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

SECOND SESSION

PART 2—ST. PETERSBURG, FLA.

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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, Florida, 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)

CONTENTS

TRENDS IN LONG-TERM CARE

(St. Petersburg, Florida)

FRIDAY, JANUARY 9, 1970

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE OF THE
SPECIAL COMMITTEE ON AGING,
St. Petersburg, Fla.

The subcommittee met at 9:25 a.m., pursuant to call, in the auditorium, Bay Front Center, St. Petersburg, Fla., 400 First Street, South, Senator Frank E. Moss (chairman) presiding.

Present: Senator Moss.

Staff members present: Val Halamandaris, professional staff member; John Guy Miller, minority staff director; Thomas E. Patton, minority professional staff member, and Mrs. Patricia Slinkard, chief clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

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

I am Senator Moss. I apologize for being a little tardy in starting. I don't know whether I should say we were frozen up or not but perhaps the cool weather did have something to do with our being a little behind on getting this hearing underway.

We are pleased to be here in Florida today. We look forward to a very interesting and constructive hearing.

These hearings conducted by the Special Committee on Aging of the U.S. Senate are for the purpose of setting forth problems that exist and situations that occur in the various parts of the country and affect the various people. They will enable us, when the record is all completed and studied by our committee, to take the necessary steps as we can take to remedy the deficiencies that have occurred or to perhaps move on into other fields where legislative action may be required.

We have been conducting our study on trends in long-term care. Our presence here indicates our very great concern with the problems that confront our senior citizens. Specifically, we focus on the problems of America's most depressed and unrepresented minority group. I am referring to the large number of Americans who carry the compound burdens of illness and advancing age.

There are reportedly some 23,000 nursing homes and related facilities in the United States according to the American Nursing Home Association. These facilities house something near 1 million Americans.

Since the inception of Medicare's extended care provisions there has been a tremendous expansion of these facilities. In 1968 Medicare paid for $500 million worth of nursing home care and Medicaid picked up the tab of about $1 billion.

Paradoxically, in 1969 many nursing homes dropped participation in Medicare's extended care program as the Administration increased Medicare premiums 32 percent, from $4 to $5.30 monthly. The reasons for those developments are complex and will receive proper focus in our hearings but there does seem to be a logical continuum between these two events.

Nursing home administrators have complained to me that accepting a Medicare patient is as unpredictable as putting a quarter in a slot machine. I have received heavy mail decrying this lack of predictability and the retroactive denial of claims. The problem has reached extremes in the State of Georgia where the Georgia State Nursing Association has recommended that its members not participate in the medicare program.

In the face of the resistance of nursing home administrators receiving Medicare patients, physicians have had little choice but to retain patients in the hospital. Again a paradox; the Medicare machinery seems willing to pay hospital costs for patients who could be housed in a nursing home for about one-third of the hospital price. In an effort to cut back on the number of days patients spent in extended care nursing homes the Social Security Administration has significantly increased the burdens on the hospital. Small wonder the Administration felt the need to increase dramatically medicare premiums.

In the final analysis it is the consumer of the service that suffers. I find it most regrettable that Medicare is beginning to take on the color of another broken promise. I can empathize with the nursing home patient who has it on the authority of his Medicare handbook that he has the guarantee of 100 days in a nursing home. I can sympathize with the nursing home administrator who must break these bubbles of misconception and often suffer a financial loss as well.

Doubtless these significant developments would in themselves serve as a proper focus for our hearings but our objectives are broader. Let our purpose be clear to all concerned; we do not seek to expose, to accuse, to assess blame or indict all nursing homes under a blanket indictment. There are many fine homes across the country, but also there are a great many with much room for improvement. Accordingly we seek to emphasize the positive in this hearing today. It is our hope to go beyond delineation of the problems and a look at root causes. We must take that necessary extra step of offering constructive solutions.

Our approach will begin with a look at model nursing homes which offer innovative solutions. We seek the assistance of all parties concerned in our search for the shape and requirements of the nursing home of the future.

First and foremost we must do everything we can to erase the bad image that burdens the nursing home industry. In-depth research by one eminent authority reveals that most Americans tend to regard admission to a nursing home as a "death sentence." The answer to this seems to be an emphasis on rehabilitation. Admission to a nursing home

should not be the first step of an inevitable slide into oblivion. With rehabilitation it is possible to interrupt regression and replace it with improved functioning, the goal being that the patient be able to operate to the best of his abilities. Where possible he should be discharged to his own home.

Certainly I have not abandoned my fight to obtain higher standards in nursing homes. I very much regret that HEW has taken so much time in implementing my 1967 amendment to title 19. I can only hope that this new year and this new decade will bring rationality that transcends partisan politics. Let us now begin our hearing. Preliminary investigations reveal that Florida can offer a most significant contribution to this committee's study.

We have several very prominent witnesses to appear before us today and we look forward to hearing their testimony. It may not be possible for us in the time that is allotted to our committee to hear from everyone who wishes to testify, so there has been a form prepared by the staff which is available. If anyone would like to fill out this form and set down some contribution that he would like to make for the record, we would be glad to have that. It will be collected and it will be printed when the record is printed up. I just wanted to call that to your attention. So if having come here today, and we do appreciate your attendance, if there is something that you would like to add, we would be very happy to have you fill out one of these forms during the time of the hearing.*

I have members of the staff sitting with me at the table here and they are available. If there is any communication you want to send up, that will go along with the hearing. We were a little late in starting and time is very pressing.

Our first witness is going to be the Honorable William Fleece, member of the Florida House of Representatives.

I think as a matter of practice we will have the witness go over and talk in the microphone there. That way he will tend to speak loud enough for me to hear and we will be sure that everyone out there will hear.

All right. Mr. Fleece, we are glad to have you come forward. We would be most pleased to have your testimony this morning.

Would you be sure to introduce the gentleman accompanying you.

STATEMENT OF HON. WILLIAM FLEECE, ATTORNEY AT LAW AND MEMBER OF THE FLORIDA HOUSE OF REPRESENTATIVES; ACCOMPANIED BY ANTHONY PETER DE GRAFF, FORMER NURSING HOME WORKER

Mr. FLEECE. Thank you, Senator Moss.

I have with me, Senator Moss, Mr. Anthony Peter de Graff who has worked for many years in the nursing home profession and during a portion of my testimony he will respond to questions which I will propound to him and emphasize a certain point.

I have submitted to your committee a fairly lengthy written statement which I will not read verbatim but which I will amplify upon.

*See appendix 3, page 236.

Senator Moss. Thank you. The full statement will be placed in the record and then you may emphasize it in parts as you wish or add to it as you like.

(The statement follows:)

Pursuant to your invitation to me to testify before the Subcommittee on Long Term Care, U.S. Senate Special Committee on Aging in St. Petersburg, Florida, January 9, 1970, I am pleased to offer the following comments and an analyses for your Subcommittee's review and appraisal. I offer these comments and analyses as Chairman of a special Subcommittee of the Committee on Public Health and Welfare of the Florida House of Representatives which is investigating nursing homes and nursing home care in the State of Florida on behalf of the Florida House of Representatives.

I wish to comment on several areas relating to the nursing home industry. The areas of special interest include cost and delivery of services, nursing homes as an industry and the growth of chains of nursing homes, nursing home residents as consumers including their treatment, problems in staffing of nursing homes including personnel shortages and the availability of suitable facilities.

Investigations by select Committees of the Florida Legislature reveal that the cost of nursing home care is rising at an alarming rate when compared to costs of other consumer services. Since the onset of Medicare and the implementation of Title 19 the overall cost of medical services is doubling the general cost of living index from the years 1967 forward. These figures are adequately documented in a study performed by the Advisory Commission on Intergovernmental Relations. In particular, the Advisory Commission cites the severe impact on the respective states which has been occasioned by the impact of Title 19.

It appears that the failure of the federal government to require certain upper limit controls on the price of services is having an adverse effect on the overall cost and delivery of services which is being felt heavily in the nursing home industry in particular. It is impossible, in my opinion, to segregate some of the problems of the nursing home industry with the overall problems in public health finance and particularly those areas dealing with indigent service finance. The shifting of costs to those patients whose stay is financed primarily under government assistance programs then, in turn, is returning and increasing the cost to those various governmental entities themselves. The states therefore should be given sufficient flexibility to implement certain local controls over the projects even though federal funds are involved. Unless this latitude is given, the entire program will erupt into a problem of massive proportion which ultimately will force various states to drop from the programs for the very simple reason that they cannot afford to participate. They must have sufficient control to establish flexible criteria for services to be rendered.

Nursing homes as a business: Hearings in Florida have elicited certain testimony which imply that the nursing home business is very lucrative. On the other hand a very intensive hearing in Miami in November 1969 evoked testimony that the nursing home industry is not a very good financial risk. Numerous owners of nursing homes in the Miami area complained of losing money on all patients supported under government assistance programs. Most of the home owners indicated their understanding to be that Medicare and Medicaid would reimburse at cost for services rendered. What appears to have happened, however, is that the reimbursement is at less than cost thereby forcing an overcharge upon patients who can afford to pay. It is suggested that the financial ceiling under Title 19 be raised. It is further suggested that supplementation by an individual family to a higher level be permitted. It is clear that the level of service provided by any nursing home is directly proportionate to its level of assistance where welfare patients are involved. This is particularly true in non-profit homes that rely heavily on involvement of the private sector for contributions to supplement their very existence. There appears to be very little incentive for doing quality work. Some of the testimony indicates a possible need to increase vendor payments. Those homes which cater predominantly to government assistance recipients seem to fare somewhat badly in their ability to offer a quality program and a full range of services. This is not to say that the personnel in the homes do not treat the patients well. On the contrary several homes which I personally visited seem to offer very good attention notwithstanding the fact that a majority of the patients were, in fact, public welfare recipients. However, the very close margin of operation appears to seriously hinder the ability of the individual

home to offer a full range of services. At the other end of the spectrum some of the more profitable homes appear to be so because of their ability to utilize the concept of volume purchasing. This is evident in the case of three related Miami homes whose owners are contemplating "going public". St. Petersburg, Florida, has several homes which are all related by way of management or ownership and it would appear that a trend is developing to combine homes under a single ownership to take advantage of volume purchasing, volume management, and volume profit. Those homes in the St. Petersburg area which utilize that concept, however, upon investigation reveal a slightly lower level of service than other homes in the same area. I believe, however, that an indepth study would have to be made before any definite conclusion could be drawn from these isolated inspections. By and large, however, the visible nursing home problems in the business sense are symptoms of a much greater problem.

Nursing home residents as consumers and personnel problems: It is in this segment of my comments and analyses that I detail the treatment of persons in nursing homes in Florida. Numerous investigations are continuing by the Florida Department of Health and Rehabilitative Services, a select committee of the Florida Senate, and the Subcommittee on Nursing Homes of the Florida House of Representatives. I have personally inspected numerous nursing homes. Based upon these various investigations it is evident that in many instances patients in nursing homes are treated badly. I would not wish to catagorically chastise the nursing home industry. As a matter of fact I would estimate that a majority of nursing homes do an adequate to better than adequate job in treating nursing home residents. However, the fact remains, that in too many nursing homes the sub-standard conditions seem to necessarily lead to sub-standard treatment. In too many cases personal health in neglected. Actual medical care and nursing care is not available as represented to the public. Many of the facilities are inadequate from a medical standpoint. Many of the facilities are dirty and unkempt. Personnel is lackadaisical and often not suited for geriatric type nursing care. In many cases there are too few registered nurses per shift and no or few orderlies. In at least two instances I have documented cases of assault and battery upon patients by nursing home employees. I do not indict the entire nursing home industry for these occurrences. However, it appears that this type of treatment is a symptom of the overall finance picture of the industry, and the greater problems in public welfare finance. The cost and delivery of service and the profit margin structure as indicated by some of the Florida hearings seems to have forced the various homes, either voluntarily or involuntarily, to select personnel who are not suited to work in such sensitive areas as nursing homes. At best, to work in a nursing home is a difficult task because of the very nature of the geriatric patient. This is particularly true where the patient is senile or a difficult medical problem. Accordingly, it would seem clear that a higher quality of personnel should be encouraged. This, of course, can only be obtained with higher salary and fringe benefits. In this connection the overall movement for collective bargaining in the public section will ultimately have a significant impact on the personnel problems of nursing homes. The nursing home owners fear mass organization because it will most probably force the wage scales and fringe benefits to higher levels than currently exist in Florida. If so it will possibly compound the existing financial problems alluded to by the nursing home owners.

Availability of facilities: It is evident in Florida that there are not enough good nursing homes. I do not think that Florida is over-built. It is evident, however, that the building of additional nursing homes per se will not answer the problems of geriatric care. It is becoming clear to me that day care facilities might well be the answer to long range care of the elderly. Instead of a family having to place a loved one in a home-away-from-home on a permanent basis it might be better for that family to be able to place the elderly person in a compatible daytime environment and still allow the person to live with the family the remainder of the day. This would be a boon to those patients who are not in need of critical medical attention. It might tend also to alleviate the overall rising cost and delivery of medical services. The Florida hearings have developed a recognition of need for this type of facility.

If long term care for the aged is to become a distinct project for the public sector involving both the states and federal government, then that partnership must be permitted to operate in such a fashion that both partners share decision-making ability. The partnership cannot exist and do a proper job if the federal

government insists on retaining the greater portion of the decision-making prerogative to the exclusion of the state's, and insists upon forcing requirements giving little recognition to the variation of individual state problems. Greater flexibility for individual state innovative programs would seem to be indicated. Easing of restrictions on income and net worth and other criteria for judging the ability of a recipient to receive supplementation might also be indicated. Involvement of the private sector including the patient's family should be encouraged. Utilization of volunteer workers is a possible way out of a dilemma.

As the committees of the Florida Legislature continue to investigate the problems of the nursing home industry in Florida, I am sure that additional recommendation can be formulated which will lead to a strengthening and improvement of the nursing home industry. It is my hope that the Florida hearings can be concluded in 1970. Concurrently, with the cooperation of the Congress, I believe that this vital industry can be strengthened to do a better job for that growing segment of society who is too often "a lost generation".

Mr. FLEECE. Let me introduce myself as William H. Fleece. I am an attorney here in St. Petersburg and I am a member of a special subcommittee of the Committee on Public Health and Welfare of the Florida House of Representatives which is investigating nursing homes and nursing home care on behalf of the Florida House of Representatives and have been engaged in this investigation for quite some time.

My counterpart in the Florida Senate I understand is here also, Senator Lou de la Parte, and will handle a portion of the investigation which that body is also conducting.

It has become somewhat evident to me, Senator, that some of the problems which beset the nursing home industry and which appear to be in existence in Florida are really in fact a symptom of what I would consider a deeper problem. We have had a lot of spectacular and emotional testimony in Florida as to the care of patients as to collective patients but I think that this really is symptomatic, if you will, of a much deeper problem.

IMPACT OF MEDICARE AND MEDICAID

Now let me go back and emphasize it in this manner. In a monograph prepared by the Advisory Commission on Intergovernmental Relations which dealt with the question of the impact of Medicare, the impact of Medicaid and the impact of the programs we are having on the Federal-State relationships, it became evident in reading this monograph that the costs of medical services which were evident from the onset of Medicare and now Medicaid seems to have placed the States, Florida being no exception, in a very difficult position and they have placed the medical consumer in a very difficult position. The documentation indicates that whereas the cost of living index from the years 1967 forward was increasing at a fairly constant rate of about 3½ percent annually that the cost of medical services and related medical services, including physicians and hospital services, was increasing at nearly double that amount or at a rate in excess of 6 percent annually.

If we view this as a fact, which the Advisory Commission on Intergovernmental Relations documented, then I think that there would be reason to project that this fact, the overall spiraling inflationary spiral if you will, has produced certain symptoms, the nursing home industry being one, which somehow or another are being reflected in inability to

provide good care, a tightening of the reigns, if you will, by nursing homes either in the form of personnel or what have you. The end result would be that the nursing home, and this is not true of all obviously, but many of them are not able to provide the type of services for which I think they were originally intended and that is a "nursing" facility.

The hearings which we had in Florida so far have taken two courses. We had a hearing here in St. Petersburg which Senator de la Parte conducted where much testimony was elicited—and I was a witness before that committee—as to actually what type of care does a nursing home resident receive. The testimony was rather startling, that in many cases a resident or consumer, if you will, of a nursing home receives somewhat bad treatment in certain homes, and in particular it would appear that this might be more true in those homes which cater predominantly to the welfare recipient or to a predominance of governmental assistance patients, including medicare. Of course Florida had not until this year implemented Medicaid so it would be hard to relate to Medicaid specifically. Here again I say it is symptomatic of what I would consider to be a much deeper problem.

Two Aspects of Nursing Home Industry

The nursing home industry as a business, therefore, has two aspects dependent upon what side of the fence you are on. Many people believe, I believe, that the nursing home business is a very lucrative business. This may be true in certain situations. On the other hand, if we buy the hypothesis that the symptoms as shown by patient care are in fact a tightening of the reigns by the nursing homes, then the opposite would be true—that in fact the business as such is not a lucrative business and it is very financially risky.

This fact was testified to by people in Dade County in the Miami area and there we have difficulty, particularly in those situations where the predominance of Medicare patients were in the homes. Now how do they attempt to get around this problem? One person said they had to utilize a volume purchasing concept.

Let's go with volume. If we cannot make it with a few patients, perhaps we can make it with a lot so let's go public. Let's go on the stock exchange, let's amalgamate several homes and maybe we will do it that way.

In the St. Petersburg area you have a conglomeration of several homes as a single business entity as mentioned. I believe it would have to be assumed, unless the contrary was shown to be true, that this is done to pool the cost of operation, to utilize volume purchasing, and hopefully to utilize a volume profit theory.

I don't know whether the information obtained from isolated inspections of this type per se would reveal a trend to a conglomerate theory of nursing home operation but I would think that nationally it would not be too difficult for you to inquire as to whether or not in fact this was a trend for the reason that the people had to go to the volume concept in order to make the business lucrative.

Now let me at this point go into some of the consumer and personnel problems which our joint committees—and I am sure Senator de la Parte will have found particularly in the St. Petersburg area.

Now I as you, Senator, do not wish to chastize the nursing home industry. I think they have been the recipient of some pretty heavy press. Newspapers have to sell and it is very easy to headline a problem and sell newspapers. The fact still remains and is the fact that certain emotional testimony might be offered. Over the past several years, and I am sure even prior to that time, in many homes there have been some definite problems for one reason or another.

