never one of these "extra" phenothiazines.

As far as all medications received by patients is concerned, Figure 1 shows that whereas most regularly receive one to four medications, in some cases seven to 12 drugs to be taken regularly are prescribed.

As mentioned above, a difficulty unforeseen, but encountered in our tabulation of diagnoses, was the failure of some physicians to chart cardiac and diabetic diagnoses on patients whom they were treating for these diseases. On the charts of 25 per cent of all patients receiving digitalis or digitalis and a diuretic no diagnosis of heart disease had been entered by a physician.

It was also found that of 61 patients under treatment for diabetes mellitus, 22 had no diagnosis of diabetes on their charts. Of the seven patients being treated only with medication (insulin or oral hypoglycemic agents but no diabetic diet) five had no diagnosis of diabetes recorded by a physician.

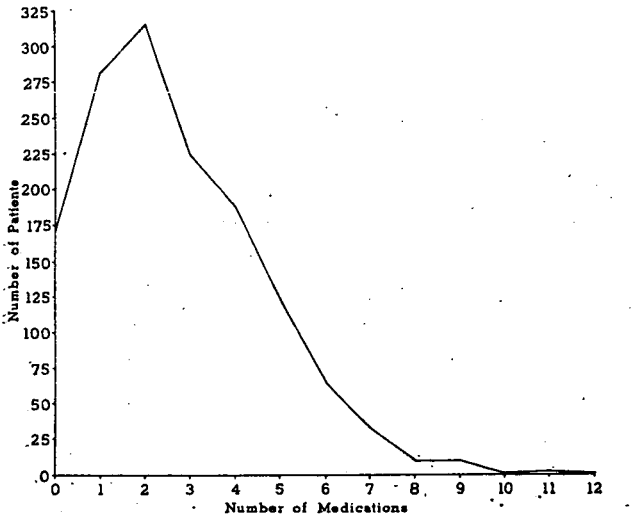

FIGURE 1. *Medications Being Taken by Patients (Excluding Those Given as Needed).*

DISCUSSION

Much has been written about the need to bring nursing homes into the main stream of modern medical care [1,6] and about nursing homes as medical facilities.[2,7] However, we found that nursing-home administrators and nurses on the one hand and the medical community on the other cling to disparate assumptions concerning the role of these homes.

An increasing number of nursing-home personnel tend to regard their task as rehabilitative. In fact, the charge nurse at a small Class B home, the only one in the study whose patients had twice-daily, monitoring of temperature, pulse and respirations despite apparent good health, complained bitterly that referring hospitals treated her nursing home as though its only functions were custodial.

Except for some of the investigators in this field, however, the opinion that *only* poor care is available in nursing homes is prevalent among doctors, even among those who treat patients in nursing homes.[8] Unlike most physicians, the investigators who have pointed to poor care practices tend to blame the patients' physicians as well as the nurses or administrators.[6]

References appear at end of article.

The medical neglect of the referred patient also appears to begin before his admission to the home. Our findings indicate that an extraordinary number of patients, some quite sick on admission, arrive at nursing homes from hospitals with neither diagnoses nor treatment orders. It is apparent that secretaries who arrange for these admissions *must* write some of this information down somewhere; suffice it to say that after an extensive search, the information was seldom found if not already charted. The importance of this transfer information will undoubtedly increase over the next several years as it becomes more apparent that some patients presently occupying hospital beds can be and should be referred to nursing homes.[9]

These and other shortcomings in the keeping of patients' charts would be irrelevant if many of the patients cared for in these homes were not quite ill. Thus, our data indicate that most patients are not merely senile but rather have diseases whose consequences, if not anticipated and promptly treated, can be disastrous. Studies in other states and countries have indicated a similar frequency of serious diseases among nursing-home patients.[10, 11] Yet nothing is usually learned from a thorough study of the chart of a hypertensive or diabetic patient about the progression of his disease. Indeed, as indicated above, the fact that he has hypertensive heart disease and congestive heart failure, for instance, may only be inferred from a single blood-pressure reading or the fact that he receives digitalis and a diuretic regularly. Likewise, the patient with uncontrolled diabetes almost invariably has minimal clinical information charted, the details of his condition being apparent only after conversation with his nurses.

As for the charting practices encouraged by some administrators, the inefficiency involved seems to spring from ignorance of good medical-record keeping rather than from the desire to cut corners. The removal of physicians' notes from the chart (even when the notes are sketchy) and the hoarding in the same charts of medication sheets accumulated over several years probably indicate the need for educating nursing-home administrators to a greater extent than has been done until now. The same discrepancy may be noted in the filing of nursing notes, doctors' notes, medication sheets and so forth, all in separate loose-leaf binders.

RECOMMENDATIONS

Given the fact that ownership of most nursing homes will continue to be private and on the basis of the data that we have gathered, a number of recommendations for the improvement of medical care in nursing homes can be offered.

In the first place, state and federal governments should study and implement plans (similar to those now undertaken in New York City [2] and Portland, Oregon [6] providing for closer affiliation of nursing homes with general hospitals and where possible with the teaching programs at university medical centers, and a system whereby physicians may see patients only in one nursing home and thus, presumably, will be able to see patients more frequently.

Secondly, in Connecticut and other states where classification systems affect nursing homes, panels of physicians should be appointed by the state agency that supervises nursing homes to investigate the possibility of medically relevant classification of nursing homes. This new system might be based on the varying degree of disability among patients, so that relatively well patients do not occupy beds in homes where sophisticated rehabilitation services are offered.

Finally, public-health codes governing nursing homes should be expanded to include the following points:

All patients being admitted to nursing homes must be accompanied by a record of history and physical examination, treatment orders and, where applicable, laboratory data.

Each patient should receive annually a complete blood count, including differential, a complete urinalysis, including microscopical examination, a chest film, a Papanicolaou smear (if female) or a prostatic examination (if male), a fasting blood sugar determination (whether or not there is a history of diabetes), a complete physical examination, including tonometry, examination of a clean-catch urine specimen for culture whenever urinalysis is positive for white cells and a rectal examination, with stool tested for blood.

An individual medical record on each patient should be kept on the ward to which he is assigned, fragmentation of the data being minimized.

Each patient should have his pulse, blood pressure and weight checked once a week.

The states should undertake the education of administrators in the elements of medical-record keeping.

References appear at end of article.

CONCLUSIONS

The typical nursing-home patient is handicapped by chronic illness and physical and mental disabilities. Examination of medical records in nursing homes in Connecticut revealed serious gaps in areas of transfer information and charting technics. Services in the field of preventive care and periodic health evaluation were limited. Patients on cardiac and psychotherapeutic drugs had inadequate follow-up studies. The nursing home is assuming a new status in medical care. Suggestions for improvements in care commensurate with this new status have been offered. The physician, the nursing home and state health departments will have to work together to help meet the standards of proper care.

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ITEM 3. LETTER FROM OTTO GOLDKAMP, M.D., PRESIDENT, CONNECTICUT SOCIETY OF PHYSICAL MEDICINE

HARTFORD, CONN., *January 21, 1970.*

DEAR SENATOR: It was a privilege to be among those interviewed in your recent Hartford hearing on "Trends in Long Term Care of the Aged." Under the pressure of time and lights there is, unfortunately, little time to debate and weigh the proposals and arguments presented which is the monumental task that undoubtedly faces you when the hearings are completed. These hearings are in the finest tradition of our system of government and with cool heads prevailing I am sure a satisfactory if not perfect system of surmounting the growing problems of our older population will result.

I write at this time to mention a few points that I neglected at the time of your hearing because on occasion I tried to confine my remarks largely to rehabilitation of the chronically ill or permanently disabled older persons. However, I should have mentioned that credit certainly deserved by the "Health Insurance Benefits Advisory Council" whose report for July 1, 1966–December 31, 1967, was published July 1969. I have reviewed this report in detail and find the committee well aware of many problems and apparently dedicated to their solution. It is unfortunate that there is so frequently a great lag between recommendations and action. Hopefully, your committee will reduce it.

The report, as complete as it is, neglects the very area upon which you have been concentrating. One of my suggestions would be that there be some dialogue

between your committee and them. But in all probability you have already anticipated this opportunity.

Also, Senator, even though I am in considerable disagreement in the way my government spends my money and the methods by which it attempts to save it, I do approve of economy, but generally such economy can be achieved through efficiency before curtailing services. Despite the righteous indignation on behalf of the elder society, there must be reasonable, intelligent and intelligible controls on services. I feel strongly that this can be done by separating our social problems from those in need of medical and nursing care. But then provision may have to be made for the social problems.

Facilities actually abound, at least in Connecticut, but skilled personnel are ever in short supply. We cannot forever add facilities without somehow planning a way to get more people into medical and paramedical services. Physical therapists (R.P.T.) are among the shortest in supply, yet many do and have proudly taken as many as 20 patients a day to treat, some even more. What I emphasize is that there must also be quality control.

In my field of rehabilitation it becomes obvious that many people are not rehabilitable, but there being no adequate control, many patients use up to $1,000.00 or more of benefits on needless treatment. Someone has to "call the turn," and it must be an informed physician.

Concerning "skilled acts," it is preposterous to say that a "skilled nurse" is necessary to feed a patient, bathe him and toilet him. We train less expensive personnel for jobs as you are aware. In fact we are in need of a whole new level of "professional helpers." Such could be trained in 3–4 months in most cases, if not less; but it is difficult to find people available from their clerical, or patient-care duties to train the aides.

Concerning the qualifications for extended care under Medicare, I can see no reason why Medicare has to give any more or less than private companies have given patients for years per premium paid—and I cannot recall a single case where there was any great difficulty with private companies concerning such coverage. A *contract* was written and spelled out specifically the privileges. "Chislers" were easily sorted out. It might be of interest to compare the experiences of Medicare and private companies and ask the carriers (who are the originators of such plans) where the difference lies.