Nursing Homes Staffing Problem

In my personal investigation of numerous nursing homes in this particular area I found conditions which I testified to previously are truly startling. I felt that it would be very difficult for me to place a member of my family in the environmental situation for nursing care which I personally observed. I will not do so if there is any way to avoid it. I felt that in certain of the homes which I visited there was a distinct staffing problem. The registered nurse shifts were staggered in other words, in my opinion too few registered nurses per shift to do an adequate job. There were no, if any, orderlies. I think that whatever way you might run homes that it would be preferable to have some orderlies in attendance.

Patient Neglect

I felt that in certain situations the homes were just unkept. I felt that the patient was a neglected patient. In order to amplify on that particular thing I brought with me Mr. de Graff who has worked in nursing homes as an orderly for quite some time, does not do so now, and he can tell you his reasons for that if he desires. Before I ask him any questions I would say, going one step further, that I have personally documented two actual cases of assault and battery by personnel upon nursing home residents, one of which I alluded to in my testimony before the Florida Senate Committee and the second which I will make known today. These are unfortunate occurrences. I am sure they do not occur often but I don't know why I found two cases in Pinellas County, Fla., which have occurred in the past 2 years, one as recently as in the past 6 months.

I don't know but that this again is a symptom of the fact that perhaps the people who are hired to take care of a geriatric patient do not have the capability or capacity to deal with that type of patient for surely that type of patient is a difficult patient to take care of at best, particularly the senile patient, the incontent patient. It is difficult and I would be the first to admit that it is difficult. I think that perhaps if you could pay the persons a better salary you may get better personnel. Money is not always the answer but perhaps it might help in this situation.

Day-Care Facilities for the Aged

I don't know whether or not nursing home building per se is one answer to the overall problem of long-term care for the aged. At this juncture I think it would be well to suggest that perhaps we look at the concept of day-care facilities for the aged so that instead of having

to place a person who is not a total medical need type of patient into a home and forgetting about him that we could let a working family take the patient to a compatible environmental situation for daytime care and then allow the patient to resume living with the family for the remainder of the day. I think that it may be necessary to reevaluate the financial ceilings which are permitted to be spent on the patient by individual families or limitation by State and local governments so that the nursing homes are not faced with certain situations where if a patient receives x amount of dollars he is then cut off from county funds and is cut off from State funds or Federal funds.

I think that current ceiling will have to be reevaluated and perhaps raised. I don't blame the Federal Government totally for this type of a problem but I think that the Federal Government must recognize, as they are a partnership in long-term care, that the States would want to have to be able to exercise a certain amount of decisionmaking authority compatible with Federal regulations and Federal funding because I think that to deny the States the flexibility to implement certain criteria of their own—and I am sure you are well aware that the Supreme Court of the United States has stricken residency requirements—that if you chip away at the States' ability to impose reasonable criteria it is not in fact a working partnership.

How much time do I have, about 5 minutes?

Senator Moss. Yes, that would be appropriate.

Mr. FLEECE. All right. At this point then let me ask Mr. de Graff just a few questions so that he might amplify on a couple of items.

Would you please state your name for the record.

STATEMENT OF MR. DE GRAFF

Mr. DE GRAFF. Anthony de Graff.

Mr. FLEECE. Where do you reside, Mr. de Graff?

Mr. DE GRAFF. Seminole, Fla.

Mr. FLEECE What is your occupation?

Mr. DE GRAFF. At present I am engaged in a private case.

Mr. FLEECE. Have you had any experience with work in nursing homes in Florida?

Mr. DE GRAFF. Yes.

Mr. FLEECE. How many years?

Mr. DE GRAFF. At least six.

Mr. FLEECE. Where were those?

Mr. DE GRAFF. All in Pinellas County.

Mr. FLEECE. Over what period of years did you work in nursing homes?

Mr. DE GRAFF. Over a period of 10 years.

Mr. FLEECE. Would you tell Senator Moss how the normal day is spent? What did you observe as you went into these nursing homes and worked in them?

Mr. DE GRAFF. Well, the best way to delineate that would be to start from the time we started on duty and go right through the day.

Mr. FLEECE. Would you do that briefly for us.

Mr. DE GRAFF. I will try to. We are supposed to report at a quarter to seven to relieve the night shift. We go on the floor at 7 o'clock, some-

times a little later than seven because on occasion we work a little longer.

Breakfast is at 7:30. Between the time we go on the floor at 7 and 7:30 we must give morning care to our patients, which means wash their face and hands, comb their hair, give them oral hygiene.

The average list of patients for a person like myself runs between nine and 13 patients. Now between 7 and 7:30 to give nine to 13 patients morning care and then be ready for breakfast at 7:30 you have got to be stepping.

At 7:30 you go to the kitchen and bring back trays to the patients, feed those patients by hand who need it and take the trays back to the kitchen. Then we were required to clean the trays and stack them, clean out the dining room, which I don't think is any part of an orderly's job.

Then when breakfast is over we provide the patients with baths, shaves, change linens, dress patients, and give whatever treatment was necessary; for example, bed sore or possibly an ulcer or even on occasion change certain dressings if the patient is just out of the hospital.

Then it is time for lunch. The same thing occurs at lunch time—the trays, the feeding and all that sort of thing.

Breakfast takes usually an hour and a half. Lunch is another hour, at least an hour and a half. That is 3 hours out of an 8 hour day. That leaves 5 hours. When you have a list of nine to 13 patients, where is the time for our lunch? I have not had a coffee break in years.

Well, out of those 5 hours you have to do all these other things—dress the patient, bathe him, shave him. When 3 o'clock comes, we go home.

Senator Moss. Is that the end of the shift, 3 o'clock?

Mr. DE GRAFF. Seven to three, yes.

Mr. FLEECE. Would you have any help from any other orderlies in your duties?

Mr. DE GRAFF. Usually there are no other orderlies because I can request help when necessary from the aides, and I have nine of them.

Mr. FLEECE. What about the availability or presence of nurses in the homes which you worked in?

Mr. DE GRAFF. I would say inadequate.

Mr. FLEECE. How about the attitude of the people who run the homes to the patients themselves?

Mr. DE GRAFF. I would say that their attitude is normal, you know, but there has not been too much contact I don't think between the owners and the patients. I mean that is left to the staff.

Mr. FLEECE. Did you ever witness any situations where there was an attempt by any of the owners to cut corners, if you will, in order to perhaps influence their gain?

Mr. DE GRAFF. Certainly.

Mr. FLEECE. Would you document what that was?

Mr. DE GRAFF. Well, I will give you one case. To give an enema nowadays you are provided with little capsules like this cast in soap. In one particular nursing home we are instructed to pick up little nubs of soap and put them in a big jar of water and let it soak and use that for a soap suds enema.

Mr. FLEECE. Did you ever witness any situations where there were any other efforts to cut on operating costs?

Mr. DE GRAFF. Yes. Electricity is a big item. Sometimes in St. Petersburg it gets too hot in the summertime, and sometimes although there are air-conditioning units installed in the nursing home they are not allowed to be turned on to save electricity.

Mr. FLEECE. Did you actually see that happen?

Mr. DE GRAFF. Yes, sir.

Mr. FLEECE. In a home in which you worked?

Mr. DE GRAFF. Yes, sir.

Mr. FLEECE. Did you go to the home and complain?

Mr. DE GRAFF. I didn't complain; that is not my point.

Mr. FLEECE. Did they turn the air conditioning on?

Mr. DE GRAFF. No, sir.

Mr. FLEECE. Was the air conditioning on in the home that summer?

Mr. DE GRAFF. Very, very seldom.

Mr. FLEECE. Were there very many patients in the home?

Mr. DE GRAFF. A little under 300.

Mr. FLEECE. What effect did it have on the patients?

Mr. DE GRAFF. Well, of course quite an effect. What else could they do?

Mr. FLEEECE. If you had to sum up, what would be your overall opinion as to the type of care you saw in these homes?

Mr. DE GRAFF. I would say to begin with, nursing personnel who knew their jobs or at least had some inkling of it, some of the personnel that I have worked with could rarely tell the scultetus bandage from a pressure bandage. I think if we could offer a better salary we could attract better educated personnel.

Mr. FLEECE. I have no other questions, Senator.

Senator Moss. Thank you, Mr. de Graff.

Mr. Fleece, I think what you are telling us is that some nursing homes at least tend to cut corners and save money.

Mr. FLEECE. Yes.

Mr. DE GRAFF. Definitely.

Senator Moss. They have neglected giving optimum service to the occupants of the nursing home.

Mr. DE GRAFF. That is exactly the word, Senator; optimum.

NURSING HOME SERVICE CHARGES

Senator Moss. The solution would be, of course, to spend more money. I suppose the next step back would be higher service charges to the nursing home.

Do you have any idea of these homes where you have given us an illustration of the charge that is being made on the daily basis to those patients?

Mr. DE GRAFF. Senator, I would not like to enter that because that is not my province.

Senator Moss. Well, I know it is not your province but I just wondered if you had any knowledge whether these people were being kept for $2 a day or $4 a day or $10 a day.

Mr. DE GRAFF. I would say the lowest one was a public assistance patient and his charge was $225 a month but that was an exception. The average I would say would be around three and a quarter.

Senator Moss. About three and a quarter.

Mr. DE GRAFF. That is to the best of my knowledge.

Senator Moss. Did you leave your employment with the nursing home because of these difficulties that you have explained?

Mr. DE GRAFF. I have mentioned many times to management improvements that could be made and I was ignored. Now, believe it or not, I have a feeling for sick people and it just got to be so bad I said I am not going to be in any more nursing homes, I am going on private cases. That is exactly why and the only reason.

Senator Moss. And your employment now is with private cases.

Mr. DE GRAFF. Yes, sir.

Senator Moss. Well, I certainly appreciate having your testimony, Mr. Fleece. The work that you have done in the position as a representative in the Florida Legislature has given you an insight and background here that is very helpful to us. You have suggested many things to our attention that would indicate steps need to be taken to improve this rather drab situation that has occurred.

You have alluded to cases that you have known of where there was an actual assault and battery, which of course is shocking to me and I think to all of us. It makes all of us wonder what kind of personnel are involved where that would happen. Bringing Mr. de Graff here to tell his experiences in working in the nursing homes will certainly help for the record in giving us quite a bit more. I think I will defer any lengthy questioning, however, under the pressure of time that we have.

You have a good, full statement in writing also in the record and we are pleased to have that. Unless you have something more to add, we will excuse you at this time.

Mr. FLEECE. I appreciate that. I know the time is very short. Thank you.

Senator Moss. Thank you, Mr. de Graff.

We are now going to have Dr. James Bax, director of health and rehabilitative service for the State of Florida.

Dr. BAX. I prefer to defer my presentation to Senator de la Parte. I will follow him.

Senator Moss. All right. That is agreeable to us.

We have Senator de la Parte from Florida who will be our second witness then.

Senator de la Parte.

We are happy to have you, Senator de la Parte, before the hearing.

STATEMENT OF HON. LOU DE LA PARTE, SENATOR, FLORIDA STATE LEGISLATURE

Mr. DE LA PARTE. Thank you very much, Senator.

First of all of course I want to welcome you to our fair State. Though I regret that the weather is not as it usually is, I would like——

Senator Moss. I will tell you that I came from temperature that was lower than this.

Mr. DE LA PARTE. Thank you also for the attention that you have given to this area of nursing home care and the leadership that you have provided in this field.

I also want to say that I appreciate the opportunity to appear before the committee and present some of the conclusions that have resulted from some of the hearings of the Senate committee—problems involved in long-term care of the aged more specifically, Senator.

Hearings were conducted by our Senate committee prior to the 1969 session of the State legislature when we were considering the implementation of Medicaid. Since this was one of the five requirements, we in the legislature were interested in knowing what in fact is the cost of delivering this type health service and what would be adequate compensation for the care of those people who were categorically, and would be in terms of chapter 19, entitled to this type of care. At that time I recognized the need for a new nursing home law in the State of Florida and the need for a more searching examination of this relatively new health service.

My earlier concerns were intensified by national media coverage and the articles published by the St. Petersburg Times concerning the entire nursing home problem. After considerable investigation we held the first hearing here in St. Petersburg in November of 1969. We chose to begin in the Tampa area because of the concentration of nursing homes in this area and because of the concern generally caused by the St. Petersburg Times articles.

Fiscal Problems of Nursing Homes

The second hearing dealt primarily with fiscal problems of nursing homes and was held 2 weeks after the first hearing. The scope of the problems is perhaps best comprehended when one knows that in Florida 13 percent of our population is over the age of 65. As of December 31, 1969, Senator, we had 360 licensed nursing homes for the aged providing 31,000 beds in this State. In Pinellas County alone there are some 50 such facilities. Our hearings and investigation disclosed that while conditions were not as serious as some of the laws would have us believe, they were far, far more serious than the apologists maintained

I do not intend, Senator, to discuss individual cases. Suffice it to say that we received evidence during our hearings that conclusively indicated to me at least that from 5 percent, 10 percent of the nursing homes in Florida were operating with serious deficiencies in physical plant or patient care or both. Many more than that failed to meet the regulatory standards.

We also are concerned that many of the facilities had been providing below standard service for extensive periods despite efforts of the County Health Department personnel to effect remedies. We concluded that our law has weaknesses but this is not the entire problem. The county inspection units simply are not staffed to provide effective surveillance. We intend to make licensing certification a state responsibility. The county will henceforth continue to provide support and react to complaints.

I might divert somewhat from the prepared comments that I have here, Senator, to emphasize the fact that Florida is no different from the other States in the Nation. We are groping with governmental reorganization not only in the State and also what in fact is the proper

relationship in terms of services and a tax source between the county, city, and State and at the same time anticipating what is the Federal policy in this respect. In Florida we are going into an intensive search to determine if the State is not the better vehicle for providing health and welfare services utilizing a much broader tax base and providing a higher degree of expertise that can be gotten by these higher dollars that can be made available.

In elaboration I can tell you that in Florida we have a county health unit supported by the property tax basis that has no relationship to the number of either sick people or no relationship between the wealth of a property base and the number of sick citizens, and yet this is the tax base which is used to support and provide services to the sick people. Consequently, we find that there is a great divergence in staffing and in pay at the county level in this area of surveillance, investigation, and certification of nursing homes.

An influencing factor in the inability to bring about the closure of deficient homes or homes providing deficient services, has of course been limited beds. Inspection personnel were reluctant to protest when there were no beds in which to place a patient displaced by a closure. While there are many vacant beds in our State there are long waiting lists of indigent clients. Reimbursement for this care has made it impossible for many homes to provide accommodations for the welfare patient.

Funding Arrangement

At the outset the State began funding at the rate of $100 a month. In July of 1968 this was raised to a maximum of $120 a month. The remaining cost for this service was borne by the counties. However, all counties did not participate in this program and this allowed for a hodge-podge in terms of how many dollars for nursing homes we were able to get from county or State or any other form of government. This funding arrangement providing from $120 to $300 a month was a combination of Federal, State, and county funds.

It had been brought to our attention during hearings held in 1969 in preparation for Medicaid and at the St. Petersburg Nursing Home hearing that the moneys provided for indigent care in this State were woefully inadequate and, in fact, Florida ranked far down the list of States in this regard. During the Miami hearing we attempted to ascertain the average cost of nursing home care in the State. We fould that in recent years the cost of health care had increased twice as much as overall cost of other services.

We found that the average per day room rates vary considerably throughout the State, ranging from a high of $20.83 for a two- to three-bed room in Miami to a low of $11.45 for the same accommodation in rural areas. Ancillary services and charges bring the average cost in Florida to almost $28 per day.

An analysis of this data made eminently clear that which we had already strongly suspected: there was no way in which adequate nursing home care could be provided for the funds which the State was making available. We had in fact established criteria for operation which were grossly unrealistic in light of the financial strictures we had imposed. With the advent of Medicaid under title 19 on January 1, 1970, the situation will be somewhat improved because this program

provides for recognizing a maximum budgetary need of $350 and the State and counties together will pay a maximum of $300 for skilled nursing home care. Only $250 maximum budgetary need is recognized for the intermediate care patient of which the State and counties will pay $200 maximum. If the per diem costs for room and ancillary charges reflected above are realistic, as we believe them to be, then it is clear that while Medicaid eases the fiscal problem faced by the nursing home industry in its care for the needy, it does not go far enough to solve the problem.

Rehabilitation Stressed

We feel that the remedies we are invoking will do much to assure protection and improve the care for nursing home patients. However, there is still much more to be done. We need to place more stress on rehabilitation. We need to further involve the private sector in assisting to provide for the social needs of the client. We must make use of the alternatives to institutionalization such as the foster homes. We are faced with an increasing number of aged people. Long-term care is rapidly becoming financially crippling even to the middle-income group.

We are searching for money and methods to provide for the men and women who helped build this country earlier in this century. We think that there is a need at the Federal level in this very important area. I just in passing will note that in the Social Security Act the emphasis apparently was on the short-term highly skilled nursing home care and that apparently was the policy of the Federal Government.

When Medicaid was being considered, the intermediate care facility was not included in title 19 and then almost as an afterthought it was finally included in title 11, and it was included without adequate definition as to what is intermediate home care. So we need to know whether or not at the Federal level there is going to be policy expressed for legislation that will provide us the guidelines for further development of State programs in the area of less than highly skilled nursing home facilities, and, if so, what will be the outlines in this respect.

We feel in summary, Senator, that there are serious incidents of abuse of our senior citizens. There have been presented to us shocking examples of the treatment of senior citizens in our nursing homes. Much of this is attributed to the inability of nursing home operators to hire the type of personnel that we want to deal with these clients. Some of it is attributed to the nursing home operators.

We are suggesting that at least it is to be the recommendation of my committee to the Senate that we strengthen the Government agency that is charged with the responsibility of enforcing our laws. We intend to strengthen our laws so that we may be in position to fully protect these helpless citizens that we are attempting to serve. At the same time we hope to be realistic about the fact that as long as the cost of this service is there we must provide funds by which those who are charged with and want to perform the services can operate.

I thank you again for this opportunity and I will be happy, Senator, to answer any questions I can. The full text of my comments has been

filed with your committee. The records of my committee are available to you and your committee, at your request.

Senator Moss. Thank you, Senator de la Parte. Your full statement will be placed in the record.

(The statement follows:)

PREPARED STATEMENT BY FLORIDA STATE SENATOR LOUIS DE LA PARTE, JR.

The ad hoc committee of the Florida Senate Committee on Health, Welfare and Institutions held two public hearings on nursing homes during the month of November, 1969. The purpose of these hearings was to enable the committee to compile and evaluate information regarding the problems and applicable operating standards relating to licensure under the provisions of the nursing home law (Chapter 69–309, Florida Statutes). The need for such a study was recognized by the committee during hearings held prior to the 1969 Legislative Session and at that time I announced in Miami our intention to complete the project prior to the 1970 session of the Legislature. The increased public interest and concern which resulted from national and local newspaper articles regarding nursing homes dictated that this matter be given a top priority consideration. We have attempted to approach this emotionally laden problem with a high degree of objectivity and have specifically precluded the hearings from developing into a forum for character assassination or unwarranted vilification of the industry or any individual.

Our goal was and is to provide a better understanding of the problems and potential of this relatively new health service field, and to implement the best possible plan to provide this essential professional service to our citizens as economically as possible with adequate safeguards for all. It should be stated at the outset that our inquiry has developed that while there are many nursing homes in Florida providing excellent care for their aged clients, there are far too many which do not meet minimum standards in physical facilities or patient care. While the publicity which the unfavorable conditions have received has tended to overshadow the efforts of those providing good service, the material printed by the *St. Petersburg Times* has been largely substantiated. It has generally been fair and accurate and has succeeded in focusing not only the attention of government, but also the attention of the private sector on the critical need for improvement.

I have previously stated that the nursing home is a relatively new health service and it is important to note that the original Florida nursing home law was passed by the Legislature in 1953. The 1969 Legislature repealed the original law and enacted the new one which is cited above. These laws and the implementing regulations have resulted in considerable improvements in the service. However, it was not until the reorganization of the executive branch of the state government, which created the Department of Health and Rehabilitative Services, and initiation of the annual legislative session with standing committees, that proper emphasis was placed upon the problem. In this state the problem is perhaps more acute than in other states, since 13% of Florida's population is over 65 years of age. As of December 31, 1969, a total of 287 nursing homes providing 22,963 beds were licensed. 46 of these licensed nursing homes, providing 2,189 beds, were on conditional licensure.

In addition, Florida has 73 homes for the aged providing 7,713 beds, of which 9 are conditionally licensed.

We also have 12 special services homes which contain 396 beds.

In summary then, the State of Florida has 372 facilities providing beds for over 31,000 people which must be licensed and controlled under the existing nursing home statute.

These facilities are spread across the state with the heaviest concentration in Broward, Dade, Hillsborough, Palm Beach and Pinellas Counties. The problem of administering the law is particularly acute in Pinellas County where we have over 50 homes. This is the highest concentration in the State and exceeds by 20 the number found in Dade County, our most populous county.

It was for this reason that the first hearing of the Ad Hoc Committee on Nursing Homes was convened in Pinellas County. We found during investigation in preparation for the hearing and during the hearing itself that while the existing conditions were not so serious as some alarmists would have us believe, they were much more serious than the apologists maintained. We were presented with

documented evidence of operating facilities which did not meet the minimum standards provided in the Life Safety Code or in the Southern Standard Building Code, and as a result were unsafe facilities in which to house the sick and aged. We also observed and were presented with documented evidence that substantiated charges of inadequate and improper patient care. We found that in some homes the standards of sanitation were not being met. We found evidence of improper and insufficient diets in homes where the preparation of food was not supervised by a qualified professional; that many times food was unappetizing and carelessly served. We were presented with evidence of inadequate care of the incontinent patient, improper or inadequate treatment of decubiti (bed sores) and indiscriminate use of restraining devices. We heard of and saw evidence of insufficient attention to physical therapy and little occupational therapy. We learned of inadequate staffing by untrained personnel who are poorly paid and changed jobs frequently. We found that required medical records were not kept and that drugs were administered by unqualified persons. We learned that the medical doctor is too often a missing element in the nursing home and that frequently his advice is telephonic, given without seeing the patient.

In short, we discovered through our investigation and the hearing that in 5% to 10% of the nursing homes the aged client was not receiving the protection and care which the law of this state requires. This would seem on the surface to indicate a gross neglect of duty on the part of those who are responsible for enforcing the requirements of the law. *This was not the case.* To understand this apparent paradox it is necessary to know that while the Division of Health, which is a state agency, is responsible by law for licensure of nursing homes, they have been inadequately staffed to conduct the licensure inspections and periodic surveillances necessary to insure compliance with the law. They have been able by diligent effort and hard work to conduct only certification surveys and periodic inspections of those homes which are in whole or in part participating in Medicare under Title XVIII. This left approximately 117 nursing homes in the state to be inspected by personnel of the county health departments. In Pinellas County two people were required to inspect for licensure and survey periodically some 50 institutions. In addition to this, they had other tasks not relating to nursing homes. While both of these individuals, one of whom is a stanitarian and the other a registered public health nurse, worked long and hard, it was humanly impossible for them to insure that the minimum standards were being maintained.

In addition, there is another consideration which mitigated against the stringent enforcement of the requirements of the law. Of the 31,000 people occupying beds in nursing homes in Florida, over 7,000 are welfare recipients. Over ⅓ of this number are in Pinellas County. You will find that the homes which have served as the bad examples in this county and throughout the state have a preponderance of the welfare patients. This is not to say that all nursing homes caring for the indigent are rendering poor service. On the contrary, there are homes in this county and throughout the state whose censuses are in excess of 80% welfare that render excellent care. The problem is that if the county health department people or the Division of Health inspectors had had the power to effect immediate closure of those homes which are consistent violators, there would have been no place available for the indigent patients. This is true even though the nursing homes in Pinellas County are probably now operating on a 70% census. The vacant beds are not available at the rate the state and county pay for the indigent. The same is true in Dade County, where there are many vacant beds, but approximately 150 aged sick waiting for admission to those homes who accommodate the poor. These counties are not exceptions but the probelm is more acute in the urban counties where costs of providing care are generally higher.

In addition to understaffed nursing home inspection units and the problem of placement of the indigent, those charged with enforcing the law encountered an additional impasse which is the inability to achieve immediate closure of those facilities which deserve such treatment. Because of the need for beds, the inspectors worked long with the administrators of the inadequate homes attempting to have the deficiencies corrected and while this was taking place had the homes involved placed on conditional licensure. This means, according to the law, that should the conditions which require this restricted license not be corrected by the end of the license year, that the home would not be relicensed. As you will recall from the statistics reflected above, we had 52 facilities on conditional licensure at the end of 1969. The fact is that a number of these homes have

been deficient for years. They have been allowed to continue with deficiencies primarily of a physical nature in the hope that they would rectify their shortcomings and continue to provide beds for the welfare patient whose care was inadequately funded by the state and counties. It was only after all else had failed that legal steps were taken to effect the closure and once this was done delaying action by the defendant in court could keep the home open for an extended period of time. Since 1964, the Division of Health has closed approximately 21 facilities by legal action. During the same period over 100 additional homes have been closed by other than legal action. Frequently, the reason for the latter closures is indicated as "owner closed". It should be noted that many of these closings resulted from pressure applied by inspection personnel where the owner did not seek legal remedy.

In short, in spite of inadequate staffing, unfair shifting of inspection responsibility to county level and an ever increasing need for indigent beds, over 120 facilities have been closed in the State of Florida during the last six years, Therefore, we know that although the situation is far from healthy in this state, it is not nearly so bad as it would have been had not the individuals involved been relentless in their efforts to upgrade the service. This is really small solace at this point and should not be regarded as a feeling of satisfaction or apathy on the part of anyone in the Legislature or in the Department of Health and Rehabilitative Services.

At the close of the first hearing it was the consensus of the committee that the problem of nursing homes had generally divided itself into two primary areas: (1) licensure inspection and enforcement of the law and implementing regulations; (2) lack of adequate financial support on the part of the state and counties to fund the care for the indigent patient. We felt that the first hearing had given us sufficient indications of the needs in the first problem area, so that we could proceed to effect the necessary remedies. Our progress in this regard will be discussed later.

The second hearing in Miami was primarily devoted to an examination of the fiscal problems of the nursing home industry and its indigent clients. As background information necessary to the understanding of the present situation we should examine the chronological program development and fiscal data relating to nursing home care in Florida. Until 1955 virtually all medical assistance provided indigent or needy persons was furnished at the local level, either by the county government or private charity. In 1955 the State began to aid the counties by providing matching funds for a hospitalization program for the indigent (HSI).

The Social Security Amendments of 1956 (Public Law 880–84th Congress) encouraged greater state participation in providing medical services to categorical recipients of public assistance due to the new federal matching formula. Federal participation in medical vendor payments had been available since 1950, but the matching formula limitations did not encourage participation by the states.

Based on the Social Security Amendments of 1956, Florida promptly began the Prescribed Medicine and Hospitalization Programs which were followed by a Nursing Home Care Program early in 1961. Florida's original program for making vendor payments to nursing homes was limited to old age recipients, but in 1963 it was expanded to include all AABD recipients under Title XVI of the Social Security Law and continued until the medical service of this Title expired on December 31, 1969.

The pertinent fiscal data which reflects the growth of the State/Federal Nursing Home Program from its beginning in early 1961 through the fiscal year ending June 30, 1969, is as follows:

Fiscal year	Average monthly cases	Percent of cases in OAA program	Total expenditures
1960–61 (part)		100	$1,276,511
1961–62	3,144	100	3,498,662
1962–63	3,822	100	4,287,459
1963–64	4,860	87	5,237,326
1964–65	5,506	90	6,233,693
1965–66	6,107	90	6,932,989
1966–67	6,045	89	7,358,398
1967–68	6,259	89	7,154,285
1968–69	6,666	89	8,932,539

The basis for operating the nursing home program summarized above *was* as follows:

In the program the need for skilled care had to be recommended by a physician, as custodial care even if furnished in a nursing home was not reimbursable. Only homes licensed by the Division of Health could be used.

In order to participate in the program, an individual had to be eligible for a cash grant after the cost of the nursing home was included within the budget. The "as paid" cost of nursing home care could be budgeted to a maximum of $300 per month for homes that had not qualified as an extended care facility under Medicare and up to $350 for those homes so qualified. Ten dollars was also budgeted to cover the cost of personal incidentals and clothing for the nursing home patient. The recognized assistance needs of a spouse who was not a recipient in his own right could be included in the budget as were other expenses which continue even though the recipient is in a nursing home. If a budget deficit existed after all available income was applied to the budgeted needs, the person was eligible for the nursing home program.

To determine the amount which the division of family Services would pay to the nursing home, all of the recipient's available income was first applied to the budgeted cost of the nursing home care. Any deficit was met by the department up to a maximum of $120 per month. If a deficit did not exist the client was not eligible for a vendor payment, and any surplus income left over was applied to meeting the cost of cash grant items. The remaining deficit was met up to the agency maximum. Prior to the passage of the claim law the maximum monthly payments made to nursing homes was $100, but the overall savings generated by this law made it possible to raise the maximum to $120 in July, 1968.

County expenditures currently totaling about $5,500,000 annually for nursing home care were in addition to the amounts shown for the state/federal program.

The 1969 Florida Legislature appropriation for the Nursing Home Program was as follows:

Medical Care Programs (to provide for existing medical care porgrams until 12–31–69). 770. Payments for Nursing Home Care to Recipients as provided in Section 409.45(2) (a) (b) (c), F. S.

From general revenue fund	$1,158,193
From State Welfare trust fund	3,495,052

Implementation of Title XI and XIX of the Social Security law for the period January 1, 1970 through June 30, 1970, 780. Payments for Nursing Home Care to Recipients as provided for in Section 409.45(2) (a) (b) (c), F. S.; not to exceed $300 per month per patient for skilled nursing home care; and not to exceed $200 per month per patient for intermediate care facilities. Skilled nursing homes or intermediate care facilities receiving vendor payments under this program shall not receive any other supplementary payment for the care from any other state or county governmental unit.

From general revenue fund	$4,198,199
From State welfare trust fund	7,495,953

During the hearings held prior to the 1969 regular legislative session regarding the implementation of Title XIX of the Social Security Law and the appropriation items shown above, it became apparent that a complete study of our Nursing Home Program was essential. It was obvious that skilled nursing home (as that term is employed in Title XIX) failed to cover many welfare recipients receiving nursing home care under Title XVI. Public Law 90–248, Sec. 250(a) (the federal answer to this problem) added section 1121 "Assistance in the Form of Institutional Services in Intermediate Care Facilities".

The appropriation provided in item 780 above is based on the estimated total required to pay the monthly amounts authorized using the following maximum budgetary needs:

Skilled nursing home care (per month)	$350
Intermediate care (per month)	250

In summary, the State of Florida moved from spending nothing for indigent nursing home care in the beginning of 1961 to spending almost $9 million for this purpose in fiscal year 1969. At the outset the State began funding each indigent nursing home patient at the rate of $100 a month. In July, 1968, this was raised to a maximum of $120 a month. The remaining costs for this service were borne by the counties. However, all counties did not participate in this program. This

funding arrangement provided a range of payment from $120 a month which was federal/state funds, to a maximum of $300 per month which was a combination of federal, state and county funds.

It had been brought to our attention during hearings held in 1969 in preparation for Medicaid and at the St. Petersburg Nursing Home hearing that the monies provided for indigent care in this state were woefully inadequate and, in fact, Florida ranked far down the list of states in this regard. During the Miami hearing we attempted to ascertain the average cost of nursing home care in the State. We found that in recent years the cost of health care had increased twice as much as overall cost of other services. The following breakdown of per day costs was provided to us by the president of the American Nursing Home Association and our correlary inquiries tend to substantiate them:

AVERAGE COST PER DAY IN FLORIDA

	1968	January–July 1969
Total patient days	694,564	477,841
Drugs	$1.46	$1.53
Radiology	.01	.01
Laboratory	.07	.11
Medical surgical supplies	.57	.86
Physical therapy	1.88	2.21
Occupational therapy	.05	.15
Speech therapy	.05	.10
Inhalation therapy	.22	.27
Other	.54	.33
Total ancillary	4.85	5.57
Room and board	16.50	17.16
Average cost	21.35	22.73

We found that the average per day room rates vary considerably throughout the state, ranging from a high of $20.83 for a two-to-three bed room in Miami to a low of $11.45 for the same accommodation in rural areas.

An analysis of this data made eminently clear that which we had already strongly suspected: there was no way in which adequate nursing home care could be provided for the funds which the state was making available. We had in fact established criteria for operation which were grossly unrealistic in light of the financial strictures we had imposed. With the advent of Medicaid under Title XIX on January 1, 1970, the situation will be somewhat improved because this program provides for recognizing a maximum budgetary need of $350 and the state and counties together will pay a maximum of $300 for Skilled Nursing Home Care. Only $250 maximum budgetary need is recognized for the Intermediate Care patient of which the state and counties will pay $200 maximum. If the per diem costs for room and ancillary charges reflected above are realistic, as we believe them to be, then it is clear that while Medicaid eases the fiscal problem faced by the nursing home industry in its care for the needy, it does not go far enough to solve the problem.

We have, we believe, recognized clearly the task which is before us in the area of licensure and enforcement and in the fiscal area. Dr. James Bax, Secretary of the Department of Health and Rehabilitative Services, has advised us that in order for the Division of Health to effectively conduct licensure certifications and peridoic surveillance of all nursing homes in Florida, an additional budgetary allocation of $422,000 per annum is necessary. This would provide for an additional 24 staff members in the Bureau of Health Facilities and Services. His proposal envisions a continuation of the existing partnership between the state and county health departments, however, it would place the responsibility for all licensure inspections upon the state. We believe this is a sound approach and feel that it would go far toward standardizing and enforcing the law and regulations which are applicable. This proposal is still under study by my committee.

We have recognized certain deficiencies in the existing law as concerns the "grandfather clause" which presently provides that minimum standards shall be

those in effect at the time of *original licensure.* This provision of the law has legally clouded the authority of the state to close nursing homes which do not comply with present-day standards. The Attorney General has not rendered an opinion on this matter as a closure case is presently before the Circuit Court of Dade County. Such was not the intent of this provision on the part of the state or the nursing home industry and it must be changed. There are other weaknesses in the statute which must be remedied or clarified. These areas concern closure procedures, the provision against public disclosure of identities of nursing homes found to be deficient by the Division of Health and others.

The existing statute did, in accordance with federal law, provide for the appointment of a Nursing Home Council which is composed of nursing home administrators, a representative of homes for the aged, a doctor specializing in geriatrics and a public spirited citizen of the state. This Council was recently appointed by the Governor and confirmed at the December, 1969 Special Session of the Legislature. We look to this group for advice and assistance in improving the status of the nursing home industry in the state.

The nursing home statute has been rewritten and is presently undergoing legal evaluation by the attorney for the Department of Health and Rehabilitative Services. When this is complete, representatives of my staff will meet with representatives of the nursing home industry and the Council in order to evaluate the new statute and incorporate additional suggestions. We anticipate completing this during the month of February, 1970.

We feel certain that with improved staffing at the state level, and an improved statute, we will have made major steps toward insuring improved physical facilities and patient care in the nursing homes of this state. We will also insure a closer coordination between the social workers of the Division of Family Services who visit the indigent patients and the Division of Health, so that deficiencies noted by the social workers during their visits will be formally and promptly brought to the attention of the proper authorities.

While we feel strongly that these provisions will make a major contribution toward solving the existing problems, we fully realize that one of the most important aspects of care in the nursing home cannot be assured by the state or any eschelon of government. The aged nursing home client all too often feels that he has been exiled by society because he receives no visitors and has little contact with the outside world. We must therefore continue to work through the Bureau on Aging in the Division of Family Services and more importantly with the private sector within each community to see that the social needs of the nursing home patients are met.

Since our experience with Medicaid is very short, we are not prepared to say what impact this program will have upon the quality of care offered to the indigent. We feel certain that in the next appropriation for this purpose it will be necessary to provide an increase. The amount of this increase will be dictated not only by what is needed, but unfortunately also by what is available. Our judgments in this matter will be tempered and influenced by what we have seen and heard during our nursing home inquiry and by the experience which we shall have in the first six months under Medicaid.