Thank you for your time. * * *

Sincerely,

OTTO GOLDKAMP, M.D.,
President, Connecticut Society of Physical Medicine.

ITEM 4. ADDITIONAL INFORMATION SUBMITTED BY PAUL DE PREAUX, ADMINISTRATOR, AVERY NURSING HOME, AND PRESIDENT, CONNECTICUT ASSOCIATION OF NONPROFIT HOSPITALS AND HOMES FOR THE AGED.

SUMMARY OF PHILOSOPHY AND FACILITIES

Church Homes, Inc. is a non-profit, non-denominational organization located at Avery Heights on 43 acres of a rolling, wooded hillside tract off New Britain Avenue.

The "Philosophy of Church Homes" is a Christian concern for the elderly. This concern is manifested by the concept of "Total Care"—from complete independence to complete dependence with intensive nursing care, and all facets in between. There are no founders' fees or down payments at Church Homes. Rents are on a monthly or day-to-day basis, and no long-term leases are required.

Avery is a pilot project for this concept of total care. It is proving that efficiency of operation together with "heart" and dedication to the needs of the elderly (physical, psychological, religious, and personal) can result in a happier old age bolstered by the knowledge that someone "cares".

This is one of the greatest needs of the elderly—the knowledge that someone, not of their immediate family, "cares". Old age is a sad time if one feels rejected, alone, or unloved. At Avery Heights, we attempt to impart the feeling of belonging, both to the Avery family and to society as a whole.

The concept of total care must, of necessity, cover four general areas.

1. COMPLETE INDEPENDENCE

The cottages are the area where those who are completely independent reside. We have 59 cottage apartments ranging from efficiency to two bedrooms for married couples. The residents pay a nominal rent and are independent in every sense of the word. Some continue to work for wages (three in the Nursing Home); others are volunteers for church or other organizations. However, the residents are incorporated in the Avery family by the Cottage Council, a central recreation and meeting room, and involvement in functions in Avery House and the Nursing Home. They are visited regularly by the resident chaplain and attend religious services in Avery House.

2. SEMI-INDEPENDENCE

Avery House is the area of communal living. The residents are presumably completely independent but desire communal living; i.e., they do not wish to cook, clean their own rooms, etc. Sixty-one residents presently live in Avery House. If they wish, they need never leave the House, for all possible services are available—libraries, bookmobile, television lounges, beauty parlor, barber shop, laundry, community room with attached kitchen, and a full time program director, community store, non-denominational religious services, central dining room and attached snack bar. The program director, volunteers, church groups, and the women's auxiliary present musical programs, movies, travelogues, lectures, outside trips, picnics, strawberry and apple pie festivals, and programs at Easter, Thanksgiving, and Christmas. A birthday party is held monthly, and the attempt is made to involve all the residents in some area of interest in order to maintain their attachment to society.

3. PARTIAL INDEPENDENCE

The proposed Avery House addition will encompass this area primarily. It will be a "Rest Home with Nursing Supervision"; and here will reside those who are partially independent, able to take care of themselves, but who require nurses to dispense medication and supervise them. These residents will not require total nursing care, but nursing surveillance.

The idea for this new addition is that it be a "convertible building" capable of being converted overnight in sequences of thirty to a facility providing whatever is needed most for the care of the residents. The entire concept is new to the field of aging, but is a necessary innovation. Everything has been designed to be readily converted by addition of bed rails, nursing station, equipment, etc. so that we can have a flexible answer to immediate needs without excessive trouble. In this way, we will be able to care for all our residents in the areas where they need the most care at the time.

4. COMPLETE DEPENDENCE

Avery Nursing Home, with the completion of 49 additional beds for a total of 90, is the answer to our pressing needs for total nursing care. It is a small hospital, without an X-ray, laboratory, or operating room. All other facilities are located on the premises. It has been accepted by the Joint Commission on Accreditation of Hospitals; received an A–1 rating from the State Department of Health (one of only fourteen in the State); and approved for Medicare.

It is not the terminus of life at Avery, and the Nursing Home functions primarily as a rehabilitation unit. Of all discharges since its opening, 72% have been returned to their homes fit for normal living to the maximum extent of their physical and mental capabilities.

Under the Avery concept, life is not a one-way street from complete independence to the Nursing Home. Many patients who were admitted to the Nursing Home from outside the facility are now residing in Avery House. Rehabilitation, both physical and mental, is our goal, resulting in a fuller life and a more active role in society. Avery is not an insulated "Old Peoples' Home", but an active adjunct of the community.

5. SUPPLEMENTARY FUND

It is our fervent hope that no residents will ever be evicted if later they need financial assistance. Our basic fees are set to cover full costs of all care and services without a profit. We feel that philanthropy should not be utilized to support elderly persons and their responsible relatives who are perfectly capable

of bearing the full cost. However, many of our residents deplete their resources and are unable to meet the basic costs. Therefore, we are endeavoring to build a Supplemental Fund sufficient to aid these needy residents. Such a fund is now in existence, but it must be greatly increased if we are to meet our Christian responsibilities.

Much has been done, but needs increase daily and involvement is necessary. We cannot afford to cast off our history which is manifested by our residents. The average age of 85.6 speaks volumes. At Avery alone, we have over 14,000 years of accumulated knowledge and experience from which to draw. What challenge it is to utilize this experience and knowledge rather than letting it waste on the vine of uninterested, uncaring society! We are all proud of what has been done in a few short years, and we are optimistic as to what the future will bring.

BLOOMFIELD CONVALESCENT HOME, INC.,
Bloomfield, Conn., September 10, 1969.

MRS. ELEANOR B. BAIRD,
Vice-President, A.N.H.A., Region I,
Twin Pines Convalescent Home,
New Milford, Conn.

DEAR ELEANOR: Enclosed you will find 7 cases written up that were either not approved for Medicare, or suspended, or the Intermediary's decision reversed. If you make a very careful analysis of these cases you will see that the Intermediary in certain cases is denying benefits to Medicare patients before they have all the facts. And, in some cases even when they do have the facts they are still denying Medicare patients. There seems to be a discriminatory movement against our senior citizens by the Intermediaries and the Government.

I am of suspicious nature that the Intermediaries have been accused of not performing their duties in the past 2 years and now have become so strict and in doing so have not hired competent persons to carry out their programs. A very good example of this is the nurses that the Intermediary has hired to review the diagnoses and the skilled care forms have never been in the geriatrics field of nursing.

It is frustrating the amount of paper work that must be completed on each Medicare patient. We are not giving good nursing care to the patients; we are providing them with paper care only.

With this new system that the Intermediaries are using, I would like to know what functions does our U. R. Board provide now? The U. R. Board's recommendations are not being taken into consideration, the doctors diagnoses are not clearly understood by the Intermediary and the services provided by a registered nurse is no longer skilled service.

In the past few weeks it has been noted that the Intermediary has been making many administrative errors, and also much duplication. In the past couple of months we, the Providers, have been abused, harassed from doctors, the families, the patients and even the employees—let alone the cost factor that has been imposed on us which we will never be fully reimbursed for. In analyzing the situation it boils down to one primary objective and that is which Intermediary is showing the best record for disqualification of Medicare payments.

The method which the Federal Government has chosen to curtail Medicare payments is poor and distasteful. It should have been the responsibility of the Intermediary to oversee the Providers, through admissions and Utilization Review Board and the penalties should have been on the Providers that were given the free 100 days for all patients.

I would like to make these recommendations:

1. That all Medicare patients be eligible for 21 days in extended care facilities.
2. After the 21 days grace period it will be the responsibility of the extended care facility to forward to the Intermediary a hospital transfer form, a medical history (if received), and a skilled care form. This would be forwarded to the Intermediary on the 14th day of the patient's stay.
3. That all Medicare patients be reviewed by the Utilization Review committee between the 14th and the 20th day of the patient's stay.

With all this information the Intermediary and the Provider can make a fair evaluation of the patient's needs and make the decision as to whether or not the patient qualifies for Medicare benefits.

Yours truly,

NORMAN A. LAROSE,
Administrator.

Enclosures.

CASE 1

Peter ——— was admitted to Bloomfield Convalescent Home on July 29, 1969, after being at Mt. Sinai Hospital from July 24 to July 29. His admitting diagnosis was:

Cirrhosis of liver severe, ascites, hepatic decompensation.

On August 8 we sent in the admission copy along with a skilled care determination form. Travelers then sent a form letter stating that payment could be made only through the date August 12, 1969, but on the SSA–1453 admission copy under the remarks section they were "awaiting hospital summary".

On August 13 we received a phone call from Travelers requesting a copy of the transferral form from the hospital. You can see that Travelers made the decision that the patient would not be covered before all information was submitted to them. After we submitted the hospital transfer form we received form letter No. 2 stating that he was receiving skilled care.

The patient was also reviewed by the U. R. Board on August 27 and was approved.

Mr. ——— expired on September 7, 1969.

CASE 2

——— was admitted to Bloomfield Convalescent Home on August 20, 1969, after being admitted to Mount Sinai Hospital from August 14 through August 20. Her admitting diagnosis was:

Severe diabetic, post-op cataract bilateral, ASHD–AF, CHF.

On August 26 Travelers requested a skilled care form from us. On August 28 the skilled care form was submitted to Travelers as well as an interreferral form. On September 3 we received a form letter from Travelers that payment could only be made through September 4, 1969. Also, on September 28 ——— was reviewed by the utilization review committee at the Bloomfield Convalescent Home and was approved for further stay. This U.R. form was also forwarded to Travelers Insurance Co.