We are faced with an increase in the number of aged and an increase in the age of the aged. Rising costs are rapidly moving nursing home care beyond the financial abilities of even the middle income group. Since the money made available by the state is the people's money we can only provide assistance to the extent that the people are willing to pay. We are searching for alternatives to institutional care as well as the funds to provide adequate support and supervision of those needing institutional care. These are indeed complex problems and we shall appreciate whatever assistance the federal government can provide.

We appreciate the opportunity of appearing before your committee to share our experiences. As you may have gathered, we are not proud of our care of the nursing home patient in the State of Florida. We clearly recognize that conditions have existed which cannot be justified or excused. We do feel that we have made considerable progress. We feel that we have clearly recognized our problems and we are proceeding to effect remedies. The care of the aged and sick is a responsibility which rests heavily on the shoulders of every legislator in this state and on the shoulders of the dedicated personnel from the Department of Health and Rehabilitative Services. We do not intend to shirk this responsibility.

Senator Moss. I have glanced through your prepared statement and it certainly will be very helpful to us. I commend you for the work that you and your committee have been doing here in Florida in recognizing the problems and moving to rectify some of the serious deficiencies quite dramatically, the amount that you have been able to raise, the contribution now for nursing home patients, the amount contributed by the States and by the counties.

I recognize that problem you point out that the basic problem falls in the county, as you say, the burden of taxation falls on real property. Property taxes already constitute a significant hardship for our elderly.

I gather also that in Florida the inspection and enforcement generally of conditions in the nursing home falls on the county, too, is that right?

Mr. DE LA PARTE. Yes, except for that portion that has to do with Medicare where we have nursing homes that are certified on the State level. Those are the nursing homes that are functioning in the Medicare program that has a proper funding for inspection personnel. We realize, at least the committee has, that we need to extend that to all nursing homes at the State level.

Senator Moss. It would appear that if it is divided in some respect to the county and some to the State, of course it needs something to bring uniformity. I am sure that is so.

I particularly liked your emphasis on your sketch of the need for more emphasis on need for rehabilitation. It seems to me this so often gets lost in the shuffle, and this is particularly true when the funding is low and everything is pressed down and where those involved just feel they have no incentive of trying to get by from day to day. We sort of lost track of the fact that what we are really trying to do is to rehabilitate and help these people hoping that they can leave the nursing home, go back to their own homes and be rehabilitated enough so that they can get along with some outside day care of some kind rather than just keeping them in storage in the nursing home until such time as their lifespan ends.

Mr. DE LA PARTE. During the course of our hearings I was in receipt of testimony from reporters of the St. Petersburg Times on conditions they observed and the testimony of others to the effect that not only had we failed to take an opportunity to make useful people out of some of our clients and some of our people, but oftentimes we add to their problem. We immobilize them and this in turn has the effect of adding attrition to their immobilization until finally we must share in the blame for increasing the processes that add to their incapabilities.

Of course, Senator, if we are paying solely for basic needs, there is great difficulty to insist on the type of personnel and the type of staffing that is necessary for this and we have to be realistic. We are not doing it and we must do it, it is our clear responsibility. I hope that your committee will continue its efforts and that together we might be able to move aggressively in this direction.

Senator Moss. Have your inspectors had to issue closure orders and close certain nursing homes because of inadequate services or other violations of standards?

Failure to Meet Basic Requirements

Mr. de la Parte. Yes. As a matter of fact, I don't know whether Dr. Bax has brought some of that information with him. At the same time that these open disclosures were made—as a matter of fact, by the Division of Health which is under the Department of Health and Rehabilitation—they have since then conducted intensive studies throughout the whole State of Florida and they have found, if my memory serves me correctly, of almost 100 homes that as many as 40 failed to meet basic requirements. I think that they can give you the information we had in the past several years.

In my prepared text I say homes were closed for failure to comply. In many instances because of the long time that the Administrator procrastinated the homes were closed more by the pressure, pressure which we do not want to brag about but in fact the homes were closed and closed other than by reason of the quasi-judiciary process. So we have homes now that we know are going to have to be closed.

Senator Moss. Has your experience shown that a good many of the nursing homes really were not housed in facilities that could adapt themselves to that use and therefore are quite inadequate, some of them? Is this part of the problem?

Inadequate Facilities

Mr. de la Parte. Yes. This is true in the sense of the real difficult problem. Incidentally, this is one of the provisions which is a controversial part of our new nursing home law which I think and I know that we will work toward changing next time, sort of grandfather facilities though they may be inadequate by other standards. We have the final word, Senator, when running a business.

Now all of a sudden we find they are going to do something and at the same time insisting that all of these facilities stay within what—Let me tell you something that impressed my committee and that is that we found in each one of them, we had very good testimony that the facility itself was less than desirable in physical standards but the attitude and the training of the staff and management were so good that we found ourselves in a real dilemma because the energy was a wholesome energy, the desire of working with the people, and yet the facility itself left a great deal to be desired. These are matters I think, Senator, that we have to work out in trying to do equity and trying to keep within general public policy.

Senator Moss. I am glad to have you point that out, but of course the staff and management are even more important than the building and can sometimes overcome these deficiencies. When you have a building that is not use designed and then because of poor staffing or lack of adequate financial support it degrades the staff in some way, then you have a compound problem. We tend to get lack of care and sometimes abuses of the patients that have to stay in a home of that sort.

Mr. de la Parte. As a matter of fact, Senator, the first push in this field was after the very tragic experience that we experienced in this county of a fire that destroyed the nursing home and took many lives, so we were quite conscious at least of the safety factor involved. Certainly people would insist under all circumstances that this is complied with.

Senator Moss. Is the State inspection staffing adequate or don't you have enough inspectors to do the job?

Mr. DE LA PARTE. Not for the fiscal year ending July 1. However, Dr. Bax testified before our committee and advised us that he was requesting from this year's further financial appropriation sufficient moneys to staff adequately, and I concur and I intend to make that available. I chair the Appropriations Committee that relates to this general area, so as I go through the State and concern myself with these problems I can relate not only to the subject matter but also the fiscal aspects of the problem.

Senator Moss. That is a happy combination and I am glad that we have that sympathetic feeling both on the fiscal side as well as the legislative and substantive side in this problem.

I certainly thank you for your testimony, Senator de la Parte.

Any staff questions?

Mr. MILLER. One question, Mr. Chairman.

"COMPARABLE FACILITIES" DIFFERENTIAL

Senator de la Parte, you made reference to a range in charges from $11 or $12 a day to $20 plus a day, as I recall, for comparable facilities. Is your use of the term "comparable facilities" in its generic sense or in the sense of actual comparability of scope of care and service?

Mr. DE LA PARTE. I think it is used in the actual scope of services.

Mr. MILLER. It would then not be correct to assume, if one institution's per diem rate is x dollars and another's is y, that these variations actually make any difference in the scope of quality of care between the two institutions?

Mr. DE LA PARTE. You say is it valid to assume that? The obvious answer is no because we have been able to determine not only in this area but in the delivery of services for children, delivery of mental health services, et cetera, that there is a great variance in the cost of providing the service depending on what part of the State you live in and the service.

Mr. MILLER. Is this differential solely a matter of geographic situation?

Mr. DE LA PARTE. Yes. I think it is a matter of the cost of living in the labor market in the different parts of the State.

I am reminded that there is some question that relates to something that we discussed before the meeting, and that is that I would like to point out, Senator, that we need to look very hard at the classification, the type of services that we are rendering in determining this and assume that there is a cost to provide a high care of skilled service and a lesser service and assume that some people do not need the high skill service and can settle for less. I think it is something the Federal and State Governments should explore.

Mr. HALAMANDARIS. Senator, we have heard many comments about the rationality that you impart to your work. I have one question. There has been a great deal of conjecture and speculation as to the accuracy of the series that was printed in the St. Petersburg Times. I just want to ask if the series was largely accurate?

Mr. DE LA PARTE. I will tell you what we did. At the conclusion of the series there was a study made of the particular nursing homes. We

have a law in Florida that prohibits the disclosure and names in the reports of this agency when it is examining and investigating nursing homes. I asked the Attorney General to determine whether or not I was foreclosed then from bringing out the formal report of the State agency with respect to the findings that had been reported and I was advised I could not.

I felt that in every case it was not proper for me then to allow one side of a story naming names and not provide the assessment of the truth or falsity of the charge that we as a State had an obligation to make. Well, some of my staff checked the nursing homes and we discussed this with the inspectors. I remember our State staff came in after the disclosure with ample opportunity to be forewarned.

Right off the bat we have to say that we were not susceptible to the law so any conclusions that we make, if you are asking for my suggestion I believe that by and large the charges were substantiated. I believe that the conditions that they described existed.

I believe that perhaps there is an exception to what I have said. People see the same thing differently but I would say substantially that in spite of the resentment by the industry which was quite articulate, and no one is hurt more than when a conscientious person who is trying to do a good job is lumped in with people who aren't. In my presentations I did everything I could to avoid hurting anybody by association in the industry that does not deserve it, dedicated people. Nonetheless, these conditions exist and we should not try to disguise that.

To the extent that these articles have focused attention on how to cope with the problem I think we are all better served by it. I commend the young reporters that did it. I think you will be as pleased as I was when you hear their testimony and observe the manner in which they conduct themselves.

Senator Moss. Thank you very much, Senator. I appreciate your comments on the fact that in the large industry you may have some who abuse and do wrong and try to spread the blame on everyone. Certainly most administrators are doing their best with what is a very difficult job.

All right. Thank you very much. As I indicated before, your full statement will be in the record as well.

Mr. DE LA PARTE. Thank you.

Senator Moss. Now we will hear from Dr. James Bax, Director of Health and Rehabilitative Service, State of Florida.

We are pleased to have you, Dr. Bax. We look forward to hearing from you.

STATEMENT OF DR. JAMES BAX, DIRECTOR, HEALTH AND REHABILITATIVE SERVICE, STATE OF FLORIDA

Dr. BAX. Thank you, Senator Moss.

I would like to echo the statements of Senator de la Parte and commend the St. Petersburg Times for bringing the spotlight on the nursing home problem and programs in Florida. At first there was a reaction of the industry, and as some put it perhaps justifiably so. Part of their reaction was to join us and extend their invitation to us, the

Department of Health and Rehabilitative Service, to improve the nursing home area.

You heard a very fine man, Senator de la Parte, testify before you. He has certainly been an outstanding leader. Dr. Hodes, the chairman of the House Committee on Hospitals and Welfare, has also been involved and also Representative Fleece.

I have a prepared statement that I will give to you.

Senator Moss. Thank you. The full statement will be placed in the record and then you may emphasize it in part or add to it as you like.

(The statement follows:)

Senator De La Parte, Members of The Committee, I want to thank you and I'm sure the people of Florida, young and old alike, want to thank you for this series of hearings on Florida's Nursing Home problems. Not as bad as some would have us believe nor as good as the apoligists would have us believe either.

I've done enough talking about the problems of nursing homes in the past. Today I want to talk briefly about the solutions.

Specifically, I want to talk about solutions to the problems it will be possible for the Legislature to take. I also want to talk about the steps it will be possible for my Department, working through local health departments, to take.

As for what this Department can do until the Legislature meets, I have already ordered the Division of Health to do everything possible to get substandard homes up to the required levels—or to begin taking whatever action they can take under present law to close them down.

Our people have already met with representatives of the Hotel and Restaurant Commission and our Division of Family Services to work out the gaps and overlaps between nursing homes, retirement homes and hotels which are de facto nursing homes for many of our older citizens.

I believe that my people are doing all that is humanly possible within the limitations of the law to improve this situation. We will continue taking whatever steps we can. We offer our full support and cooperation to this Committee and to the Legislature as it begins wrestling with this problem. A more detailed presentation of our efforts and capabilities in this field will be made by some of the Division of Health representatives here today.

But I think it is important to frame this hearing within a discussion of the possible and not the ideal.

I think we must realize that while there is much we can do, there are also things which state and local government cannot do, either this year or next year.

We must realize that a major problem of the nursing home industry is not, in the end, a problem of regulation or staffing of local and state agencies, but a problem of many factors—not the least of which is money.

And they are problems of a society in which the young and the old no longer live together in many cases. In Florida they are the problems of the state where 13% of the population—an estimated 750,000 people—are over 65.

So while state government can do much, it cannot do everything. All we can do is pledge ourselves to do—all that we can do—realizing that the problems of the sick and the aged are not going to vanish from the Florida scene, but will grow with the state, and maybe even faster than the state.

Dr. BAX. I would like to point out some thoughts that I have had relating the Florida nursing home problems to the Federal Government, and this is a national problem. It is a problem that we in Florida can give you an unusual perspective of because in a sense Florida is a large nursing home for the whole United States. People coming to Florida to retire have a beautiful place to come to retire. The nursing home problem is part of the greater problem that has been agitated and complicated by certain Federal and State action and this is the spiraling and runaway cost of health care.

Let us look at the people who come to Florida to retire. They save all their lives to retire, they pay their social security and taxes in other States and then come to Florida. They live here and they see inflation

right away. What is going to happen if one of them gets sick? Minimal adequate nursing home care costs $450 a month, yet we pay $300 under our Medicaid program.

Several years ago $450 was a pretty adequate salary. That is all they make for everything. They were saving on that and now it is going to cost that much to maintain just one of them. So they came to Florida. Now, what is going to happen to them when they get sick?

So really social security has become social insecurity. That is a very personal problem and it is very ironic, too. Where is the national priority to set some adequate floor for decent adequate health care? Is adequate health care going to be that which is left only to the wealthy? I think not. On the other hand we cannot use the nursing home operators solely as a whipping boy when we have failed in our responsibility to set up health care, social security and other National Government commitments in this regard.

Improved Level of Care Needed

The answer is not in and of itself more and more money for Medicaid or Medicare because that is not going to be the answer. We found that there are a limited number of health resources, there are a limited number of nurses, there are a limited number of doctors, there are a limited number of nursing homes. Additional money in this case causes nothing but pure inflation.

We need more nursing homes. We need to put money in to train people—nurses, doctors, medical personnel. We need to be thinking in terms of working with the nursing homes and with the hospitals, not just to inspect but to help them improve their level care.

Now what are we doing in the cases were we inspect facilities? We are inspecting more facilities than we did before Medicaid. Just last week we turned 59 nursing homes over to the State fire marshall because we want the State to assume the responsibility for some uniform minimal fire standard regulation. I think that is important.

You just cannot inspect facilities because that is not the most important part. The most important part is what kind of care, what kind of treatment, how often does the doctor come, how can we work with the medical people, the nursing home, and provide services to help them operate at an adequate level of care, recognizing at the same time there should be a support level for medical care. The State of Florida cannot yet approach that financial level of support so in a sense we are forced to do the best we can. We are not providing enough money as we should to support our own Medicaid patients.

I think also though in the general area of medical care that there is certainly going to have to be more self-control on the part of health care providers or I think some will propose medical price controls but I would hope that the industry is going to move into areas to keep its own house in order.

I think the Federal Government should consider that interstate people come to us from New York, Pennsylvania, Ohio, Utah and elsewhere to retire—they pay taxes elsewhere, yet part of the Medicaid and part of the county welfare is provided by State governments for people who have paid taxes in other States. I think that the matter of inflation is also part of the national problem, so we need a national

interest in this. It is a national problem, too as it affects other States. You may want to consider establishing realistic minimum nursing home support levels as a part of title 18 and title 19 in your provisions.

Gradation of Treatment Facilities

I think another thing that we need to do, as Senator de la Parte mentioned, is to establish a gradation of treatment facilities and also a gradation of support. In many of our social programs, someone has to be destitute, we have to wipe them out financially and make them poor before they then qualify for any support. It is an either/or problem. Unless you are poor you get nothing. The people do not fit into these rigid categories so we need gradation. We need to develop some indexes for many of these services, indexes based on a person's ability to pay based on a sliding scale rather than either/or.

In many cases, society, the sons and daughters, the churches have neglected their responsibility to our elderly, yet Government has been unable to effectively respond in solving the problems. The people are expecting Government to do it.

We have to also support private enterprise at the same time because we recognize that proper incentive plays a valuable role in delivering these services but we don't think that ought to be the prime consideration in areas of support. We would like to see Government join the private sector in constructing additional facilities, training help, establishing new support levels and moving not only in nursing home care but all levels of care, recognizing the differences in the kind of care that these people need and recognizing it is something that at times even foster homes can provide.

The problem is based on medical economics. It has been our finding that you can put in so much money if there is a direct relationship to medical benefits, and when you pass that point you are putting fins on the Cadillac. We have to be looking at that point, too; what is the basic minimum level of medical care that Government should provide? If people want to go on beyond that, then that is their responsibility but I do not think the taxpayers ought to be providing that part.

We want to take the positive approach in Florida, we want to join the elderly people in provision of adequate health care. Let us all work out the problem together.

Of the 137 nursing homes that were closed, a hundred of those were closed voluntarily by the nursing home operators. We revoked the licenses of 22 but this is negligent. We need to be working not to close nursing homes but to produce more effective, better managed, more trained personnel and a more realistic approach to the State and Federal Government role in this whole area and prevent these tragic individual cases that happen in Florida where a retired couple comes to Florida, one of them gets sick and goes to the nursing home, the complete life savings are wiped out and they both die hungry. I don't think that the government can fail to respond to this kind of a problem.

That concludes my remarks.

Senator Moss. Thank you very much, Dr. Bax. We appreciate that. Your written statement is in the record.

You point out the need for more nursing homes and the need for

more nursing skills, more nursing personnel. It does seem to be a poor time to be closing any of the homes, and yet those who failed to meet the standard by a depreciable margin can be disciplined only by closure, so we have both ends working against us on that.

What we really need is to encourage the building of more nursing homes and training more nursing personnel. That of course gets us down to the problem of money. What you say about the unusual problem of Florida of course is obvious to all of us. A lot of people come to Florida because of the climate for retirement. They are the older people and therefore you have a larger percentage of older people here and therefore more of them needing nursing home care although the tax burden falling at least in part on the local property tax base again is overloaded in that sense.

So we have an unusual problem and a government financial problem which plays a bigger and bigger part, picking it up because it is the national problem with our population, migratory as it is, moving about.

It has been alleged that those that were public welfare patients were sometimes segregated and given a different type of care or treatment and food than those who were able to pay a more adequate amount. Does your inspection confirm that?