On September 4 upon the receipt of Travelers form letter No. 4 the doctor and the patient were notified of Traveler's decision to suspend payment effective September 4th. On September 11, a form letter No. 5 was sent to us requesting doctor's orders. On Monday, September 15, I called Travelers Insurance Co. and asked them what was going on. First they suspend payment and now they want doctor's orders. Mr. William Wieland returned my call late Monday afternoon and told me that ——— was still being covered. That decision was made after they had received our U.S. form, but no notification was sent to us that ——— was still in the home. I told him that the patient was discharged on September 4, late in the afternoon, and just before being discharged the nurse found the patient lying on the floor. We suspect that she had an insulin reaction. Mr. Wieland mentioned to me that if ——— came back to the home she would be covered.

CASE 3

——— was admitted to Bloomfield Convalescent Home on June 28, 1969, after she was discharged from Mt. Sinai Hospital, after a stay there from May 27, 1969 through June 28, 1969. Her admitting diagnosis was: Coronary—diabetic.

During her stay here we have had requests from Travelers for skilled care forms on July 3, 1969, July 25, 1969, August 19, 1969, and again on September 3, 1969. On September 9 I received in the mail a Travelers form letter No. 4 saying that payment could only be made through September 10. This determination was made prior to our submission of the recent skilled care form which was mailed on the eveining of September 8. Again, I would like to point out that Travelers is prejudging some of their cases.

After filing all these skilled care forms we did not receive one form back stating that ——— was covered.

CASE 4

——— was admitted to Bloomfield Convalescent Home on July 19, 1969, after a hospital stay from June 30, 1969 to July 19, 1969 at St. Francis Hospital. Her admitting diagnosis was:

CVA with hemiplegia; myocardial infarction; avitaminosis; hypertension with ASHD; enteritis with E. Coli infarction.

On August 6 a skilled care form was submitted to Travelers along with the interreferral form from St. Francis Hospital. On August 18 I was notified that ——— did not qualify for medicare and no payments would be made.

A phone call to Dr. ——— was made, and on the following day Dr. ——— visited his patient and called Travelers Insurance Co. He spoke with Mrs. Bosak, Travelers' R. N. After the conversation the doctor ordered a physical therapy evaluation to be done on the patient. This physical therapy evaluation was forwarded to Travelers, and on August 28 we received form letter No. 2 from Travelers that ——— was receiving skilled care.

CASE 5

——— was admitted to Bloomfield Convalescent Home on July 7, 1969 from her home. She was in the New Britain General Hospital from June 23, 1969 to July 5, 1969.

Her admitting diagnosis was: Diabetes mellitus; arthritis, probably mixed rheumatoid and osteo.

A skilled care determination was submitted with SSA–1453 admission form.

On July 22 we received notice from Travelers Insurance Co. that no payment could be made on ———, and the SSA–1453 admission copy stated "Non-covered".

A letter was sent to New Britain General Hospital authorizing them to release a medical summary on ———. We received her medical summary late in August, and her case was presented to our medical board for review on August 29.

It was the opinion of the board that ——— should have been covered under medicare. On August 28, 1969, a letter was sent to Travelers Insurance Co. informing them that her admission was justified under medicare by Dr. Schmoll.

On September 4 we received a form letter reversing their decision of July 22, 1969.

——— was able to ambulate independently to the point where she was discharged to her home on August 14, 1969. She was here 37 days.

CASE 6

John ——— was admitted to Bloomfield Convalescent Home July 9, 1969 from Mt. Sinai Hospital after being there from June 24, 1969 to July 9, 1969. His admitting diagnosis was:

Fracture acetabulum (left), contusion of bladder, ASHD old coronary.

The SSA–1453 was sent to Travelers, and a skilled care determination was sent on July 15, 1969; and on July 21, 1969, Mr. Ernstrom requested another skilled care determination form.

On July 30, 1969, Travelers requested the doctor's progress notes, which were sent to them on July 31, 1969. On August 4, 1969, we received form letter No. 2, stating that Mr. ——— was receiving skilled nursing care.

Travelers again requested a skilled care form and physical therapy notes on September 4. In reviewing the skilled care form we submitted I saw nothing on physical therapy for this patient. On September 6 we sent a skilled care form on Mr. ———, along with utilization review form and the minutes of the meeting of August 28 showing that a letter was sent to the doctor for more information. This letter to the doctor and his reply were forwarded to Travelers on September 9. I received form letter No. 4 from Travelers that payment would be terminated on September 4, 1969.

I called Mr. Charles Caleffy and asked if Travelers was prejudging this case or were they waiting for the information they had requested. After the conversation it was discovered that an error was made and that Mr. ——— would continue to be on medicare.

CASE 7

——— was admitted to Bloomfield Convalescent Home June 10, 1969, after being at St. Francis Hospital from April 17 to June 10, 1969. Her admitting diagnosis was: Chronic cholocystitis, chronic pyclonephritis, hypertension, ASHD.

We received SSA–1453 admission copy with the notation showing a possibility that Mrs. ——— would be potential custodial. On June 19 we received a request for a skilled care determination form from Travelers, and on June 20 we sent in a completed skilled care form. On June 26 we received a form from Travelers stating that she was receiving skilled nursing care. On June 10 she was approved by the utilization review board for another 2 weeks, and was to be reviewed at the next meeting.

I received a telephone call on July 17 from William Wieland that payment would be made only through July 18, 1969. Once again I started making phone calls to the doctor and family, and requested a letter from Dr. ——— that the program of

rehabilitation was made and should continue. Travelers sent another form letter on July 29, 1969 stating that skilled nursing care was being provided and the patient was covered. The patient was discharged to home on August 15, 1969. She was here 66 days.

CASE 8

M——— M——— was admitted to Bloomfield Convalescent Home on July 9, 1969 after being at Hartford Hospital from June 9, 1969 to July 9, 1969. Her admitting diagnosis was: Idiopathic (viral?) pleuropericarditis, klepsilla pneumonia.

We submitted a skilled care form to Travelers per their letter of July 17, 1969, and received a form letter No. 4 from Travelers stating that they could make payment through July 21, 1969. It was clear to us that this person needed skilled nursing care because of her medication and the amount given.

I telephoned Dr.——— to make known that Travelers was not covering Mrs. M——— after July 21. A conference call was placed between Dr.——— and Mrs. Bosak (R.N. at Travelers) and Mr. LaRose, administrator. Dr.——— explained that the medication and the amount constituted skilled care by a nurse. It was quite clear that Mrs. Bosak had not associated the medication with the diagnosis or was fully aware of the diagnosis.

Travelers reversed their decision and covered Mrs. M——— until her discharge on August 6, 1969. She was here 28 days.

CHESHIRE CONVALESCENT HOSPITAL

CASE 1

Case of Mrs. I. L.—HI 045-32-4783A—82-year-old female first admitted, CC Hospital No. 390, on July 22, 1969 from Waterbury Hospital. Diagnosis: Thrombophlebitis, left leg; duodenal ulcer; ulceration transverse colon of unknown origin; post-op resection of colon; arteriosclerotic heart disease.

Determined covered care by medicare. On August 31, patient was discharged home of own volition. On September 13, patient was readmitted at request of her physician, patient could not stay at home, required continuous medical and dietary control.

Case was resubmitted to medicare. No adverse comments, nor any requests for supportive information, were noted on the admission form nor accompanied it. In routine manner, bill was submitted for period September 13-30, end of the fiscal year. Payment was made by Travelers. Based on 100 days, benefits expired November 10, 1969, bill was submitted to medicare in the normal manner. On November 18, 1969, Travelers sent request for doctor's orders, progress notes, and hospital discharge summary. No further communication was received from Travelers after the requested information had been sent to them. The bill was not paid.

On December 22, called Travelers regarding the unpaid bill. At that time was advised by W. Wieland that due to backlog, bill had not been processed. On December 31, called Travelers again. Wieland had no information no case or on bill but promised to call back later that day. Wieland called back to advise us that the case had been denied for medical reasons, the payment made for September had been in error, that no further payment would be made in this case for the period October 1 through November 10.

CASE 2

Case of Mrs. M. F. -HI 048-19-6382B- 81-year-old female, a former patient of the Cheshire Convalescent Hospital, was readmitted from Waterbury Hospital on November 20, 1969, CC Hospital No. 400, after 13 day stay in Waterbury Hospital. Diagnosis: Post-amputation left great toe; post CVA with left hemiplegia; diabetes mellitus. Patient had been transferred to the hospital for amputation of the gangrenous toe. Admission form was returned by Travelers with notation of covered care through December 12, 1969. Patient's son filed appeal. December 15, Travelers forwarded an extension of payment covered through January 2, 1970, after a review of the medical data.

CASE 3

Case of Mrs. M. M. -HI 040-07-1407D- 87-year-old female admitted October 25, 1969 from Gaylord Sanitarium (stay there September 4, 1969-

October 25, 1969) and prior stay at St. Raphael's Hospital (June 28, 1969-September 4, 1969), CC Hospital No. 394. Diagnosis: Post-op interochanteric fracture left hip; cardiac decompensation; arteriosclerotic heart disease; gastric bleeding; old fracture right hip. Application made to medicare in normal manner; admission form never returned by Travelers. Request received for copy of discharge summary from Gaylord. Gaylord was asked to send discharge summary to us, which after repeated calling was finally received by us at the end of November, a copy was then promptly forwarded to Travelers. There was no response from Travelers, we then called after about 10 days. Were told by Travelers that they had not received discharge summary from us whereupon we sent them another copy. On December 19, 1969 we were sent an advice by Travelers, no reason given, that no payment could be made in this case.

Between the time of admission and the present, patient has had massive gastric hemorrhages, with constant follow-up in the laboratory.