Dr. Bax. Well, I think necessarily speaking that there should be a different type of treatment to some degree based on whether the Government is paying for it. I think we ought to provide for a minimal adequate level of care. Someone spending their own money, may want the fins on the Cadillac. This is well and good, but the public should only pay for a Ford.

State Medicaid Support Inadequate

I think I made it very clear the level of State Medicaid support is not adequate and there is no question in my mind but that welfare cases do not get the same level of treatment that you can get in an exclusive nursing home.

Senator Moss. So your answer is that the State inspection requires that there be adequate nursing home care recognizing that there may be additional care given to others who are able to pay more for that service?

Dr. Bax. Yes; I think that is the point I alluded to, what the other level of care is, and we should support it on that basis which we are not now doing. Again we find that adequate minimal nursing home care we feel costs, with a reasonable profit, about $450 a month and the State is paying $300 a month. Now who picks up the difference? The man in the nursing home business wants to have a little nest egg so when he gets old he can go to a nursing home and pay for it. If he tries to pick up the $150 a month gap. He is going to go out of business.

Senator Moss. As long as the nursing home is a private enterprise operation, and we depend on them there has to be a reasonable amount of profit for those who operate it.

Dr. Bax. One of the State mental hospitals at Chattahoochee has about 7,000 patients. There are over 3,000 who are over 65 years old. So the State is involved, not intentionally but in the custodial nursing home care of the elderly through a legal declaration.

Senator Moss. They have been committed there and they are kept on because that is an easier way for the State to take care of that problem rather than have them released and go out to nursing homes. Is that what you are saying?

Dr. BAX. One of the State mental hospitals at Chattahoochee has arrangement where the welfare department has placed them in a nursing home. There are problems that accompany aging in many cases so we are through the backdoor becoming directly involved. We are thinking about rehabilitation. We need to treat the aged, rehabilitate the aged. We really subscribe to rehabilitation and the natural conclusion is we would not want to put them in an 8,000 to 10,000 patient institution because you cannot rehabilitate people in a vacuum.

Senator Moss. I think I got your figure. You say there were 137 homes that were closed and only 22 had to go through the legal procedure of having their license revoked, is that right?

Dr. BAX. That is right. Now as Senator de la Parte said, we are pressing for more people to do more inspection, to work with the nursing home people and to improve their skills and many other areas of nursing home operation. We found in most cases the nursing home operators want this kind of help, they invite them to work cooperatively. This is a majority of the nursing home people in Florida.

STATE'S FUNDING RESPONSIBILITIES

Now one point. This again is part of our problem in Florida. The county health employees are local employees of the State of Florida, but the State of Florida each year has dropped their proportionate share of funding in the county health offices. The county health people enforce the regulations yet the counties have to assume a larger and larger burden and in the legislature fixed the top that the counties could tax, so now the counties are in a box. They need the States to support the county health, yet they cannot increase taxes by law.

So again we have a responsibility at the State level to increase a part or portion of its share. In our budget this year we put in, I think, $2.5 million in additional money just to take a larger share of the State's responsibilities for supporting county health.

Senator Moss. Have you been able to observe here in Florida the problems we have seen in some other places of elderly people who have gone into the hospital on Medicare and stay well beyond the time that they needed to be in the intensive care of the hospital because of this difficulty of financing them into a nursing home?

Dr. BAX. Coming back to the need of gradation of care, I think Secretary Finch said a couple of months ago that the hospital stay has been influenced by Medicare policies. We found that unless we have policies responsive to medical practice that in many cases it cost us more, our allowances for Medicare were higher than what the pysicians had been charging. This caused inflation not only for the Federal taxpayer but for all the other patients as well, all the other people who are not covered by these third party arrangements or by the insurance moneys.

People who pay their own bills, all have to pay based on these increased costs set by Federal standards. This leads me to say we ought to evaluate, we ought to leave more flexibility for the States in these

plans to set realistic standards based on costs in the State. In Florida, for instance, we may want to look at some of these programs in terms of our relatively larger need for the care for the aged.

Medicare and Medicaid need to be realistically related to nursing homes. I am not criticizing the Federal Government necessarily, I think you could criticize State government as well. We must sometime pull these things together. Our Department of Health and Rehabilitative Service plans cooperatively the use of this tax money in the State of Florida with Federal Government.

Senator Moss. Thank you. I am impressed with the reorganization that you have in effect in Florida in your various personnel and health services now grouped together in one department where they can be interrelated and planned, each within view of the other with a rational supervision. I think this will help greatly. I agree we ought to do the same kind of job on the Federal level.

Any staff questions?

Thank you very much, Dr. Bax. We appreciate it.

Dr. BAX. Thank you.

Senator Moss. We now call Mr. Michael Richardson and Miss Peggy Vlerebome. If these two will come up here to the table, we will hear each of them. We look forward to their testimony.

We are pelased to have you with us, Mr. Richardson and Miss Vlerebome.

Who goes first? You may decide among yourselves.

Mr. RICHARDSON. Ladies first.

Senator Moss. All right. Miss Vlerebome.

STATEMENTS OF PEGGY VLEREBOME AND MICHAEL RICHARDSON, REPORTERS, ST. PETERSBURG TIMES

Miss VLEREBOME. You have a printed copy of my statement so I am going to say only a few words.

Over a period of months we at the Times got a lot of telephone calls about conditions in the nursing homes in our county. A lot of people had a lot of things to say about a lot of nursing homes. So late last summer we decided to see if all these calls were justified or at least if many of them were.

We decided to do a series regardless of what we found. If we had found that Pinellas nursing homes were of the quality that you would expect from the quantity of nursing homes, we still would have run a series.

Mike did several weeks of research compiling files, consulting the nurses, and reading about nursing home care. The two of us did additional research background work talking to specialists and then it came time to find firsthand if what we had read was borne out in practice in this county.

We chose seven homes, a cross section—big homes, small homes, corporation homes, privately run homes, good homes, and bad homes. We were determined not to have a preconceived notion of what we would find. Between us we worked all three shifts. After we completed our work in the homes we did research on 22 other homes.

Finally it came time to write. After 2 weeks of writing we found that we had written a very unbalanced story so we rewrote, putting

in the good things that we had found. If we had known what we know now, what we have learned since the series was run, I don't think we would have toned the story down as much. Just yesterday I had a telephone call from a nurse in several nursing homes. Three of the homes in which she had worked in the last 2 weeks were homes in which we worked. The conditions are still the same.

In general we found the incidence of bad cares was as high as 25 percent. In one home you can find good care and poor care. We feel generally that we have said as much as we can in writing.

I want to turn now to Michael.

Senator Moss. Thank you very much.

STATEMENT OF MICHAEL RICHARDSON

Senator Moss. We will hear from Mike Richardson and then we may have questions to you both.

Mr. RICHARDSON. Thank you, Senator.

I will just tell you that last evening as I was preparing my statement one of the members of our staff, his vocabulary slipped for a moment and he asked me, "When is your trial?" I am happy to be here though, very pleased.

I hope we may give you some idea that it is more difficult to live with a headline than it is to write or to seek it. Only three of the 10 stories in our series of articles* dealt with the bad care, the others to the cause and what could be done beforehand. I hope that all in the stories have every opportunity.

I am not quite sure, but as it turns out, because of the very nature of a nursing home, we touched on a nerve of the health care problems on the State and Federal level for more than one select area as a symbol of intergovernmental relationship problems that exist here as in other areas.

Senator, you made several claims that I would like to quickly allude to myself because of my personal experience. The recently new interpretations of Medicare policies that were handed down—from whence they came has yet to be clearly established to my knowledge, so-called adjustments as you have said—to determine what illnesses were deemed coverable under Medicare and HEW tried to make these adjustments retroactive. This resulted in nursing home patients being left without Medicare coverage and often unable to pay their bills, which left nursing homeowners alone in trying to recover amounts due them.

It would seem that Medicare today is far less than it was intended or publicized to be at its inception. An Atlanta department of health, education, and welfare official told me these adjustments had been contemplated at the time Medicare was authorized and that after a couple of years of liberal coverage Medicare would be cut back.

CRISIS IN NURSING HOMES

Senator, I don't believe the nursing home industry, as we are aware of it, had any opportunity to anticipate such adjustments.

At this point, as my statement says, I would not be the first to cry "crisis in nursing homes," but I think we must acknowledge serious deficiencies in nursing home operations. Florida's nursing homes are

*See appendix 4 for newspaper articles from the St. Petersburg (Fla.) Times.

probably no worse nor better than those in other States, although it seems that health care professionals in this State are trying to improve those conditions.

I am sure that a working relationship is available toward improving these conditions. Florida's nursing home regulations are more stringent in building requirements and in nursing staff per patient than those in other States that I have studied, these being States where there are also high concentrations of nursing homes.

There is no doubt that Federal and State Governments must be actively involved in nursing homes, that is very clear. Right now, one out of every 19 or 20 persons over 65 is a resident in nursing homes and some of those over 65 are not residents that should be.

Senator Moss, if you do nothing else from this hearing, I would appreciate that you speak with HEW and see if they cannot abandon the ludicrous practice of giving advance notification to the nursing home before annual Medicare inspections.

It is a fact that in the operation of the nursing homes, 25 and up to 40 percent of the nursing homes are deficient in some way in the State. These homes are operating on what you might call bare minimum standard requirements. Whether it is the State or Federal Government that takes the lead in initiating reform in the nursing homes, whatever the agency, the natural inclination is going to be to upgrade those standards. If that is where the home is going to function and it is not very good, then they will have to raise the standards where 40 percent will be good.

Nomenclature for Levels of Care

One further thing I think the Federal Government might have to operate on, and this is for the medical consumer, is to clarify the nomenclature in the nursing homes. You call them under Medicaid intermediate care facilities. The State of Florida calls them comprehensive skill, custodial, domiciliary, proprietary, and other lingo that you try to understand. The consumer cannot really separate; he knows what kind of care he needs because he talked to his doctor but he cannot be sure, unless he examines a medical dictionary, he cannot be sure whether this is what he wants. I believe there is certainly an opportunity for the Federal Government to work with State governments to make uniform these nomenclatures, these terms used in describing the level of care.

Perhaps I missed something. I don't know if there is any inspection into nursing care operators; perhaps they, too, would like to know what the terms means a facility has to offer. Of course whatever recommendations and regulations, we will have to worry about enforcement.

The State of Florida has not had adequate inspection forces; mainly, however, from lack of money. Senator de la Parte hopes to change this situation. We wish them well but maybe in the next session of the legislature we won't have that success. We have a relationship between the State and Federal Government to guarantee that you are going to have an adequate inspection force at least for the Medicare and Medicaid facilities, and then in our mind, in the total number of inspections and inspectors.

I am familiar with the State statutes and I find nursing homes

enjoy privileges, especially on information about the operations. Perhaps if we had a freer flow of information from nursing homes about nursing homes we could haye State and Federal operation which in itself would not have these breakdowns. I think it is time we were able to know more, and more often, about nursing homes, where so much of our Federal and State welfare dollar is going. No other enterprise so intertwined with government seems to enjoy such secrecy.

Strict Regulation of Nursing Care Practices

Now the limit of the authority is strict regulation of any nursing home's nursing care practices. Other States that I have studied their regulations, while they are not as stringent, they have at least said when a patient gets bedridden you shall—not should, not may—but you shall turn him each 2 hours, at least each 2 hours. That is a standard, accepted professional nursing practice. But it seems because there is a shortage of nurses and the aide is left quite often to see to this and maybe she just does not know that person that is bedfast should be turned every 2 hours. Little things like pointing out this negligence—in a nursing home you shall see that the bedfast patients are turned every 2 hours.

There are certain other rules requiring this type of care, I don't know that I have time to enumerate them. Certain rules and regulations should be set forth. More important than any of this, there must be doctors involved in the nursing home. Under Medicare there are only a maximum number of visits per month and frequently HEW will challenge as to whether these patients are in fact coverable under Medicare. This amounts to a deterrent, not encouragement of the doctor's presence in the nursing home. Somewhere in this completely new health care scheme for the aged, medical professional competence has got to take command. I think only the doctor can do this effectively.

Few nursing home operators have medical and psychological geriatric training, so at least the doctor can make explicit orders about health care and see that they are followed through, the doctors that arrange this type of practice.

So I would say, Senator Moss, the Federal Government should not be involved in constructing facilities in the State of Florida. Our occupancy rate is 69 percent in Pinellas County. Let's use Federal money for the care, for training, for first of all sponsoring courses in university medical schools. I can quote you all kinds of medical journals that the doctors confess they do not teach at all adequately about aging.

Also, sponsorship of course. Perhaps even this may one day be a requirement that a nurse in a nursing home shall have had one semester of gerontology or geriatric orientation which is not required today, she just has to be a nurse. Nursing home people will tell you it takes a special attitude to provide good care to a nursing home patient. I think there should be a cooperative—perhaps not necessarily entirely Federal—effort to study techniques.

Something that each nursing home patient looks forward to is an event. He has a meal, he is going to see the aide or the orderly, he is going to get to exchange a moment of conversation, he is going to get

to eat something and so on. Many homes have served five meals a day and perhaps that is something. That is the kind of thing when I say explore the other techniques for better utilization in the nursing home. That is one that I know of.

Of course nursing homes are a symbol of how our technology has out paced our understanding. We are able to build, equip, staff these facilities. But is our understanding of those patient's needs as thorough as our planning skills? What should our goal be? A policy of first of all positive response to create homes where a patient can try to live with the realistic view of being rehabilitated and leaving, not staying and dying—at least a place to pass one's final hours in comfort and safety.

Thank you.

Senator Moss. Thank you very much, Mr. Richardson, for that statement. I am a little surprised hearing you say that nursing homes are only 69 percent occupied in Pinellas County. Is that a very recent figure?

Mr. RICHARDSON. Yes sir, it is. I think Florida is unique in this right now. I think one of the reasons is the overbuilding and second I think the State nursing home people and the State legislature are trying to do something about their problems.

Senator Moss. Overbuilt but understaffed judging from the testimony of Mr. de Graff.

One thing that you suggested and which I have felt for some time is the need to involve the medical doctors more in the field of geriatrics. It seems to me, a layman and outsider, that doctors have been much more intrigued with the more intensive care of surgery and dealing with the dramatic illnesses where they can sort of see the result of their work dramatically come out when they are able to effect a cure or remedy to the person. Geriatrics is a lot less glamourous, the change of this is more slow and is not very spectacular. Do you have any feeling like that from your dealing with this series or research that you have done?

Mr. RICHARDSON. Very definitely, Senator. As a matter of fact, I have spent some time with doctors because I am curious and want to establish why we don't identify with doctors. The statistics in the county have not been unusual for Florida. There are about 350 physicians but less than one-fourth are general practitioners or internal medicine doctors. In other words, one in four is a potential nursing home doctor. Not only that, but that one in four or 25 percent is really taking fewer doctors who are actually providing the nursing home service because they are in the general practice field and they have some concern. They may have the same type of patient but the problem is there are not enough of them.

I recently talked to a doctor who confessed that the care of the aged—he's a medical examiner of Dade County—his medical training for the aged at the time in medical school amounted to determining death. So I think this is something that is significant.

ADVANCE NOTICE OF INSPECTION

Senator Moss. I noted your recommendation that the advance notice of inspection not be given of the nursing homes. Is this a regular prac-

tice now, are they told in advance when the inspection is going to come?

Miss VLEREBOME. Yes, sir.

Senator Moss. They are told in advance. That pretty much destroys the element of the inspection because knowing they are going to be inspected, obviously things will look a lot better.

Mr. RICHARDSON. Senator, it may have changed in the last 6 weeks but the last time I looked that was the practice.

Senator Moss. How can we get at your recommendation that an inspection or observation be made of the care given in a nursing home? That cannot very well happen from an inspector who walks in. Even though he is unexpected, it has to be somebody that is on more than a day-to-day observation. How can we get at that?

Miss VLEREBOME. First of all, if you have the doctor and all I think that is a day to day thing. These homes that were not expecting us, when we first went in, with as little as we know about medicine—it was not hard to tell at all where the deficiencies were. It would take a couple of days to learn, but you don't have bed sores coming overnight, that takes a while. You don't have a stench coming overnight, that takes a while. You don't have people with beards—I mean with maybe a month's growth of beard, you don't have that happen oevrnight. So most of these problems are long-term problems that can be seen by an inspector.

Mr. RICHARDSON. I had another thought. I just wanted to say that the inspectors that we spoke of were very competent people, and I say that they could tell on a once a month glance if they walk into the room and, up with the cover, and let's see the backs. They can see this if they have enough time and there are enough of them.

Senator Moss. I understand that both of you obtained employment in the nursing homes during the time that you were doing your research. Was this fairly simple, to get the job?

Miss VLEREBOME. Yes. Nothing much was required. We filled out application forms. I found out last week that one home checked one recommendation that I had given, the other ones did not check on background. A couple of places I told them I wanted to be a nurse and they were probably more willing to take me. I confessed no knowledge of taking care of anybody. People just sort of came and went, the aides did, without training.

In one home I was to be given training, the next week I think it was, but in the meantime I worked 2 days without supposedly even knowing what a bedpan was. In another home I worked 1 day but I left because I was to be training new aides the next day. This was supposedly my first day on the job and I just learned to take temperatures.

Senator Moss. The conclusion then that we would reach from your ability to secure employment is that there is a considerable turnover among the personnel in the nursing home.

Mr. RICHARDSON. Seventy-one percent, including the nurses.

Senator Moss. Including the nurses?

Mr. RICHARDSON. Yes.

Miss VLEREBOME. Among aides, orderlies, RN's, overall 71 percent.

Senator Moss. Then I appreciate the awesome prediction that your whole series makes available. I have not had the opportunity to see it

yet but I want to read the series, all of the articles. Undoubtedly many of these facts or perhaps all of them are detailed there.

We heard earlier, and I guess you were in the room when Mr. de Graff said he felt that he was overworked to the point where he no longer wanted to work in a nursing home. Is that a rather common thing, do you believe?

Demand for Orderlies

Mr. Richardson. Senator, Mr. de Graff worked as an orderly and orderlies are really in demand, I think, in nursing homes. I wonder if one orderly should not be on duty especially during the day because in some cases I was the only orderly, or the first orderly for a couple of weeks. There are still a dozen male patients there and these men expect to be cared for with some dignity and respect and care which a male orderly could do.