REVIEW

On Thursday, January 8, 1970, we met with Mr. Gerry Enstrom and Miss Budzik, R.N. of Travelers. In addition to reviewing the above three cases with the Travelers representatives, we also reviewed their evaluation criteria so that we could be aware of what conditions might be covered.

Case No. 1.—Decision was reversed on the basis that there had been an administrative failure on the part of Travelers.

Case No. 2.—Limitation of coverage had been based on the interpretation that a diabetic patient on Ornase therapy was not unstable and therefore not eligible for coverage. If on insulin, care would be covered. After review of case, noting that all other diabetic criteria were being met, i.e., blood sugars, clinitest, acetest, and so forth, decision was reversed and coverage extended.

Case No. 3—At this point there has been no additional decision by Travelers medical staff who agreed to review this case.

ITEM 5. LETTER FROM DR. MICHAEL B. MILLER, MEDICAL DIRECTOR, WHITE PLAINS CENTER FOR NURSING CARE, WHITE PLAINS, N.Y.

MICHAEL B. MILLER, M.D.,
White Plains, N.Y., January 10, 1970.

The HONORABLE FRANK E. MOSS
Attention: Mr. VAL HALAMANDARIS

DEAR MR. HALAMANDARIS: I want to thank you for inviting me to testify before the Subcommittee on Long-Term Care, United States Senate Special Committee on Aging, in Hartford, Connecticut, January 15.

May I initially inform you your letter of December 23, 1969, did not reach my office until January 5, 1970. The delay may have been due to the Christmas mail overload.

Enclosed is a written presentation, "Phasing Out Medicare: Skilled Nursing Care Versus Custodial Care," which was presented to a medical journal for publication. It states specifically the message I wish expressed to your Subcommittee. There is no way in which I can deliver 75 copies of that long article to the Statler Hilton in Hartford. Feel free, however, to reproduce same.

Public Health Law 89-97 (Medicare) as promulgated by Congress, is a good law and is in the best interest of our chronic ill aged population. The intent of Congress was to provide continuous skilled nursing services, restorative nursing services, as well as the total complex of comprehensive rehabilitation techniques to the ill aged. As might be anticipated during the developmental phase of new medical and social legislation, problems relating to the equitable application of the law, the determination of who are the chronic ill aged and the nature of the needs of the ill aged, certainly can be expected to arise, particularly during a period of national spiraling inflation.

The spiraling costs of care, however, provide no reasonable basis for the hysterical reaction of the Social Security Administration in Washington. While spiraling costs of medical, as well as other services provided by our government is of major concern to the government and to our nation as a whole, there are other concerns which are of equal import, namely: Are the People getting what they need and deserve?

The Social Security Administration, in an attempt to curb rising costs, have over-reacted by invading the vacuum of definition of "skilled care" provided by Congress. They have instituted self-concocted definitions which in effect invalidate the Medicare Law as promulgated by Congress and the expressed wishes of the People of this country. By instituting restrictive definitions of skilled care (to be developed during my testimony), and by altering the Conditions of Participation, Extended Care Facilities, as defined in the Federal Health Insurance for the Aged pamphlet HIR-11-2-68, the Social Security Administration is effectively placing a strangle-hold on the effective development of a meaningful Medical program in this country.

One year ago the medicare patient population of our two extended care facilities in White Plains, N.Y., was approximately 40 percent of the total patient census. Today it is 5 percent of the total patient population and is in effect in the process of being phased out entirely. Many ill aged do indeed require the help Congress intended under the medicare provisions. These people, however, are currently being denied their rights under the insurance program that constitutes medicare. Denial of their rights is being accomplished by capricious, arbitrary, medically indefensible definitions of "skilled care," which deserve public study.

I would like, therefore, to address myself to the following items at the pleasure of your committee:

1. Definitions of skilled nursing care the application of those definitions by the fiscal intermediary, in this instance Aetna Life and Casualty, as described in Medicare Bulletin, ECF 144, May 22, 1969, make a mockery of clinical medicine and clinical professional nursing, and reveals a surprising lack of understanding of the practices as described. (Exhibit enclosed.)

The Social Security Administration definitions of "Custodial Care," as applied to skilled or covered services, are sufficiently obscure to place the deserving patient at a total disadvantage and deny him his rights for care under the medicare law.

2. Fiscal intermediaries, and for that matter, the Social Security Administration, employ professionals with limited prior clinical experience or training in geriatric medicine, who are essentially administrators rather than clinicians. Thus, they are unprepared conceptually to interpret the clinical needs of the aged patient. Their workmanship reflects this lack of preparedness. The patient not infrequently suffers undeservedly. A review of charts submitted to the fiscal intermediary most usually poorly documenting the patient problems, again placed the patient at a serious disadvantage with respect to his legislated rights of "covered care."

The law initially designated local physicians to determine the actual medical needs of his patient. However, the Social Security Administration and the professional staff of the fiscal intermediary have, in effect, superceded the local physician in determining the patient's rights to covered care.

3. Conditions of participation, extended care facilities, Federal Health Insurance for the Aged, described Congress' intent to use the local utilization and review committees to determine at a local level the clinical needs of the patient. In actual practice today the local attending physician and the local utilization review committee have generally been superceded by the previously untrained review committees of the fiscal intermediaries who in turn are attempting to interpret the confusing directives of the Social Security Administration emanating from Washington.

I am pleased to have the opportunity to develop in detail the findings upon which the above statements are made, and hope that the Senate subcommittee will be sufficiently moved to correct the present injustices and make into reality the great piece of sociomedical legislation which the medicare law constitutes.

Very truly yours,

MICHAEL B. MILLER, M.D., FACP.

Enclosures.

MEDICARE BULLETIN

DETERMINING COVERAGE OF CARE IN AN EXTENDED CARE FACILITY

Our Medicare Bulletin ECF-106 established a procedure for making prompt coverage determinations on extended care facility admissions involving types of care that are neither clearly covered nor excluded. The following guidelines are intended to provide greater detail regarding the factors that should be taken into account in making these determinations.

It should be clearly understood that the examples that appear in these instructions are intended to serve as basic guidelines and do not remove the judgmental factor necessary to resolve questionable cases.

Coverage of post-hospital extended care services

The medicare statute imposes the following requirements for coverage of inpatient services received by a beneficiary inpatient of an extended care facility:

1. The beneficiary must have been an inpatient of a hospital for at least 3 consecutive calendar days; and
2. The beneficiary must have been transferred to the extended care facility within 14 days after discharge from the hospital; and
3. The services must be required for treatment of a condition or conditions with respect to which the beneficiary was receiving inpatient hospital services prior to transfer to the facility or for a condition which arose while receiving extended care for treatment of a condition or conditions for which he was receiving inpatient hospital services; and
4. The condition or conditions must require skilled nursing care on a continuing basis; and
5. A physician must certify (and recertify where the services are provided over a period of time) that requirements 3 and 4 are met.

Concept of extended care

The term "extended" refers not to provision of care over an extended period, but to provision of active treatment as an *extension* of inpatient hospital care. The overall goal is to provide an alternative to hospital care for patients who still require general medical management and skilled nursing care on a continuing basis, but who do not require the constant availability of physician services ordinarily found only in the hospital setting.

All extended care facilities participating in the program are considered capable of rendering the skilled care which constitutes extended care. However, the Medicare law identifies a specific type of inpatient nursing care which will be reimbursable under the program. For this reason, personnel who review claims from ECF's should be particularly familiar with those characteristics which distinguish "extended care" from other types of inpatient nursing care.

Level of care determinations—general

There are three basic considerations in every level of care determination:

1. The individual patient's *medical* needs.
2. The specific services *required to fill* these needs.
3. The health personnel required to adequately provide these services.

Determining a patient's medical condition and the appropriate services for that condition is primarily a physician's function. Physicians should refer a hospitalized patient to an extended care facility as soon as his condition has improved or stabilized sufficiently that it requires continuous skilled services but does not require the constant availability of medical services as provided in a hospital. If questions arise regarding the propriety of some or all of the services ordered by the attending physician because the services ordered appear unusual for the type of patient involved, the case should be referred to the intermediary's medical staff or consultant.

Skilled care

Skilled *nursing care* includes components which distinguish it from *supportive care* which does not require professional health training. (1) One component is the *observation* and assessment of the *total needs* of the patient. (2) Another component is the planning, organization and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. (3) An additional component is the rendering of direct services to a patient where the ability to provide the services requires specialized training.

In evaluating whether the services required by the patient are the continuous skilled services which constitute "extended care," several basic principles must be kept in mind:

1. Since extended care represents skilled nursing care on a *continuous* basis, the need for a single skilled service—for example, intramuscular injections twice a week—would rarely justify finding that the care constitutes extended care services.
2. The classification of a particular service as skilled is based on the technical or professional health training required to effectively perform or supervise the service. For example, a patient, following instructions, can normally take oral medication. Consequently, the act of giving an oral medication to a patient who is too senile to take it himself would not be a skilled service, even when a licensed nurse gives the medication (although the *observation* and evaluation that may be required of the nursing personnel might be skilled).

3. The importance of a particular service to an individual patient does not necessarily make it a skilled service. For example, a primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubiti. If changing the patient's position is the only regular and frequent service provided, it would not be a skilled service.

4. The possibility of adverse effects from improper performance of an otherwise unskilled service—for example improper transfer of patients from bed to wheelchair—does not change it to a skilled service.

The following sections list those services commonly furnished by nursing personnel in ECF's and their usual skill classification. Any generally nonskilled service could, because of special medical complications in an individual case, require skilled performance, supervision or observation. However, the complications and special services involved should be documented by nursing notes and/or physician orders. Recording may include the observations made of physical findings, new developments in the course of the disease, the carrying out of details of treatment prescribed, and the results of the treatment.

Administration of medication.—Medications given by intravenous or intramuscular injections usually require skilled services. The frequency of injections would be particularly significant in determining whether the patient needs continuous skilled nursing care. Injections which can usually be self-administered—for example, the well-regulated diabetic who receives a daily insulin injection—do not require skilled services. Oral medications which require immediate changes in dosages because of sudden undesirable side effects or reactions should be administered to the patient and observed by licensed nurses. This is a skilled service. Where a prolonged regimen of oral drug therapy is instituted, the need for continued presence of skilled nursing personnel can be presumed only during the period in which the routine is being established and changes in dosage cannot be anticipated or accomplished by unskilled personnel.

Administration of eye drops and topical ointments (including those required following cataract surgery) is not a skilled service. In some states, institutional patients must receive all medications from licensed nurses; this fact, however, would not make the administration of oral medication a skilled service where the same type of medications are frequently prescribed for home use without skilled personnel being present.

Intravenous feeding.—See action on medications.

Levine tube and gastrostomy feedings.—These feedings must be properly prepared and administered. Supervision and observation by licensed nurses are required, thus making this procedure a skilled service.

Naso-pharyngeal aspiration.—The services and observation required for such care constitute skilled nursing care.

Colostomy or ileostomy.—Skilled service might be required during the immediate post-operative period following a newly created or revised opening. The need for such care should be documented by physician and nursing notes. General maintenance care of this condition can usually be performed by the patient himself or by a person without professional training and would not usually require skilled services.

Catheters.—Insertion or replacement of urethral catheters constitutes skilled services. Repeated catheterizations during the immediate post-operative period following abdominal surgery could, with a few other skilled services, constitute continuous skilled nursing care. Routine services in connection with indwelling bladder catheters do not constitute skilled care. Catheters used in other parts of the body, such as bile ducts, chest cavity, etc., require skilled care.

Incontinence.—General methods of treating incontinence, such as use of diapers and rubber sheets, are not skilled services. Secondary skin problems resulting from incontinence may require special treatment. Physican's orders should indicate the treatment required and should be noted in the patient's record.

Skin care.—Existence of extensive decubiti or other widespread skin disorder may necessitate skilled care. Physician's orders for treating the skin (rather than diagnosis) would be the principal indication of whether skilled care is required.

Routine prophylactic and palliative skin care, such as bathing, application of creams, etc., does not constitute skilled services. Presence of a small decubitus ulcer, rash or other relatively minor skin irritation does not generally indicate a need for skilled care.

Dressings.—Special services in connection with application of dressings involving prescription medications and aseptic technique constitute skilled services. Routine changes of dressings, particularly in non-infected post-operative or chronic conditions, generally do not require skilled services or supervision.

Plaster casts.—Special care for patients who have casts over any part of the body should be reflected in the physician's orders. Ordinarily however, the presence of a cast does not necessarily establish a need for skilled services.

Braces and similar devices.—Routine care in connection with such appliances does not constitute skilled services. Care involving training in proper use of a particular appliance should be evaluated in relation to the need for physical therapy. (See section on physical therapy.)

Heat treatments.—The therapeutic use of sun lamps, infrared lamps, diathermy and similar equipment constitutes skilled care when:

1. The service is specifically ordered by a physician as part of an active treatment regimen.
2. Observation by skilled personnel is required in order to adequately evaluate the results of the treatment and inform the physician of the patient's progress.

Routine use of such equipment for palliative and comfort purposes is not a skilled service.

Restraints.—The use of protective restraints generally does not require services of skilled personnel. This includes such devices as bed rails, soft binders and wheelchair patient supports.

Administration of medical gas.—Any regimen involving regular administration of medical gases would be instituted only upon specific physician order. The initial phases of instituting such a regimen would be skilled care. However, when such administration becomes a part of regular routine, it would not generally be considered a skilled service since patients can usually be taught to operate their own inhalation equipment.

Restorative nursing.—Restorative nursing procedures constitute skilled services when they are prescribed by a physician, are designed to restore functions which have been lost or reduced by illness or injury, and are a type whose performance requires the presence of licensed nurses. In many cases, these procedures would be an adjunct to an intensive program of physical therapy.

When a patient has attained his restoration potential, the services required to maintain him at this level generally would not constitute skilled nursing care. General supervision of exercises which have been taught to the patient would not be considered skilled services.

PHYSICAL THERAPY

Physical therapy, one aspect of restorative care, consists of the application of a complex and sophisticated group of physical modalities and therapeutic services. Physical therapy, therefore, is a skilled service. However, since the statute defines extended care as skilled nursing care on a continuing basis, provision of physical therapy only would not justify a finding that the patient requires extended care. In some situations, however, a patient whose primary need is for physical therapy will also require sufficient skilled nursing to meet the definition of extended care. The need for such supportive skilled nursing on a continuing basis may be presumed when:

1. The therapy is directed by the physician who determines the need for therapy, the capacity and tolerance of the patient, and the treatment objectives.
2. The physician, in consultation with the therapist, prescribes the specific modalities to be used and frequency of therapy services.
3. The therapy is rendered by or under the supervision of a physical therapist who meets the qualifications established by regulations; when the qualified therapist is the supervisor, he is available and on the premises of the facility while the therapy is being given, he makes regular and frequent evaluations of the patient, records findings on the patient's chart, and communicates with the physician as indicated.
4. The therapy is actively concerned with restoration of a lost or impaired function. For example, frequent physical therapy treatments in connection with a fractured back or hip or a CVA can be presumed to be directed toward restoration of lost or impaired function during the early phase—when physical therapy can be presumed to be effective. However, when the condition has stabilized, the presumption that continuing supportive skilled nursing services are required is no longer valid. Such cases must be evaluated in relation to the specific amount of skilled nursing attention required in the individual case as evidenced by physician orders and nursing notes.

IDENTIFYING PROBLEM CASES

There are some situations in which a patient's condition requires the institutional services provided by an extended care facility but does not require the type of care

which is defined as extended care. Such situations often arise where a patient needs extensive personal services due to permanent handicap or general debility and alternative living arrangements are impractical.

Cases where the primary diagnosis or the primary needs of the patient are psychiatric rather than medical represent an important segment of problem cases. The Medicare statute prohibits an institution which is primarily engaged in treating psychiatric disorders from participating as an ECF since only active psychiatric treatment is intended to be covered by Medicare in institutions. This type of active psychiatric treatment requires considerably more sophisticated nursing techniques and physician attention than are available in any but very unusual ECF's. Therefore, the type of mental condition which could be adequately handled in the usual ECF would be one which requires only a supportive environment that does not involve continuous skilled services. (Where the patient who is suffering from mental illness needs the types of services which constitute "extended care," the need would normally occur because the mental condition was secondary to another more acute medical disorder.) Where a patient is transferred to an ECF from a psychiatric hospital, the normal presumption would be that the primary need was for noncovered care unless evidence revealed the presence of an acute medical condition requiring continuous skilled nursing services as described in these guidelines or the provision of a high degree of psychiatric nursing services which require specialized training beyond the usual professional nursing curriculum.

NOTE.—When any of the following circumstances exist there must be evidence that continuous skilled nursing service is also concurrently required and received:

1. The primary service is one or more of the following:
(*a*) Oral medication.
(*b*) Skin care to prevent decubiti.
(*c*) Restraints.
(*d*) Frequent laboratory tests.
2. The patient is capable of independent ambulation, dressing, feeding and hygeine.
3. The patient has outside privileges.
4. The stay is for uncomplicated post-cataract surgery convalescence.
5. The diagnosis shown is not of a type which is sufficiently specific to indicate skilled treatment regimen, i.e., the diagnosis is chronic brain syndrome, senility arteriosclerosis, "old" CVA, et cetera.
6. The patient had been confined in a hospital or ECF between 60–90 days prior to the qualifying hospital stay for this admission.
7. The patient had been confined in a hospital for 60 days or longer before admitted to your ECF.
8. The patient was admitted to your ECF after only 3, 4 or 5 days confinement in a hospital.

PHYSICAL THERAPY SERVICES

A. *Introduction*

It appears that the program may be receiving bills for services which do not constitute Physical Therapy as defined for purposes of the Medicare low.

The following paragraphs were taken from a SSA directive which defines the conditions under which Physical Therapy must be furnished in order for reimbursement to be made. It further distinguishes other types of restorative and maintenance services which are not reimbursable as Physical Therapy services.

Restorative care, of which physical therapy is one major aspect, is composed of a wide range of services. Some restorative care services consist of routinely assisting the bedfast patient to change positions on a regular basis. Other types of restorative care may involve specialized equipment or be of such complexity that in order to assure the effectiveness of the treatment or the safety of the patient this treatment must be rendered by a qualified therapist. Within this range a distinction must be made, for Medicare purposes, between those services which constitute an appropriate part of restorative nursing care and those services which would properly constitute physical therapy. An additional distinction must also be made between those rountine services which may be performed by other personnel under the general instruction of the qualified physical therapist and physical therapy services which must be furnished by or under the supervision of the qualified therapist in order to assure the safety of the patient and the effectiveness of the treatment (see C. 2).

B. *Restorative Nursing Care*

In line with the concept of inpatient care, the conditions of participation for hospitals and extended care facilities require that an active program of nursing care be pursued with the goal of assisting each patient to achieve and maintian his highest level of self care and independence. *Restorative nursing care* would *include such measures* as *maintaining good body alignment* and *proper positioning* of *bedfast patients, keeping patients active* and *out of bed* in accordance with physicians' orders, and *developing patients' dependence in activities* of *daily living* by *teaching self care, transfer* and *ambulation activities*. In addition, nursing personnel should assist patients in adjusting to their disabilities, in practicing the use of prosthetic devices, and in carrying out prescribed physical therapy exercises between visits of the physical therapist. Restorative nursing procedures performed by licensed nurses constitute a part of skilled nursing care when they are prescribed by a physician and are designed to restore functions which have been lost or reduced by illness or injury. In many cases, these procedures will be an adjunct to an intensive program of physical therapy. Generally, it is expected that in the inpatient setting the types of routine exercises and other related services used to maintain function will be performed by nursing personnel under the supervision of a licensed nurse. The rendition of both restorative and maitenance nursing procedures is an appropriate use of nursing personnel and, assuming the patient requires continuous skilled nursing care, will be reimbursed as a part of routine nursing care.