The fact that an orderly might be overworked, I won't claim that. I can see how Mr. de Graff might be. I came home very tired many an evening because in addition to care for male patients you are supposed to be the strong man on the staff and if there is a very heavy box to be lifted—the aide should not be lifting the heavy things. So, yes, that is true of the whole health care industry of all types, but the shortage of orderlies in particular.

Senator Moss. Well, we certainly appreciate having you come here to testify. I commend you in your enterprise in digging out the story and publishing it about the operation of the nursing homes in this particular area. As you point out, you did try to present a fair and across-the-board picture regardless of what has been stirred up. Of course anybody who feels that they have been reflected in any way to indicate that they have not done the very best reacts that way.

I think you have done a great service to the people who are still in the nursing homes to have this information made public and available to all the people so that we could get an appropriate reaction perhaps to remedy these deficiencies that you have been able to point to. I am most happy to have them labeled for the committee to read. What you have recommended seems to be very reasonable, very sound; it will be helpful to us in trying to determine what we ought to do on the Federal level in this matter.

Do you have any questions?

Thank you very much. We appreciate it.

Mr. Richardson. Thank you, Senator.

(The statement of Mr. Richardson follows:)

Statement of Michael Richardson

I would like to testify to events following the publication of our series on nursing homes. First, there was a great public outpouring: We received at least 117 letters, and more than 90 of them were in support of the series, often including personal incidents from nursing workers and patients: there were more than 100 telephone calls within the first four days and again 90 per cent were supporting.

Second, there was a response from state government: Dr. James Bax, Secretary of the Department of Health and Rehabilitative Services, ordered a special investigation of selected Pinellas County homes, and a followup inspection of nursing homes statewide: these studies showed that eight of 13 Pinellas homes

investigated had facilities of care procedures that were inadequate—and 40 of 118 homes statewide also were cited for serious deficiencies! I find these results remarkable in view of the fact that the nursing home operators knew in advance through publicity that these inspections were coming.

Third, certain members of the state legislature, who had planned earlier in the year to study nursing home conditions, accepted the series of articles as further justification for their own probe; State Sen. Louis de la Parte Jr., chairman of the Senate Health, Welfare and Institutions committee, held hearings in St. Petersburg and in Miami on nursing homes. State Rep. William H. Fleece of St. Petersburg was appointed chairman of a special House committee that sat jointly with the Senate committee. The net effect of these hearings has been a gathering of knowledge by legislatures which, when coupled with the professional experience of state health administrators, will hopefully lead to positive progressive reform of nursing home operations.

Meanwhile, in another area related to nursing homes, the federal government was acting—but apparently not so positively. New "interpretations" of Medicare regulations were handed down—from whence they came has yet to be clearly established, to my knowledge. The effect of these so-called adjustments was to (1) Limit what persons and what illnesses were deemed coverable under Medicare and (2) Try to make these adjustments retroactive. This resulted in nursing home patients being left without Medicare coverage and often unable to pay their bills, which left nursing home owners alone in trying to recover amounts due them.

It would seem that Medicare today is far less than it was intended or publicized to be at its inception. An Atlanta HEW official told me these adjustments had been contemplated at the time Medicare was authorized, that after a couple years of liberal coverage, Medicare would be cut back.

At any rate, hundreds of retired Floridians entitled to benefits (or thinking they were) have been running scared, not knowing whether they can get coverage or not. Moreover, I have learned that some doctors have ceased to admit patients to nursing homes because their judgment of what is coverable under Medicaid has been challenged so often recently. This has resulted in more elderly persons in hospital beds at triple the cost of similar care in nursing homes—just the opposite effect of what Medicare was designed to do.

Whether, in fact, Florida's new Medicaid program will alleviate this situation remains to be seen. Nursing home operators do not appear overly optimistic.

At this juncture, I would not be the first to cry "crisis in nursing homes." But I will be first to acknowledge serious deficiencies in nursing home operations. Florida's nursing homes are probably no worse or better than those in other states, although it seems that health care professionals in this state are trying to improve conditions. Florida's nursing home regulations are more stringent in building requirements and in nursing staff per patients than those rules of 10 other states I have studied.

There is no doubt that federal and state governments must be actively involved in nursing homes; at present, as you probably know, one of 19 persons age 65 or over are residents of nursing homes—more probably should be now—and more will be as the over-65 population increases.

While I would not support government-operated nursing homes, I see them as possibilities if the government-private enterprise relationship is not more efficient.

I do believe state government can be most effective in upgrading nursing home care, with federal money to help pay the bills for more inspectors and inspections. If the federal government does nothing else, it should abandon the ludicrous practice of notifying nursing home owners in advance of its annual Medicare inspections.

Further there is a tendency among the 25 to 40 per cent of nursing homes found inadequate in this state to operate at bare-bones levels, hovering around the state and federal minimum standards. Of course, the better homes charge more frequently and operate above these standards.

Therefore, whatever agency takes the lead in nursing home reform the natural inclination would be to upgrade the minimum standards.

That leads us to a second point: enforcement. If a nursing home isn't performing properly, the federal government should lift its Medicare or Medicaid certification with dispatch; the state government should reduce its licensing to a conditional status. After a reasonable time, if the poor conditions still exist, the

state should revoke the license indefinitely—meanwhile, telling the public every step of the way which homes have been cited.

Nursing homes, perhaps because of the very nature of their business, enjoy unique privileges: some tax exemptions and in both federal and state regulations, an immunity from public access to information about their operations. It's time we were able to know more—more often—about nursing homes, where so much of our federal and state welfare dollar is going. No other enterprise so intertwined with government seems to enjoy such secrecy.

Government standards have succeeded to some degree in raising the standards of construction of nursing homes, making the buildings safe for the elderly.

Now it's time to get to the nitty-gritty of the problem: Strict regulation of in-home nursing care practices.

Certain rules can be passed requiring that all homes operate according to accepted professional nursing care practices. The state and-or federal government, however, must say so before some homes will adopt these practices.

More importantly, doctors must be encouraged to be involved in the nursing home. Allowing him only a maximum number of coverable visits per month and frequent challenging of his medical opinion serve as a deterrent not an encouragement. Somewhere, in this relatively new health scheme for the aged, professional competence must take command. I believe only the doctor can do this effectively—not accountants in a fiscal intermediary's office. Many nursing home operators have no medical or psychological training, either.

It is for the doctor to leave explicit health care orders and raise the devil with the head nurse and administrator if those orders are not carried out. But first, more doctors need to be interested in the problems of the aged. Federal sponsorship of courses in geriatrics to better orient physicians with the aged patient and training for nurses and aides in this little-known field could be initial steps.

The nursing home is many things, and one of them, I believe is a symbol of how technology can outpace human understanding. We are able to build, equip and staff these facilities and admit people to them. But is our understanding of their needs as thorough as our planning skills?

What should our goal be? Positive response to create homes where a retired person can be admitted with a realistic view toward being rehabilitated and leaving—not staying to die; or at least, a place to pass one's final hours in caring comfort.

Senator Moss. I am now going to ask Mr. Charles Pruitt, executive director of the Cathedral Foundation of Jacksonville, Inc., and Mr. Thomas Routh of the Hillsborough Department of Health and Welfare; and Mr. Scott Houston, executive director of Wesley Homes, Inc., from Atlanta if they would come to the table here and we will hear from each of you.

Thank you, gentlemen. We appreciate your coming, all of you. We expect to hear from all three of you.

I think, Mr. Houston, perhaps you could begin if you would. You have come down here from Atlanta and we appreciate your coming. If you would proceed, and then we will have the other gentlemen.

STATEMENTS OF SCOTT HOUSTON, EXECUTIVE DIRECTOR OF WESLEY HOMES, INC.; CHARLES W. PRUITT, JR., EXECUTIVE DIRECTOR OF THE CATHEDRAL FOUNDATION OF JACKSONVILLE, INC.; AND THOMAS ROUTH, HILLSBOROUGH DEPARTMENT OF HEALTH AND WELFARE

Mr. HOUSTON. Thank you, Senator.

I am Scott Houston, executive director of Wesley Homes, Inc., an agency sponsored by the North Georgia Conference of the United Methodist Church.

Our particular institution has cared for more Medicare patients in

Georgia, than any other ECF in the Medicare program. On the whole our experience has been a good one. However, these are serious and basic problems in Medicare, and briefly I would like to mention some of these and then to make some recommendations.

First, the Medicare amendments appear to have become law without comprehension by Congress or HEW of the implications for the patient, the physician and the medical institutions serving the elderly. Specifically, the concept of an extended care facility envisioned an institution which was virtually nonexistent at the time the Medicare legislation was passed. The great majority of the Nation's nursing homes were serving primarily persons who required some type of permanent care. They were not geared to function as ECF's as defined by HEW.

Reasonable Costs

Many nursing homes did, however, agree to participate in Medicare with the assurance that reasonable costs would be paid for Medicare patients. It has become painfully evident to the nursing home field after 3 years of Medicare operation that in many instances the cost of serving Medicare patients is not paid for by the Social Security Administration. Institutions are thus put in the position of subsidizing the Government's health insurance program.

Another concept which defies practical administration is that a fiscal intermediary can properly determine when a patient's condition changes from "covered" care to that which is ineligible under the law.

The nonprofit nursing homes and homes for the aging largely sponsored by religious organizations have found it particularly difficult to operate under Medicare because their focus is on the needs of the patients. In order to qualify their residents for Medicare benefits it has often become necessary to move them from their rooms to special sections of a facility like so much furniture without regard to the needs or the welfare of the patients.

The second problem I would like to mention is that the Federal government has done a poor job of interpreting Medicare benefits to the public. Through what it has published and through lack of other effort HEW has left the public with the impression that a patient requiring post hospital care will receive 100 days of Medicare benefits in an extended care facility. This is not true. A patient may be eligible for such benefits but the restrictions on eligibility confuse not only the patients but the doctors and the nursing homes as well.

There have been cases where ECF benefits have been terminated at one nursing home after which the patient went to another one and got "covered" there. If there must be limitations on benefits, surely the Federal Government can be honest in telling the public that realistically few persons eligible for medicare are likely to get 100 days of benefits after leaving a hospital.

Medicare Reimbursement Rate

Third, the Social Security Administration without a change in the law has changed cost reimbursement formulas and procedures arbitrarily, adversely affecting the financial survival of institutions which

had dealt with HEW in good faith. For example, a recent regulation was announced which equaled the Medicare reimbursement rate to the lowest rate for a similar room in an ECF. This makes no provision for differentials in the cost of caring for patients. Actually Medicare patients in a nursing home will generally be more ill and require much more staff time than permanent residents of such a home.

Changing the rules after the game starts is not the way to make a program work, particularly if an institution has spent money under one set of regulations only to learn later that the rules have changed effective at the beginning of the game. If changes must be made, would it not be proper to announce their effective date in the future rather than make them ex post facto?

Medicare Admissions Decrease

Next, unless there are some modifications in title 13 policies toward ECF's, I fear that many institutions will decrease or eliminate admissions of extended care patients denying our older people care to which they are entitled. In my State of Georgia one dramatic example of the realization of this fear is that earlier this year a survey revealed that in southwest Georgia where there are over 20 nursing homes certified as ECF's there were only four Medicare patients in all of these 20 homes.

The board of directors of the Georgia Nursing Home Association recommended to its members that they disassociate from the Medicare program.

The American Association of Homes for the Aging and the American Nursing Home Association have repeatedly relayed to SSA the problems I am discussing and others. Polite reception from the Federal officials has not resulted in essential changes which would encourago nonprofit and proprietary nursing homes to serve Medicare patients.

There has undoubtedly been misuse of the Medicare program by some institutions. There is much room for disagreement on what is a reasonable return on investment for proprietary homes. But the widespread disillusionment of both nonprofit and profitmaking homes should bring an immediate comprehensive review by HEW of the ECF phase of Medicare with consequent changes to insure future care of patients.

The majority of Methodist nursing homes in the country which have become certified as ECF's find that offering several levels of care, including "covered" ECF services, has become agonizingly difficult under SSA regulations. Here no profit is sought. These homes want to give patients the benefits of Medicare but they are increasingly forced to the conclusion stated earlier in my testimony that the only way ECF care can be satisfactorily given under present regulations is in a facility which has a large majority of Medicare patients. Numerically such institutions are few compared to the total number of nursing homes in the country.

If the Federal Government wants to utilize the Nation's present nursing home resources, regulations and even the law should be changed. If such changes are not made, the only alternative if patients are to be given the benefits they deserve is to embark on a massive build-

ing program of facilities which would serve Medicare patients almost exclusively. Such a program is not likely to be undertaken by private investors under present restrictions. Nonprofit groups could hardly do this without adequate reimbursement of costs from either Government or sponsors such as churches. The massive resources required could not, in my opinion, be expected from sponsors of nonprofit institutions.

The ECF goal of rehabilitation has great merit. Many aged persons can and should be brought again to self-dependency through the emphasis on restorative care. This goal is being frustrated in too many situations by Medicare policies applicable to institutions offering multilevels of care and by the lack of sufficient facilities specializing as extended care facilities.

I shall restrict my comments on Medicaid to two points. First, increasing operating costs for nursing homes will force many of them out of existence unless more adequate reimbursement is made for welfare patients. In Georgia, for example, over 70 percent of all nursing home patients are public assistance recipients. Second, the plan to eliminate family supplemental payments to medical institutions for Medicaid patients without increases in governmental payments for their care can create a crisis in areas where Federal and State funding is less than the cost of patient care.

Before making a few specific recommendations I should like to say a further word about something that has been mentioned this morning, the burgeoning medical costs which so disturb the public and the governments. While recognizing that efficiency can and must be improved, I believe that the time is past when America can expect the cost of institutional care to be subsidized by thousands of aides, orderlies, nurses, technicians and other workers who have for decades been paid unreasonably low wages. Although there are other factors involved, institutional costs have had to rise sharply merely to bring all employees to the minimum wage for so long given to workers in many industries.

Recommendations

I would like to make the following recommendations:

1. Elimination of the three day hospitalization requirement before extended care benefits begin.
2. An effective effort by HEW to inform the public and specifically persons eligible for Medicare that 100 days of ECF care is not guaranteed by Medicare and that in fact the average benefits a recipient may expect to receive are for less than 100 days.
3. Equalization of coinsurance timing for extended care facilities with the schedule for hospitals.
4. Modification of Medicare regulations to encourage use of the program by nursing institutions which offer several levels of care.
5. Eliminate changes in reimbursement procedures made retroactive to the time they are announced by SSA.
6. A guarantee of 7 days of reimbursement for ECF patient care before retroactive denial of benefits can be made by SSA.
7. Improvement of administrative procedures by SSA and fiscal intermediaries to minimize retroactive denial or benefits which cause great problems to patients, physicians, and institutions.

8. Elimination of discriminatory reimbursement policy between nonprofit and proprietary institutions which penalizes the nonprofit agency with a lower rate of reimbursement solely because of sponsorship.

9. Increase the medical component in the administration of Medicare to focus more on the needs of patients rather than on a system which fits bureaucratic needs.

Lastly, an upgrading of the standards of care for institutions receiving Government funds for Medicare or Medicaid services.

Thank you. [Applause.]

Senator Moss. Thank you. The statement and recommendations are very succinct and pointed and I appreciate very much having them in the record. With the position you occupy and the background and experience you have had, it was good of you to come to us. Of course this is something to which we must give great attention. I appreciate your coming here from Atlanta to testify before us.

If it is all right with you, we will proceed on with Mr. Pruitt who is the executive director of the Cathedral Foundation of Jacksonville, Inc., and I understand president-elect for 1970 of the Florida Association of Non-Profit Homes for the Elderly.

STATEMENT OF MR PRUITT

Mr. PRUITT. Thank you, Senator.

May I reiterate it is a pleasure to welcome you to sunny—not warm—Florida.

The organization I administer serves some 600 persons in a residential-care facility and is opening the first phase of a 250-bed rehabilitation and long-term care facility in March 1970.

We have just this week opened a neighborhood health clinic in a Negro section of Jacksonville that serves approximately 70 percent older persons. This demonstration health center will allow us to bring minority groups into the mainstream of health care in our city for the first time.

I consider it a real privilege to be speaking on "Trends in Long-Term Care" as this particular moment of time. The sixties saw growing recognition and understanding of long-term care in the context of total community health and it is my belief that we are now ready to put into action what we have learned in the past.

The monumental work of the Commission on Chronic Illness, which made its report in 1956, laid the groundwork for much of the creative thought, research and actions of the sixties. Certainly the Medicare and Medicaid programs resulted from our national concern for good health for older and disadvantaged citizens and generally followed the Commission's recommendations as national goals in providing health services. However, the lofty goals of Medicare and Medicaid have been unrealized due to the problems and inconsistencies which have resulted as these programs such as Medicare and Medicaid have been implemented by the Federal Government and regulated by the State governments. It appears to me that we have the knowledge, techniques, and resources which are required to provide quality long-term care and that it is time we stopped talking and theorizing and begin to get the

job done. To do the job, there are trends which I feel are shaping long-term care in the United States and my comments will focus on several of them. We are very fortunate in having a reorganized State health administration in Florida. This revitalized State health and rehabilitative department is going to be a very great asset to us as we struggle to restructure our health institutions and system in the seventies.

First, Community Health Services

Long-term care is inseparable from other community health services. To compartmentalize the chronically ill patient's care by shifting him from home, to hospital, to nursing home, to outpatient clinic without communication or coordination between the institution's providing the care, will further deteriorate the quality of patient care that is given to our citizens. Comprehensive community health planning will bring about greater public awareness of the individual's health needs in a total sense and the absolute necessity for communication and coordination between health institutions and personnel.

I personally feel we can look forward to better and more economical patient care as we learn to effectively plan for our overall community health needs. But, our work is cut out for those of us in this field as we must secure more community responsive representation on health planning agencies which have been heavily facility-oriented in the past. Little thought or effort has been made to effect integrated health-care programs between hospitals, long-term care facilities and other health-related agencies, and this we must focus our attention on.

The emphasis and preoccupation of most health personnel with dramatic and short-term illnesses will change with the impact of community and geriatric health courses in our educational institutions and the upgrading of long-term care facilities. A major step in this trend will be the increasing number of health workers (physicians, nurses, administrators and other health professionals) who understand and practice "team" health care. The "team" approach has been developed for some time in most of our university medical centers. As these health professionals enter the field, we can look for a dramatic change in attitude toward long-term care in health personnel.

The upgrading of long-term care facilities will demand our most serious attention as we must avoid the proliferation of poorly designed and constructed facilities. A mechanism to insure coordination and approval of proprietary and nonprofit construction is essential to effective community health planning. Hopefully, the planning control mechanism can remain voluntary, through the establishment of standards of excellence in construction, staffing and accreditation of such facilities. However, further control will probably come in the form of a requirement on the part of lending institutions that proposed facilities be approved by the community health planning agency before financing could be finalized.

Health Maintenance

The surest way to solve the problems of providing long-term care is to educate people to practice preventive health thus maintaining their health at its highest potential. When this happens we can keep people

out of long-term care institutions and allow them to live happier and more useful lives in their normal habitat.

Individual health maintenance at a high level of wellness requires constant individual attention and support and counseling by a team of health professionals. All public and private health agencies will have to understand and focus on this technique to make individual health maintenance a "way of life" for all age groups.

My organization is currently demonstrating a 3 year health maintenance program for older persons. We hope to produce important conclusions concerning this subject as it relates specifically to older people living in a residential-care facility. This research project is partially funded by a title 3 grant.

From the Florida Bureau on Aging

The economics of providing health care will force us to a better understanding and appreciation of preventive health. We simply cannot afford to build the institutional beds that will be required if we continue our present health-care system which is focused on acute care.

Rehabilitation

Rehabilitation as a health-care concept will dramatically change long-term care in the seventies. The benefits of rehabilitation have long been known but, unfortunately, practiced in but few long-term care facilities. Rehabilitation in long-term care facilities has usually meant having a full- or part-time physical therapist on the staff. A "rehabilitation team" of the physician, registered nurse, physical therapist, occupational therapist, speech therapist, rehabilitation counselor, psychologist, medical social worker, and the administrator is essential for the rehabilitation concept to really work.

Not every long-term care patient will need the services of all of these health professionals, but an assessment of those services which the patient does require must be made when he is admitted and arrangements made to provide those services which the physician orders. Again, we have our work cut out for us to educate the public and health professionals to the benefits of rehabilitation, but the economics and patient results achieved make our efforts worthwhile.

Long-term rehabilitation is tedious and demanding. It often is painful and calls for great understanding on the part of the family. It calls for a skilled staff. But I emphasize the results are more rewarding than words can describe.

Classifications of Levels of Care

Differentiation of levels of long-term care will bring more effective and economic long-term care. The grouping of patients who have similar needs make it more efficient to provide required health services and it also creates a more pleasant environment for the patients. The accrediting program of the Joint Commission on Accreditation of Hospitals defines three categories of long-term care facilities: extended care, nursing care and residential care.

The requirements for these categories are spelled out in the Joint Commission on Accreditation of Hospitals' manual on long-term care facilities. In my opinion, these three categories provide an effective framework to classify levels of long-term care as they represent the combined thought of the most qualified national health organizations which deal with providing health services. Today, unfortunately, these terms and definitions are not universally used in our Federal, State and private health insurance programs and the result is almost total confusion concerning the definitions of the various classifications of long-term care.

Extended care, comprehensive nursing care, custodial care, intermediate care, skilled nursing care have entirely different meanings in the various States. And to the provider and the patient's detriment, the level or levels of care offered in a given long-term care facility is generally used as the determinant in the classification of the facility for State licensure and reimbursement under Medicare and Medicaid. A real problem arises if you try to provide more than one level of care in a given health facility.

Legislative clarity as well as clarity in the field will be achieved when the Joint Commission on Accreditation of Hospitals' terminology and requirements are adopted as a universal standard. An effect of this standardization will be to dramatically change the concept of extended care as we know it today. Extended care as a level of care cannot, and was probably never intended to be provided in the average nursing home. Specifically designed and equipped facilities will have to be constructed to provide this level of care and most will be attached to or located nearby a general hospital.

The unfortunate interpretation of extended care, which was allowed under Medicare when it was initiated, permitted most nursing homes to attempt to provide this level of care. This decision will haunt us for several years and will cause continued misunderstanding of the term. However, extended care, in its true sense, will flourish in the seventies and bring about its potential of better and more economical health care. The attitudes of health administrators and physicians toward the extended-care concept will be the determinant factor in how quickly the community can benefit.

Rise of Voluntary, Nonprofit Facilities

The seventies will see the rise of the voluntary nonprofit sponsor as the dominant force in the long-term care field. Why this has not happened before probably parallels the reason why our health system has failed to meet the needs of our people and will be the subject of social researchers in the future. Factors which will bring about this change from proprietary to voluntary nonprofit dominance in the field are: community health planning, higher standards for licensure and accreditation, development of health personnel standards by professional groups, the entry of increasing numbers of hospitals into the long-term care field, the public's demand for quality service at the lowest possible cost, and the growing number of housing for the elderly projects sponsored by nonprofit groups.

Effective community health planning brings about broadened community interest and awareness of quality health care with a resultant

growth in community support for facilities which can provide health services at the lowest cost. Further, as hospitals accept responsibility for providing broader community health services their sponsorship, which is primarily voluntary and nonprofit, will become involved in operating long-term care and related health facilities either as integral organizational parts or as satellite facilities.

The development of higher construction and staffing standards by State health agencies for licensure will make it increasingly difficult for proprietary facilities to meet these standards and maintain the profit ratio demanded by owners and investors.

The development of standards by health personnel will call for staffing patterns and organization that will make it difficult to maintain an adequate profit. An example of this activity is the standards being developed by the Division on Geriatric Practice of the American Nursing Association. The ANA is deeply concerned over the lack of safeguards to insure good nursing practice in long-term care facilities. Dean Lois Knowles of the University of Florida College of Nursing, who was asked to prepare a statement for this committee, is on the ANA committee which is developing these standards.

The increasing awareness of the community's health needs will cause a demand on the public's part for better health services at the lowest cost. Further, the community's voluntary nonprofit agencies will become responsive to involvement in long-term care as the general public becomes more aware of the problems of older people in general and the need to provide health services to this group becomes a widely recognized community need.

Housing for the Elderly

The recent entry of voluntary nonprofit sponsors into the housing for the elderly field will result in more sophisticated and knowledgeable sponsors for long-term-care facilities. It is natural for these sponsors to broaden their services to the elderly by adding health care facilities. Many of these sponsors are church related and have accepted total responsibility for their residents, including providing for or arranging for health services. Also, these sponsors often enter the housing field as the first step in an overall community service program which includes comprehensive programs of residential, health, and recreation services.

Unified Inspection, Licensure, and Accreditation Standards

The present wasteful and disruptive practice of duplicate inspections and audits for accreditation, licensure, and certification will be unified into single audits, single inspections, and a single formula of reimbursements. This will require the adoption of a national pattern of uniform benefits for the indigent and medically indigent. Further, a single, adequate, and uniform formula of reimbursement will demand a uniform accounting procedure to guarantee equity and to provide statistical information concerning facilities and costs of care.

To summarize: Vigorous programs of community health planning will bring about major changes in the way we provide long-term care in the seventies. Design, program, and staff will reflect these changes.

The goal of providing adequate health services for all the people will be reached only if we are successful in this planning. To be successful, we must proceed toward this goal in an atmosphere of cooperation, excellence, and mutual understanding.

The seventies will bring new and creative approaches to the long-term-care field. The potential of extended care, rehabilitation, home health services, day-care centers, neighborhood health centers, and health programs not even thought of yet, will be demonstrated and explored. Full community support will be focused on the design of a system of integrated health care.

Universities and junior colleges will become increasingly involved in these health care models and offer their technical and consultive advice in return for the utilization of the facilities for clinical education and student training. This involvement in education and research efforts on the part of long-term-care facilities will have a positive and direct effect on the upgrading of the quality of care offered in these facilities.

Senator Moss, I appreciate the opportunity of appearing before you today and hope that your visit to Florida is productive and enjoyable.

Senator Moss. Thank you very much, Mr. Pruitt. This is certainly a fine statement. I am glad to have you pointing ahead to the progress we are going to make in the seventies, and I am sure we will, despite the problems that we have now. There are solutions to be found, and I rather share your optimism. I think the focus on the need for community involvement in the health care services gives a lot of the answers to us so that we can give adequate services.

This 69-percent occupancy figure keeps coming up. Is that peculiar just to this county area or is this statewide?

Mr. PRUITT. I believe that Jacksonville is in this occupancy category. However, most nonprofit facilities maintain long waiting lists for admission.

Senator Moss. I see. This is having its effect then on the proprietary homes who are finding it difficult then to utilize the plant fully and therefore have an inadequate income, is that right?

Mr. PRUITT. Yes, sir. Senator, in our city a dramatic instance of this is a large proprietary facility of approximately 220 beds. The effects of its policy of only accepting Medicare patients keeps its occupancy at approximately 25 percent. The effect of this one poorly utilized facility is very great on our communitywide occupancy figures.

Senator Moss. I see. Approximately what size did you say? How many beds in this facility?

Mr. PRUITT. 220; with 25-percent occupancy.

Senator Moss. very low.

I liked your stress also on health maintenance as the surest attack on the problem involved on care. I could not agree more and I think that with more emphasis on health and maintenance, we will have fewer of these problems to work out on the other end.

It is a very excellent statement and I do appreciate it.

Mr. PRUITT. Thank you, Senator.

Senator Moss. I would like to hear now from Mr. Routh, Hillsborough Department of Health and Welfare, who has written two very excellent books in this field. We look forward to hearing your testimony, sir.

STATEMENT OF MR. ROUTH

Mr. ROUTH. Thank you, Senator Moss. It is a pleasure to be here. I, too, apologize for the weather while you are in the Tampa Bay area.

Let me say, in my opinion there is an urgent need for reform in many nursing homes in America today. Undoubtedly there are many homes which are fine and packed to capacity. There are some homes run exclusively with the patients in mind. These are at one end of the scale.

The opposite end of the scale are those nursing homes, probably licensed as such, some of which are more properly licensed as hovels, firetraps, ramshackel dumps, and dubious business enterprises run at the expense of good, quality, patient care.

The senior citizen is carrying the cross when he contemplates entering a nursing home. Whether he is fighting against the good, or carrying it bravely depends not only on his basic personality structure but on the type of nursing home in which he may find himself. The burden can be light and the yoke sweet if he finds himself in a medically oriented, patient-centered home wherein most of his needs are provided for, where he is cared about, and above all, where he has an opportunity for social intercourse.

Life in an inferior type of nursing home can be an intolerable, almost catastrophic burden, with death itself preferable to the inhumane, cold, disinterested, and unprofessional attitude that is passed on to the patients. Many of our senior citizens who need the services of a nursing home may come to regard them as havens of refuge and comfort for the sick and the afflicted rather than a fate worse than death.

Unfortunately, the view taken by the average senior citizen is that he may never have to go to one. Many of today's nursing homes are considered as a cross between an aslyum and the Spanish inquisition, masquerading—as the greatest boon ever given to an ungrateful segment of the population. The above statement certainly does not apply to that nursing home which, like Ceasar's wife, is beyond reproach. Unfortunately, the type of operations of many of the current-day shacks passing as nursing homes makes the above statement justifiable.

COMPLAINTS VOICED

There are many complaints voiced against nursing homes. Some of the problems are as follows:

1. Unsanitary conditions.
2. Poor quality health care.
3. Unsafe and overcrowded conditions.
4. Lack of therapy facilities.
5. No variety in menus.
6. Absence of a social service department.
7. Inadequate staffing.
8. Finances.
9. Legal loopholes.
10. Most of the other objections can be placed under this last point. They range all the way from lack of central air conditioning, inadequate lighting, heat, electrical fixtures, poor color schemes, drab and cheerless atmosphere of the home, all the way over to little effort being made by the home to get the patient out of bed daily. One fla-

grant abuse noted by the speaker was the presence of political campaign slogans on the entrance driveway of a nursing home.

There are, of course, many other criticisms which could be leveled against some nursing homes. In the main, however, the above 10 points are fairly representative of the major objections. These criticisms are not intended to paint nursing homes all black. Hopefully, however, the American people can look forward to the time when many of these objections will no longer be voiced as some nursing homes are eliminated, and as standards for the licensing of nursing home administrators become law.

Any nursing home must provide more than mere custodial care if it is to be an essential, vital, and valuable extended health care facility in the community. Residential care really means long-term care for the patient and embraces far more than simply providing for his survival needs.

Some of these older nursing homes are now too costly to operate. A number of them are really obsolete facilities which should be replaced or materially reconditioned. Failing to do this, they will probably fade from the scene as their licenses are not renewed.

Significantly, those nursing home operators—we dare not call them administrators—who disclaim the loudest in stating that national standards of nursing home accreditation are a "racket" usually operate the worst homes. The very vehemence of their protest is ample indictment against them. And, while we freely grant that death may be preferable to the abominable and abysmal conditions in some of these homes, we also maintain that as national standards of accreditation become the norm, many of these inadequate and inferior nursing homes will be driven from the scene by an enlightened and aroused public interest and concern.

Services for the Needy by the Greedy

Too often have we seen the management of some homes blatantly point out their modus operandi, namely that of existing in a parasitic vacuum of almost total dependence for their livelihood and very existence on medically indigent welfare patients. Put in another manner, some of these nursing home operators personify the idea of providing services for the needy by the greedy. Some of them give the impression that health and welfare facilities literally owe them a living. In many cases this type of home is being subsidized by the taxpayers, and in some instances by the private paying patient, thus creating a glaring national inequity.

Some nursing homes are notoriously prone to employ financial excuses to explain away their inadequacies. Some say, "Just pay us enough, and we'll meet any set of standards you establish." Many homes maintain they either cannot expand or enlarge their services because the bulk of their patients are subsidized by State and local welfare facilities. We may ask, however, precisely where do these excuses leave the patient?

An increase in the fees paid for medically indigent welfare patients will not change the operating conditions of many of these inferior nursing homes until the philosophy and attitude of the owner is

changed. Those homes operated exclusively on the profit principle must give way to those which operate exclusively for the ultimate welfare of the patient.

Hopefully we are about to enter a new day in the field of nursing home administration. This is the day when the emphasis must be placed on continuing patient care; when homes are regarded as extended care health facilities in the community rendering an essential service rather than places providing simply custodial care, and providing only for the bare survival needs of patients. Because the emphasis is now on the patient as well as on an overall program of services for him, many homes will have to upgrade their programs in order to do this.

In view of the implications of the Medicare Act, many changes will have to be effected in a great number of currently licensed nursing homes, not only from the point of view of the types of services rendered, but also from that of the quality of those services. Thus, it would seem that there has to be an immediate reassessment in the minds of some administrators. Unless the home is administered from a multidisciplinary point of view, utilizing the science of medicine, psychology, social work and the experience of nursing home administration, many of the currently licensed homes probably will cease to function.

In the future, in my opinion, we will see a decline in the smaller home with fewer beds and an increase in the large home able to provide more beds and a larger variety of services, such as rehabilitation and restoration services. Better standards will be available, yet not so high as to be unattainable.

Conflicting Standards

There is a continuing need for the licensing authority of nursing homes to enforce health laws to the letter. Too often this may be overlooked if this authority is delegated. In some cases, there are as many different and oftentimes conflicting standards and interpretations of the nursing home licensing law as there are individuals to interpret it. The mere licensing of a home, then, in no way makes it a good or even acceptable home. We look forward to the day when the State licensing authority assumes the full responsibility for the licensing and inspection of all nursing homes by establishing a strong central inspection unit for this purpose alone. When States do this, and when counties are made aware of this, inadequate and inferior nursing homes may cease to exist.

In the future, licensing agencies probably will demand a definite pattern of services for their patients over and above the mere providing for their survival needs. No longer can they be regarded as facilities for the terminal placement of people over 65. Thus, a whole new field of patients will be encountered. Some nursing homes of the future may well become specialized facilities providing services exclusively for specific disability conditions such as the psychotic or the paraplegic patient. One thing is certain: The nursing home of the future must be a medically oriented facility which offers an extension of hospital services on an extended care basis.

The problem confronting administrators is to give a new lease on life to the patient, to help him establish new goals and, where possible,

to give him the rehabilitative desire to be a productive individual again. It is not enough that a home provide only for the physical needs of the patient. Food, clothing, shelter, and medical services are not enough. The overall continued well-being of the patient necessarily is connected intimately with his feelings, attitudes, emotions, drives, and motivations. He needs socialization for the sake of socialization. He has a need for self-expression, a need to have something to do, a need to have companionship in the doing. The patient has to be helped in utilizing his time constructively so that he may use himself creatively.

At this time I would like to say something about the program of services for nursing home patients by the Hillsborough County Division of Welfare. Hillsborough County is the only county in the State offering a higher per diem rate to those homes offering better quality services to nursing home patients.

Hillsborough County is the only county in the State to have on our staff a trained recreational therapist whose main service is to provide and implement activities and recreation for nursing home patients. In addition, we also provide a comprehensive program of social services to these patients.

Now may I conclude my remarks by references to the general condition of seniors in need of nursing home care. We spend billions of dollars of tax money to keep the world outside of the United States—fed with food they don't eat, clothes they don't wear, and machinery that is reduced to rust while our most precious possession, the seniors, who built what they thought was a way of life, are given short shift when it comes to appropriations for research, care, and remedies that they so desperately need.

Admittedly, in many cases some nursing homes are inadequate in rendering high quality patient care, the shortage of trained personnel, an inadequate budget, and a host of other problems which plague the administrator.

Professionally Trained Administrators

It is not unreasonable to maintain that the key to solving many nursing home problems lies exclusively with the administrator and how professionally trained he is to cope with these problems. Gradually we are moving toward a higher degree of professionalism, in the training of nursing home administrators. This must be the case. We live in a nation of great affluence in which more services are available to the citizenry than at any prior time in our history. Despite the impact of social security, many additional new homes must be built or older homes expanded and modernized.

Whether we will ever be able to reconcile the cost of patient care and the constant upward spiraling of medical service costs to the actual income of the vast majority of the senior citizens, is impossible to state at this time. And yet, we are confronted with the inescapable fact that for the average senior citizen, his pitifully inadequate social security check does not even cover the bare necessities of life much less extended medical care. Perhaps we face a dilemma. Perhaps there is no answer to the problem of senior citizens requiring nursing home care. And indeed, if an answer there be, it will not be found in any small percentage increase in any social security check. The cost of nursing home

care for any prolonged period of time will reduce the average senior to the status of a pauper. Perforce there must be another, more equitable answer.