C. *Physical Therapy Services*

In addition to restorative nursing care, some providers may furnish a sophisticated level of certain specialized therapeutic and restorative disciplines such as physical therapy. Based on the comments we have received, there seem to be three main areas of misunderstanding regarding these services.

1. First, there has been some question as to the role of the physician. When physical therapy services are provided, they must be rendered according to the written orders of a physician. Within this context it must be emphasized that physical therapy is reimbursable under the Medicare program only when it is directly related to the active treatment regimen designed by the physician to restore the patient's level of function which has been lost or reduced by reason of injury or illness. Consequently, the level of services contemplated by the Medicare program as constituting physical therapy services requires the direction of a physican to determine the need for therapy, the acpacity and tolerance of the patient, and the treatment objectives. Thus, in order for physical therapy services to be reimbursable under Medicare, the physician, in consultation with the physical therapist, must prescribe (that is, authorize in writing) the specific modalities to be used by the therapist and the frequency of the therapy services which are a part of his total care of the patient. Without this involvement, coordination between the physical therapy services and other skilled services required by the patient cannot be assured. It should be noted at this point that an order for "physical therapy as needed," or a similarly worded blanket authorization, does not satisfy the requirement for physician direction since, in such cases where no specific treatment is named by the physician, the physical therapist would be, in effect, prescribing the patient's regimen.

2. The second area of apparent misunderstanding relates to the use of supportive personnel. Under the Medicare program, physical therapy must be rendered by or under the *supervision* of a physical therapist who meets the qualifications established by regulations. The determination of how much supervision is needed will, of course, depend on the training and experience of the supportive personnel. However, the essence of the requirement that physical therapy be rendered by or under the supervision of a person who meets certain specified qualifications is a recognition of the technical and specialized aspects of physical therapy services. Therefore, whenever physical therapy is rendered by a person who does not meet these qualifications, the concept of supervision implies that the qualified therapist can be quickly available to handle any emergency which may arise during treatment or to provide the skilled assistance and knowledge which the physical therapy aide or assistant may require due to, for example, a change in the patient's condition since the last physical therapy treatment. Supervision by the physical therapist must also involve regular and frequent evaluation of the patient, the findings of which are recorded on the patient's record, discussed with the physical therapy aide or assistant, and, where significant, promptly relayed to the physician. Since the types of routine exercises and other related services used to maintain function and prevent deterioration are appropriately performed by nursing personnel, it is expected that physical therapy will con-

stitute primarily those services involving a complex and sophisticated level of modalities. Consequently, whenever physical therapy services are rendered by persons other than qualified physical therapists, it is expected that the level of service rendered will necessitate the premises of the inpatient facility.

3. In addition to the actual treatment of patients, providers of services may utilize the professional knowledge of physical therapists by including them on utilization review committees, advisory groups, and in other consultative capacities. The prorated share of the cost incurred for such administrative or consultative services is properly included as an allowable cost in determining the provider's reimbursement.

ITEM 6. ST. JOSEPH'S MANOR, 1969 HEALTH SERVICES REPORT, SUBMITTED BY MOTHER M. BERNADETTE DE LOURDES, O. CARM., TRUMBULL, CONN.

BOARD OF DIRECTORS

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Michael A. Dean, M.D.
John J. Lawrence, M.D.
Mr. Paul A. Deegan
Mr. David Goldstein

HEALTH RELATED PERSONNEL

Registered nurses, 45; licensed practical nurses, 17; nurses' aides, 58; physical therapist, 1; physical therapy aide, 1; occupational therapist, 1; creative activity assistants, 5; speech therapist, 1.

FOOD SERVICE

Consultant dietician, 1; chefs, 3; pastry chef, 1; chefs helpers, 9; clerical secretary, 1.

DIETARY AIDES

Floors, 16; main dining room, 10; other dining rooms, 3; bus boys, 8; coffee shop, 1.

HOUSEKEEPING SERVICES

Supervisors, 3; general aides, 12; porters, 16; seamstresses, 2; laundry manager and aides, 9.

ADMINISTRATION

Bookkeeping assistants, 2; medical secretary, 1; medical clerk, 1; switchboard operators, 2.

MAINTENANCE

Maintenance men, 6; security guards, 3; beauticians, 2.

SOCIAL SERVICE

Bed capacity: Rest home with nursing supervision section, 85; skilled nursing care section, 90; extended care facility section, 71; chronic disease hosptial section, 39.

Total application during 1969, 360.

Total applications received as of December 31, 1969, 4,434.
Number of residents cared for to date, 885.
Admissions during 1969, 66.
Deaths occurring in 1969, 53.
Returned to other living arrangements, 10.
Transferred to mental hospital, none.
Transferred to general hospital, 54.
Readmitted to Manor from mental hospital, none.
Readmitted to Manor from general hospital, 48.
Average length of stay in general hospitals, 12 days.

AGE DISTRIBUTION OF RESIDENTS

	Women	Men
65 to 69	5	1
70 to 79	82	17
80 to 89	124	26
90 to 99	23	1
100 plus	1	0

Note.—Average age of residents at St. Joseph's Manor as of Dec. 31, 1969, 81.8.

DIETARY SERVICES

	Seating capacity	Tray service
First floor main dining room	205	
Skilled nursing care section dining room	25	31
Extended care facility section dining room	21	19
Chronic disease hospital section dining room	25	7

Therapeutic diets: Regular, 193; low fat, 16; low salt, 34; diabetic, 16; bland, 15; low calorie, 5; high protein 3.

HEALTH SERVICES

Physicians visits, 3,243; dental services, 1,055; podiatry services, 794; otolaryngology services, 4; ophthalmology services, 259; surgical consultations, 67; psychiatric consultations, 5 plus; orthopedic consultations, 52; dermatology consultations, 3 plus; gynocology consultations, 3; urology consultations, 1 plus.
Employees physicals, 212.

DIAGNOSTIC SERVICES

X-ray services:	
Routine P/A chest	460
Flat plate of abdomen	57
Hips	53
Pelvis	8
Skull	10
Lumbar sacral	28
Wrist	9
Ankle or foot	14
Shoulder	17
Ribs	3
Knee	12
Barium enemas	17
Gall bladder series	6
Elbow	1
Femur	10
Cervical	3
Thoracic	4
I.V.P	0
Upper G.I. series	17
Subtotal	731
Employees' Routine P/A chest	268
Total	999
Electrocardiograms	168

LABORATORY SERVICES

Type of Test	*Number of Tests*
Urinalysis	665
Blood urea nitrogen	96
Fasting blood sugars	300
White blood cell counts	14
Red blood cell counts	4
Hemoglobins	554
Hematocrits	336
Complete blood counts	215
Prothrombin time	81
Clotting time	7
Bleeding time	1
Differential slide	1
Sedimentation rate	1
Platelets count	32
Reticulocyte count	14
Stool Guaiac test	28
Routine cultures	16
Antibiotic Sensitivity tests	16
Indices	1
Subtotal	2, 379
Tests sent to St. Vincent's Hospital	146
Total	2, 520
Laboratory tests done as part of employees' annual physical	560

REHABILITATION SERVICES

Hearing tests	114
Inhalation therapy:	
Vital capacity	73
Sputum culture	38
Postural drainage	2
I.P.P.B	55
Electronic nebulizer	552
De Vilbiss	194
Tine test	4
Breathing exercises	81
	243
Total	1, 242
Clinic visits	190
Occupational therapy:	
Eye and hand activities	70
Range of motion	181
Activities of daily living	6
P.N.F. exercises	55
Grasp and strength	139
Motivation	16
Splints	3
Adapted equipment	6
Evaluations	22
Total	498
Physical therapy:	
Whirlpool	620
Hot packs	1, 105
Range of motion and progressive resistive exercise	2, 426
Tilt table	48
Restorator	759
Ultra-sound	93
Ambulation	2, 556
Parafin bath	83
Traction	8

Pulleys	1,208
Diathermy	51
Total	8,957
Clinical consultations by the physiatrist	326
Remotivation:	
Residents actively involved in sessions	234
Staff remotivators	15
Speech therapy: Treatments	291

RECREATIVE THERAPEUTIC ACTIVITIES

	Attendance	Annual total
Daily:		
Creative activities	310	16,200
Bedside handcrafts	15	963
Art instructions	2	524
Library committee	11	493
Biweekly:		
Recreation program for persons with chronic brain syndrome	22	1,144
Recreation program for mildly disoriented persons	33	1,716
Ceramics	12	624
Weekly:		
Bingo	52	2,604
Glee club	15	728
Music appreciation	25	1,300
Creative drama (as of June 1969)	5	225
Adult education	43	2,326
Bus trips to shopping center	20	1,000
Exercise class (as of Oct. 1969)	28	336
Bimonthly: Movies and outside entertainments		14,836
Monthly:		
Birthday parties		324
Special educational programs		1,285
Program committee		120
Card parties		315
Occasional:		
Travelogs		428
Resident entertainments		739
Special activity trips		443
Picnics		457
Community service projects		2,340
Holiday parties		1,500
REACT (residents encourage active concern today) as of Dec. 1969		52

VOLUNTEERS

	Number of persons	Hours of service
Junior: Carmelettes	85	16,821
Senior:		
Laurel Ladies	49	5,628
Gray Ladies	12	873
Nutmeggers	9	2,018

League of St. Joseph's Manor:	
Life members	19
Regular members	280
Total	390

Appendix 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM HAROLD GLICKLIN, R.P.T., PRESIDENT, CONNECTICUT CHAPTER

Dear SENATOR MOSS: As a representative of the Connecticut Chapter of the American Physical Therapy Association, I would like to make the following comments in answer to statements made by Otto Goldkamp, M.D., at the hearing in Hartford, Connecticut, January 15, 1970, on "Trends in Long-Term Care."

1. Physical Therapists are well trained, professional people with the necessary educational and licensure requirements to permit them to treat disabled patients in a competent manner. The fact that many physicians trust the judgement of a physical therapist when planning a treatment program is an acknowledgement that the training, experience and ethical values of the therapist warrants this trust.

2. When consultation by more highly trained specialists is required, attending physicians have no qualms about seeking the needed advice. However, for the great majority of those patients needing physical therapy, the shared knowledge of the attending physician and the therapist is usually adequate for the insurance of proper care.

3. If "costly hours and months of physical therapy and rehabilitation are wasted" it is not usually because the attending physician or therapist lacks understanding or medical knowledge. There probably are some practitioners who allow financial considerations to bend their ethics and this occurs in all vocations and all medical specialties and I support any program that would minimize moral and ethical abuses. However, giving any specialized medical group mandatory consultation authority over their fellow physicians would be a disruption of traditional patient-physician relationships, would not guarantee any significant alteration of treatment procedures, and would probably be more costly to the insurors in the long run.

4. The stringent review procedures now being used by fiscal intermediaries to reduce the number of ineligible patients receiving medicare benefits in extended care facilities have already had significant effects. Unfortunately, a number of worthy patients have also been denied service, due in large part to unqualified personnel determining eligibility for rehabilitation service. The use of rehabilitation specialists by the fiscal intermediaries to assist in determining eligibility for service should favorably affect future determinations.

5. The statement made by Dr. Goldkamp that "physical therapists are avoiding Medicare patients because of a lack of medical direction" is absolutely untrue. In recent months fiscal intermediaries have arbitrarily reduced their allowance of fees for services, and have refused to covere the costs of fees in many cases. This may encourage therapists to avoid medicare patients.

I appreciate the privilege of being able to express the above views and I hope they will be helpful to your research.

Respectfully yours,

HAROLD GLICKLIN, R.P.T.,
President, Connecticut Chapter.

ITEM 2. STATEMENT FROM EDUARD C. BRANDT, WEST HARTFORD, CONN.

The subject matter which I am about to present relates to needed Amendments to HEW in this 91st Session of Congress, providing in part: nursing services—daye care centers—financial assistance—and a new concept of housing for families of senior citizens where a mother or spouse suffers from prolonged chronic disease, and, in the respect of my proposals, and receiving under the practical application of the law, *zero* benefits.

I. DEFINITIONS

1. *Chronic sickness.*—A malady or disease which has afflicted a Senior Citizen for a consecutive prior period of 6 months, with total disability, requiring custodial and/or nursing care.
2. *Eligibility.*—All diseased and totally disabled American Citizens over age 65 suffering from chronic sickness, including those not covered but a spouse or parent of a covered person, under HEW.
3. *Nurse.*—Any individual performing required nursing care of a Senior Citizen as attested to by a physician.
4. *Family housing.*—New apartment units restricted to families caring for a Senior Citizen suffering chronic disease and/or requiring nursing care, excluding mental and contagious ailments.
4. *Family housing.*—New aprtment units restricted to families caring for a Senior Citizen suffering chronic disease and/or requiring nursing care, excluding mental and contagious ailments
5. *New major medical insurance programs.*—To be superimposed coverage on 80% co-insurance basis commencing at age 65.

II. RECOMMENDATIONS

A. *Nursing Care.*

That nursing care for the elderly be defined as care, including registered nurse, visiting nurse, "custodial care", nurse's aide, etc. for a sick person, performed by any person other than spouse, authorized and attested to by the sick person's physician or Christian Science Practitioner, in any location of residence where the patient is cared for, and be reimbursed under provisions of Medicare.

B. *Nursing Corps.*

Utilizing the services of thousands of men and women, an entirely new Federally-sponsored national nursing organization be created and named NATIONAL HEALTH NURSING CORPS, to be a division of HEW, who can be employed for custodial care for Senior Citizens chronically sick, in their homes or any other place.

C. *Monthly Payments.*

Monthly income benefits payable under Social Security to Senior Citizens with chronic sickness to commence after 6 months of continuous disability and be payable as long as the Insured is disabled, even for life. The first six months of withholding shall be paid in one payment including the seventh monthly payment.

The amount of Social Security payment shall be the actuarial equivalent of early retirement for one person. No monthly payment shall be withheld because the working spouse of the diseased invalid has earned monthly or annual income in excess of the disqualified amount for himself prior to age 72. No payment shall be withheld because the diseased spouse has no benefit credits for self under Social Security. All medical costs for a given month shall be deducted as an income test for meeting Social Security benefits of the non-disabled spouse.

D. Major medical or catastrophic insurance coverage

The adoption of supplementary Senior Citizen co-insurance program to pay 80% of all medical expenses not covered under any other provision of the HEW Act or Amendments. These Major Medical expenses to include hospital, convalescent home, doctors, dental, eye, nursing and custodial care and prescribe supplies as defined in these Amendments—wherever performed.

E. Family housing for chronically sick

a. *Pilot Program.*—A separate department of housing to create house facilities to provide "day-care", custodial, medical, dental, and emergency hospitalization requirements for a diseased spouse, parent or grandparent living with the family.

These provisions to enable the supporting spouse or family member to be free to engage in outside employment. Apartments to be rented at an appropriate rental. There be an immediate appropriation of $10,000,000.00 to finance research of special design requirements and fireproof construction—an entirely new concept—of a high rise *pilot* home project to embody the projected care and recreational facilities indoors and outdoors. Applications by eligible tenants to be processed through nearest HEW office.

b. *Additional Housing.*—To be constructed under the authority of this Act as needed in each State and in conjunction with State Government. That the cose of each unit be financed by such Federal guarantees as may be required under teh authority of this Amendment, including issuance of bonds secured and unsecurety

c. *HEW Real Estate Department.*—This Department be established immediated. with authority to approve layout, acquire sites and building designs for suitabll apartments and facilities to fulfill the objectives of these Amendments, management and rental.

New amendments will:

1. Provide Social Security monthly income payments to a diseased spouse irrespective of any individual coverage credits or the amount of monthly earnings of the other spouse prior to age 72.

2. Provide nursing care under the creation and sponsorship of an entirely new national nursing organization.

3. Construct housing with "day care" centers, emergency hospital service, recreation, shops, indoor and outdoor enjoyment through an entirely new plan of housing restricted to families of Senior Citizens with a spouse or parent chronically diseased and requiring custodial care, in order that the supporting spouse can engage in gainful employment.

4. Provide directives for housing, research, selection—the vehicle for financing a site and construction cost and rental term of apartments.

5. Provide a new insurance program embodying catastrophic coverage similar to that in most businesses on a co-insurance basis.

In brief, herein lies the immeasurable opportunity for Congress to adopt an entirely new concept of a co-operative living venture on a co-operative payment basis for the Senior Citizens supporting a diseased spouse, and to relieve unbearable burdens of elderly families—the millions now excluded from Federal, State, City, or any outside aid.

Thank you for listening to my plea for Amendments to the HEW Act.

ITEM 3. STATEMENTS FROM MONROE H. PALMER, BUSINESS AGENT, NORWICH HOSPITAL EMPLOYEES UNION, AFL-CIO

Senator Moss, members of the committee, there are problems within the Convalescent Hospital Industry that cannot be easily set aside.

The criteria set by the Federal Government that a patient require "skilled nursing care" in order to be covered by Medicare is many times detrimental to the patients. Speaking for many non-professional nursing employees (nurse's aides and orderlies) it is our feeling that skilled nursing care is essential to the critically ill and those making a recovery, but many times those far removed from the actual work area do not understand the needs of the patient.

Indeed, it seems that there are times when those administering the hospitals do not understand the patients needs. Here in Connecticut, our Public Health Code sets certain requirements for staffing these homes.

As an example let's take a hospital with 120 beds: From 7 a.m. to 3 p.m. there must be a registered or licensed practical nurse for every 30 patients; from 3 p.m. to 11 p.m. there must be a registered or licensed practical nurse for every 45 patients; from 11 p.m. to 7 a.m. there must be a registered or licensed practical nurse for every 60 patients.

These are the absolute minimums necessary to provide "Skilled nursing care", I emphasize the word "minimum".

In addition to the above there must be additional nursing aides so that there will be a minimum of one attendant for every 10 patients on the day shift, one for every 15 patients on the evening shift and one for every 20 patients on the night shift. These nursing aides provide the "Non-skilled nursing care". They are the ones who do the washing, the dressing, the feeding, and dozens of other

small items that speed the patients recovery. Do you realize the boost to a persons spirits if their hair is combed or their finger nails cleaned, especially if that patient is a woman, even more so if she is elderly and was raised at a time when these small items were a mark of respectability?

Truly, recovery is more than restoring the body. It is also restoring the dignity of the patient. That is where the nursing aide and orderly come into the most important phase of their work.

Yet, in many cases they are prevented from providing this essential service by the desire of the employer to cut cost and improve profit.

No detailed plan of training exist for these people. They are told to "follow another aide for a day" and then put on their own. Because there is no training, skills take an extremely long time in developing, and this supports the concept of paying low wages.

The low wages, coupled with the lack of dignity that is felt by the aides, and the frustration of not being able to provide the services cause an outrageous turnover in personnel and an accute shortage of people in this classification.

Viewed in terms of one hospital it may not look serious, but when one realizes that this is the third largest industry in the United States it becomes critical.

The elderly, simply because they are advanced in years, need care and it is our hope that the Government will make adjustments that will benefit them not simply lower the standards, but assure that they will receive treatment that will restore their bodies and lift their spirits.

Thank you for your time and consideration.

Appendix 3

STATEMENTS FROM THE HEARING AUDIENCE

During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read:

Dear Senator Moss: If there had been time for everyone to speak at the hearing in Hartford, Connecticut, January 15, 1970, on "Trends in Long-Term Care," I would have said:

(The committee received the following responses:)

CLAIRE BARONE, R.N., EAST HARTFORD, CONN.

As a public health nurse with many years experience, I feel present medical policies for screening patients is excellent, particularly in reference to the criteria for b_{12} injections. This medication is so often used for placebo effect over a period of many years.

I also feel congratulations are in order to the committee establishing rules for screening patients for baths. The individual independence of the patients and the families ability to cooperate are greatly undermined by continued bathing of patients capable of partial or total self-care.

It is unfortunate that so many people feel that they should depend upon public funds to provide what they can do for themselves just because such funds are available to abuse.

JOSEPH H. CHRISTOPH, MANCHESTER, CONN.

That I wished to call attention to the fact that there is another very serious condition existing in the present medicare program which is depriving our elderly citizens of money that they as a group are least able to afford.

I refer to hearings on disputed claims. You are permitted to have an impartial hearing to be conducted by an impartial person serving as hearing officer—now get this—the person selected can and usually is an employee of the insurance company. So how can you get an impartial hearing? Now here is the clincher—"There is no provision in the law for judicial review of hearing decisions." Well if that isn't a fine situation—first you can't get a hearing officer other than an employee of the insurance and then you can't even go into court and get a review of the decision. Where is the justice in this situation?

MRS. NANCY L. GLICKLIN, WESTPORT, CONN.

(1) The criteria for admission to extended care facilities should allow for those who need convalescent or protective custody, even if skilled nursing care or rehabilitation is not a necessity.

(2) The long-term patients who are unrehabilitatable or senile are the ones whose families suffer most financially and need the most help in paying for nursing home costs.

(3) The public is generally unaware of the true meaning of the official requirements for nursing home services. Those who have been rejected for payment feel that they have been misled.

(4) The establishment of extended care facilities by "nonprofit" agencies should be encouraged. A nonprofit institution should be less likely to short-change the sick and senile in food and services. (No nursing home owner would admit to the lengths they go to save pennies.)

HARTFORD, CONN.,
AUGUST 26, 1969.

CONNECTICUT GENERAL LIFE INSURANCE CO.,
Medicare Claim Office, Meriden, Conn.

Reference: Health Insurance Claim Number 046-05-2773B for Katherine Krause

GENTLEMEN: I, as the husband, am writing in behalf of my wife, Katherine Krause who is still in the hospital and unable to write. Your last checks in the amounts of $155.60 and $324.80, also the notice of May 5, 1969 informing my wife about the reduced rates, have been received. A protest is being made herewith about the reduction and a complaint about the delay of handling claims. Why does it take 3 months to settle a claim? I visited your office protesting about the delay and also wrote a reminder later and still it took 3 months. Already on previous claims I had to write several times requesting settlements. A private insurance company pays within 2 to 3 weeks. If we don't pay our $4.00 a month premium on time, you will drop us immediately and if we don't pay our Federal Taxes on time, we will get fined with interest charges, but are not allowed to charge you interest on overdue payments.

The reductions you made from $10.00 a visit to $6.00 for services rendered in the hospital by Dr. Frederick Nichols are being disputed. You seem to put it on the same basis as Medic-Aid which it is not. Dr. Nichols' charges of $10.00 a hospital visit is a reasonable charge in this area and was paid by you up to this reduction. Other doctors in this area are charging the same amount. The Government Medicare Handbook issued in May 1968 by the Department of Health, Education and Welfare states that under Medicare B reasonable charges are covered by this insurance. What right do you have to reduce this charge.

The reduction you applied makes the Medicare B a very expensive insurance. An insurer pays $4.00 a month which is duplicated by the Government with the same amount making it $96.00 premium per year. The Government having no money, pays these $4.00 out of other taxes including ours. If the doctor would charge $10.00 every day for one year his bill would be $3650.00. You would deduct $50.00 and pay 80% on $3600.00, meaning $2800.00. At $96.00 premium an insured person would recieve $30.00 insurance payment for $1.00 premium. At the reduced rate of $6.00 a visit, an insured person would only receive $1712.00 in a year, a ratio of $17.83 insurance payments for $1.00 premium. The ratio will change to $35.66 insurance payments for $1.00 premium when only figuring $48.00 yearly premium the insured person pays. The private insurance company, CMS over 65, Plan "A" pays a maximum of $2500.00 per year for a premium of $55.80, in other words, $44.80 insured money for $1.00 premium. You seem to make it harder on people with prolonged illness instead of being of help.

By reducing the doctor's visit to $6.00 my wife not only received less money from the Government, she also received less from CMS as they pay for the 20% co-insurance deduction.

It is very unfortunate that my wife contracted this rare illness and is in the hospital for over two years. Fortunately, she is improving.

New claims will be mailed to you shortly and we expect full payment according to the book the Government issued.

If no satisfactory answer is forthcoming, I not only shall contact our Senators or Representatives, I shall also contact the Department of Health, Education and Welfare. I delayed this letter just as you delay claims.

Very truly yours,

WILLIAM E. KRAUSE.

CONNECTICUT GENERAL LIFE INSURANCE CO.,
September 11, 1969.

DEAR MR. KRAUSE: Upon receipt of your letter of August 26th, your wife's file was referred to me for review. I have contacted the Hartford Hospital Utilization Committee for information regarding this case. They have advised me that they will discuss this case at their next meeting.

I also feel it will be necessary for us to refer this case to the Hartford County Medical Society Review Committee for a determination of the medical necessity of daily visits by Dr. Nichols for management of such a lengthy case. This will help us to determine the liability of the Medicare Program to pay for these visits.

If you feel that you should like to contact any Senator, Representative, or the Department of Health, Education, and Welfare, please feel free to do so. This case might well serve as a good example to them in evaluating why the cost of the Medicare Program is so high.

We will be unable to make any further allowance regarding this claim or any subsequent claims until a decision has been reached regarding our liability in this matter. We will contact you regarding this matter as soon as a decision has been reached.

Thank you for calling this to our attention and for your interest in the Medicare Program.

Sincerely,

E. STUART MCCLEARY,
Assistant Medical Director.

MISS MARJORIE TOLAND, WETHERSFIELD, CONN.

As representative from the Council on Medical and Health Services of the Northern and Southern Connecticut chapters of the National Association of Social Workers that we are in general in agreement with many of the comments and suggestions for changes in the Medicare program as presented at the Subcommittee on Long Term Care of the Senate Special Committee on Aging in Hartford on January 15, 1970.

However, as there was little said of the interest in and concern that social services be available throughout the Medicare program, including the extensive care facilities, we express our grave concern about the inadequacy of this service. Elderly people, as do people of all ages, experience many personal, emotional, family and social problems which doctors, nurses, recreational workers while frequently concerned, are not prepared to handle. Many of the existing programs focus on the physical needs of the ill person and do not offer services to meet the social and environmental needs.

Individuals in extended care facilities, and their relatives, if appropriate should have the opportunity to discuss fully their situation, future plans and be aware of alternative courses of action with the assistance of a trained and skilled social worker.

The way in which plans are made for the continuum of care affects for good or ill, the elderly person who is hospitalized, transferred to an extended care unit, transferred to a convalescent facility, transferred to his home, etc. depending upon what understanding and help his is given through his various experiences and the opportunity he, as a person of integrity and dignity, is given to understand and share in the planning.

For example, it is to be hoped that more consideration can be given with the assistance of the Medicare program in considering with other Federal Programs the important alternative of the individual remaining in his own home as much as possible throughout his illness and disability. This would be possible if sufficient and varied community services such as home care services, meals on wheels, social services, etc. were adequately developed and financed. The tragedy of the unhappy and "lost" elderly person traveling around into one facility after another is a poor reward for those who have contributed to our society and may still have the potentials for care at home if appropriate services were available.

It is suggested that this total area of care including the preventive services need full consideration in conjunction with the Medicare program.

The State of Connecticut since the beginning of the Medicare Program has failed to employ a "Medical Social Consultant" on the State level to work with the State staff and to develop a social work program. This has created a serious situation and a failure to meet the needs of the elderly.

We feel that Medicare should be pointing the way so that all ill people, whether under Medicare or not, could eventually have the benefit of Social Services. Experimental programs funded by public funds would be helpful in exploring this important area.

Can we expect relevant action to meet these pressing human needs?

MRS. EDWARD TRUEX, WESTERFIELD, CONN.

I would urge the Subcommittee on Long Term Care to review carefully the entire program of long-term care for elderly persons and to focus its attention on the feasibility of maintaining these elderly persons in their own homes through the services of a homemaker or home health-aid program. Such a program would make it possible for many elderly persons to remain in their own homes where they are happiest and at the same time result in lower costs of medical care.

WML. WOODS, MERIDIAN, CONN.

Current trends are depriving many needy people of needed services to make them functional and independent individuals.

There is now a situation where there is too much categorizing and generalizing as far as the various types of patients are concerned. Each case is different even with the same diagnosis. They must be considered individually on their own merit or potential.

The intermediaries have gone from the extreme of authorizing everyone to now denying so many who really need the coverage.

In many situations decisions are being made by unqualified people.

O