In a nation which gives abundant service and very little else, to the essential worthwhileness of senior citizens, some more constructive approach must be found other than forcing an individual into a state of dependency based on becoming a recipient of welfare. In defense of welfare agencies, they simply do not have the funds to do the job at hand adequately.

We can see no other recourse than adding provisions to the existing social security law which will completely liberalize the provisions of title 18 dealing with benefits in the nursing home. If this proves infeasible, then, the Federal Government should build its own nursing homes.

The approach taken to our aged, infirm seniors has been a travesty and untruth.

We say that our senior citizens are valuable to the economy, and then reduce them to penury and dependence when illness strikes requiring they be placed in a nursing home. One thing is certain: If we continue to prostitute truth and logic, our seniors will have little recourse other than contained in the soliloquy of Hamlet wherein he says "Perchance to dream." Surely we owe more to our senior citizens than merely providing them with a chance to dream and nothing more, a chance to retreat into the inner recesses of their minds and think of the good old days.

The senior's needs are urgent and pressing. He cannot wait. He will not be denied. The time for action is now. Unless and until all seniors band together in one national organization which will be their spokesman to the American people, unless they unite in a vigorous program of political action, the admonition of the Scriptures to the effect that the last state of this man is worse than the first, will be eminently true of them.

In conclusion, this Nation has spent countless billions of dollars in feeding the world and in trying to see that oppressed peoples are liberated from their enforced bondage. The senior citizens of the United States deserve more. Do our aged, infirm, sick, senior citizens deserve less care and attention, less of the American bounty than the underdeveloped nations of the world? If they do, then some form of glaring national inequity is being foisted upon them.

If in this land of promise, of abundance, of plenty, if we can do no better for our senior citizens who may require prolonged nursing home care, than promises and lipservice then, the words "Grow old along with me, the best is yet to be" must remain the futile, frustrated dream and lament of those in their golden years. This Nation owes them more. It must provide more. To do less is to violate the principles of liberty and justice on which the American Republic was founded.

Thank you for the privilege of appearing before this committee.

Senator Moss. Thank you, Mr. Routh, for a very eloquant exposition of the problem we have of finding adequate ways to meet the needs of our senior citizens. What you saw, of course, reinforces the desire to resolve the problems of your preface in which you also point out that there are good administrators and nursing homes, many people

that are doing a good job. Correctly you point out that many homes are very inadequate and they are giving service that is not only inadequate but is really useless to our older citizens.

You pointed out that it is going to take a commitment on the part of the Government to get this done, either one way or another. I liked your alternative. You said if we cannot liberalize title 18 to the point where it will be done by the proprietary institutions, the Government will have to build the nursing homes themselves. I am sure none of us contemplate that as the optimum solution to the problem.

Knowing the long time that you have studied this problem and the experience you have, I am glad to have in the record the things that you said to us here.

Now by giving increased attention do you have any estimate as to financially how much more the Federal Government ought to be doing at this point to give us an opportunity to give the kind of care we are talking about?

Mr. ROUTH. I could only give a guesstimate on this because so much is going to depend on the home, the professional competence of the administrator, how professionally trained he is, the type of services and the staffing requirements of the home, this type of thing.

Senator MOSS. Well, I was struck by your calling attention to the fact that just shelter and food and medicine is not enough, that we need all of these other services of training to qualify people that can appeal to emotional needs.

Mr. ROUTH. I think the intent of the Medicare provisions so far as they are concerned is good. This is the intent. I can go to any administrator, and, if I pay him enough money he will be able to hire anyone, and he can give some of the most magnificient services in the world. My problem is, where do we fund it? Somebody has to begin, somebody has got to make it available, whether it be the Federal Government or whether it be the States.

I do not mean to philosophize and be absolutely pragmatic and say that money is all but many problems of the administrator will be resolved with money.

PRIME NEED—FUNDING

Senator MOSS. Well, I would agree this is probably the prime need, to have adequate funding. I do not know at what level your statement points out but of course, we do have a wealthy and affluent country taken as a whole. Unfortunately, we have a large group of poor people many of whom are older people who are trying to live on a fixed pension or social security which in the present circumstances is being eaten away very rapidly by inflation. These are the people that are suffering and we simply have to find some way to care for them. Of course the older person who is ill is in the worst position of all because he cannot afford the costs of services, and at the present time the amount provided for him under Medicare and Medicaid is quite inadequate under these circumstances.

I appreciate having your statement and all your suggested solutions. Certainly this is the urgency that we feel upon us.

I do appreciate the testimony of all three of you very distinguished witnesses and I think you have added greatly to our record. We thank you, Mr. Houston, Mr. Pruitt and Mr. Routh.

Mr. ROUTH. Thank you, sir.

Senator Moss. I will ask the next two gentlemen to come to the witness table together. Mr. David Mosher, president of the American Nursing Home Association, and Mr. Richard Preston, president of the Florida Nursing Home Association.

Will those two gentlemen come forward, please.

Mr. Mosher, would you proceed first.

STATEMENTS OF DAVID MOSHER, PRESIDENT, AMERICAN NURSING HOME ASSOCIATION, AND RICHARD PRESTON, PRESIDENT, FLORIDA NURSING HOME ASSOCIATION

Mr. MOSHER. My name is David R. Mosher, president of the American Nursing Home Association in Washington. I am the owner of three homes in St. Petersburg, Fla., having 329 beds, certified as extended care facilities. I have been in the nursing home business for 15 years in this area and also another part of the country.

Our association represents some 7,000 members both proprietary and nonproprietary facilities, with about 450,000 beds. As a little introduction in the larger facility we had approximately 125 physicians in and out of that facility during the year to visit with patients. So we do operate a rehabilitation type of home with the current discharge rate of between 50 and 66⅔ percent of the patients going home during the year which is somewhat of a contrast to the testimony that has been heard here.

I think that several previous witnesses have said they did not expect good care in the health care field. In any type of enterprise, there is good as well as poor care and administration. Some administrators have relatively little experience. Some of the others have very great experience. So try to balance the picture, I have been asked to come here and speak to you.

Originally I was under the impression that my testimony was to be regarding Medicare and Medicaid. I have been associated with Mr. Routh who preceded us for a good many years and know of the very fine things that he is doing over there. However, many things he talked about are an indication of the fact as it was in the past. In the not too distant past his homes in Hillsborough County had a rate of $86 a month, $106 a month.

About a year and a half ago Hillsborough County started to supplement these payments and got up to $8 a day which is what it is now just before Medicaid comes into effect in Florida. I don't think that it takes a magician to tell you that on $3 a day per patient, very little care can be given. I do feel that the licensure of administrators of course is important, and also accreditation. These two forces are fine, they are to be commended.

I am sure you remember that at two recent congressional hearings, District of Columbia General Hospital was a good example of an accredited hospital that was and is in a deplorable condition.

Licensure should be extended to all health care administrators, not just the nursing homes. It should include hospital administrators, it should include inspectors of hospitals and nursing homes, administrators of clinics and nursing homes. If we are to have licensure, it should cover the whole gamut of the health care field.

Now the mere use of licensure or accreditation standards does not guarantee anything unless we charge attitudes of the people in charge. Hopefully this will come about. I don't think that the creation of a central czar of inspection at any level has ever solved anything. We see the Federal HEW moving back, from a total concentration in Washington, to the regions and putting the authority back down closer to where the people are. This is true in the state. This action is still over on the local level.

Now to turn to the basic original testimony which has to do with the Medicare and Medicaid situation and some of the things that can be remedied at the Federal level. We would say initially that Medicare is not an unqualified success. Your opening statement indicated that it did in the beginning bring a tremendous now element of health care for the needy people.

Medicare Policy Change

However, since July of this year, and perhaps a little before that, there has been a sharp turn down in the benefits the aged were getting under the Medicare program. This is at the direction of Social Security and HEW. To prove the point, all you have to do is look at the statistics of the fiscal intermediary.

In Florida since July there have been some drastic changes and you can look at the fiscal records and see that they dropped 20 percent in August and September and they dropped one-third in November. They look like they may go down to 50 percent and stabilize somewhere between 50 percent and two-thirds of former service levels. This has nothing to do with the medicine need, it has to do with new regulations which were promulgated because of the skyrocketing costs which we all recognize.

This policy change means that more and more older patients are either not going to nursing homes or they are leaving when they get there. As a result the costs are skyrocketing and there is a tremendous overutilization of hospitals right here and now. In effect, patients are now getting ECF care in a hospital at hospital rates. We see the patients staying there for skilled nursing care, and they come to the nursing home and are declared custodial. Then the question logically arises: Well, where did you get the term "extended care"? The answer of course is in the hospital.

An examination of some of the so-called continuing care wings of hospitals indicates that these are in some cases offering less medical care than any nursing home. They come to a point at which the patients are walking to the desk and getting their own pills and this is being paid for not at full hospital rates but at a lower rate, but much higher than nursing home rates.

So they may stay in the hospital because patients are not being moved downward to lower cost facilities. I would agree an attempt to save money at any level of care is almost impossible because we keep talking about increasing quality. This is true whether it is in the hospital or nursing home or home care program. However, it is our belief that much money can be saved by making medical utilization review work and move the patient from hospital to nursing home to home health care and back.

For instance, in the counties just south of here in the last 6 weeks there have been only eight patients discharged from the hospital to Medicare ECF facilities. We had a specific case where a patient was discharged from one of those hospitals on November 5 to go to ECF. This patient is still in the hospital, the case has been reported to the fiscal intermediary and it is being looked into. But he is still there, $36 a day instead of at a nursing home at $15 a day. This has occurred all over this county.

What is the situation that causes this? If the patient is denied benefits in a nursing home, as our senior citizens are now, then the economic pressure is to stay in the hospital where they get free care, and in this instance that is exactly what happened. There is no coinsurance until the patient has been in a hospital 60 days.

If the patient comes to the nursing home and (he is covered) the coinsurance begins on the 20th day. So he can stay in a $65 room for 60 days free or he can go to a $15 a day ECF room, and after 20 days it is going to cost the family $5 a day or $6.50. Therefore, it costs the family more money for the patient to go to the least costly facility and costs them that much sooner.

If the patient does go to the nursing home, especially in Florida, he is running a high risk of being declared a custodial patient. Since July the cost of administering the program has skyrocketed in this area. As I remember, where there were 10 or 12 staff members in the fiscal intermediary's office and in the last 6 months they have increased to 40.

The fiscal intermediary has an office in Clearwater that is making medical decisions about patients that are in bed in Miami, Fla., and this is certainly not a good way to make medical decisions. This means the administrator's costs have skyrocketed. The accounting costs and the "cost of preparing reports" are now running about 20 percent of the cost of the program.

We make reference to the famous ambulance cure. The patient leaves the hospital for the certified ECF. He arrives at the ECF in an ambulance and is declared a custodial patient, he no longer needs care.

We now have a crisis in the nursing home the first few days, "Where am I going to get money?" "What am I going to do?" We have seen utter frustration. The doctor who says this patient really needs care eventually puts the patient back in the ambulance and sends him back to the hospital, and he has had an ambulance relapse. He had the cure when he came to the nursing home and he relapsed in the ambulance on the way back to the hospital, he is again an acute patient. All right. What is wrong?

Efficient Institutions Penalized

The program itself has built into it an encouragement on the utilization of the high cost of services and facilities combined with an incentive to waste and no incentive for the patient, the doctor, the hospital or the nursing home to be efficient. In fact, if any of these four people or institutions become efficient or lower costs, they are penalized for doing so.

To make sure you understand what I am saying, let's go to a nursing home that lowers costs. If they do, they get penalized. If the nursing home reduces the cost in some area, there is just no sharing of these

costs, as there are in all other forms of Government contracts. The nursing homes have less money to run on, and a disincentive to save money.

Since the Medicare program itself is less than the cost reimbursement program to start with, you just would be getting less money. You still have the overhead, you still have the other expenses, and they continue on. The same thing occurs in the hospital. If the hospital sends the patient to a nursing home, it loses a high level reimbursement patient compared to welfare patient.

Now what do we suggest as corrections (1) build into the program some sound insurance principles; (2) build into the program policies which do not carry overutilization of any particular facilities; (3) build into the program an incentive for the patient and the family to seek the best combination of quality care and cost; (4) build into the program some incentive to be efficient and rewards for being efficient.

I suppose it is difficult in a Federal program of this type to reduce the complexity, the accounting, the forms, the reports, the endless duplication. We can hire a secretary to do more typing but the nurse is constantly required to fill out more and more forms, so the cost in her time means that she has less time to care for the patients or to supervise other employees.

The business of overbuilding which was mentioned here is often encouraged by Federal funding agencies. We have an example right here. We have just had an announcement by the FHA of a new 120 bed facility to be built in an overbuilt situation.

There is another FHA facility, 100 beds, also to be built. You have heard testimony of 69 percent occupancy. The county health department has been keeping these statistics every month for 4 or 5 years, and still they do not take them into account. FHA apartments have gone under and I suppose that nursing homes are next.

The last recommendation is to bring to your attention the question of length of stay in the hospital and nursing home. We recommend that these be reduced to 50 days each, and to apply the coinsurance principle and make this effective on the 15th day in the hospital and on the 15 to 20th day in the nursing home. There is no incentive then to stay in a high cost facility.

For those patients who cannot pay their way and who are welfare or Medicaid patients, then pick up their coinsurance under these programs. Of course this is in one pocket now but the same concept puts the economic pressure on everybody—the doctors, the patients, the family and the institution.

To summarize these suggestions we would say that the ideal solution is the good care of the patient, fair cost to the taxpayer and a fair return to the institutions, the incentive for each provider of services to do a job.

Retroactive Changes in Rules and Regulations

To move now to a broader suggestion which has been presented to you before in testimony, retroactive changes in rules and regulations and denial of coverage for the patient. If there are any changes, legistive or regulatory, that they ought to be made effective for some future

date even if that date is today. In December of 1969, for instance, to get a directive as to what the nursing home can pay for certain salaries for people who worked on the 1967 manifest nonsense—it happened in December of 1969. The rules on what was to be paid for certain salaries (fixing salaries for 1967), were published in secret form. Now anybody can outguess this situation.

The person may be dead and buried and we get a letter that Mrs. Smith was eligible for only 11 days. She is dead. She was with us for 35 days. Months later we find out the program did not pay for her case, where do we get payment?

When we are not getting reimbursements for the cost to start with, it means that we have the financial cash flow in our lap. We have serious financial difficulty, bankruptcies, largely because of the Medicare program.

This is a fact, it might as well be in the record. We have homes withdrawing from the Medicare program. We have many more homes that are simply seeking not to participate while staying in the program. This type of thing is happening.

Another broad change which we recommend is the right to equitable treatment of the ECF should be guaranteed in law. The laws that have been passed prevent any provider of service from going to the courts to get equity. It is in the law and we cannot go to any court, except through a costly constitutional case.

Why is one institution denied the right to appeal to anybody? This is what the social security law now says. So-called due process of the law of the United States is denied under Medicare. We need an amendment to straighten this out, allow us access to the Federal courts in questions involving $10,000 or more. No one wants to litigate over every little dime and nickel but they want the right to relief of due process extended to this program.

As an example, a strange retroactive denial occurred last week. An unsigned mandate from Washington was sent to two intermediaries reversing what certain States had done in the Medicaid program because the State officials and the legislators recognized that the Medicare program was not adequately reimbursing nursing homes or hospitals. Therefore, they set their payments at a higher amount than the Medicare program would allow.

Last week the unsigned mandate said it is impossible, it cannot be. The Medicaid program cannot pay more than the less-than-cost Medicare program. Last February there was put in the Federal Register by Dr. Land an article stating this was permissible and now suddenly 9 months later the legislators have gone home, and the program is reversed. You cannot find out who sent the telegram from HEW, at least we were not able to yesterday.

These are some of the problems that we have.

A final broad recommendation which we would like to make is that all direct costs of the Medicare program should be paid for by the Medicare program itself. Do not confuse this but the normal accounting that goes on is spread across the whole Nation. For the cost of Medicare you get 10 percent; private patients shall pay 90-percent cost. This is a rather dramatic illustration. We would like that kind of legislation.

I will, of course, at the end of this be very happy to answer any questions that you have. With your permission, I would like to submit the attached statement presented by Miss Betty A. Maloney, before the House Ways and Means Committee, October 30, 1969.

Senator Moss. Granted, of course.

(The statement follows:)

PREPARED STATEMENT OF BETTY A. MALONEY ON BEHALF LOUISIANA NURSING HOME ASSOCIATION BEFORE THE COMMITTEE ON WAYS AND MEANS, UNITED STATES HOUSE OF REPRESENTATIVES, OCTOBER 30, 1969

My name is Betty A. Maloney. I am appearing today on behalf of the Louisiana Nursing Home Association. I am a graduate of Louisiana State University with a B.S. Degree. I am also a registered professional nurse, having taken my training at Charity Hospital in New Orleans. During World War II I was a member of the Navy Corps. For 3 years I was with the Department of Hospitals for the State of Louisiana. During this time I aided in upgrading the nursing home regulations for the State.

I have been a nursing home administrator for the past 7 years. I am a member of the American Nurses Association and a member of the Louisiana Nursing Home Association and the Louisiana Hospital Association. I am on the Continuing Education Committee for the Regional Medical Program of U.S. Public Health Service.

At the present time, I am part-owner and administrator of two nursing homes in New Orleans, Louisiana—one, Plantation Nursing Home at 7800 Chef Monteur Highway, is a 119 bed facility, and Providence House, a 112 bed facility on Delechaise Street, near 5 hospitals. Both nursing homes are certified extended care facilities. However, Providence House is less than two years old and was opened with the hope hat it would care for Medicare patients exclusively. It takes patients from Baptist, Mon Dieu Turo, Sara Mayo and Charity Hospitals.

The Social Security Administration has issued countless regulations, some without consultation with national associations or organizations, and very few of which have been published in the Federal Register, which are designed "purportedly" to protect the reasonable cost formula.

CUSTODIAL CARE

Congress was concerned that the Medicare program should not provide custodial care. There are several built-in protections against custodial care in ECFs in the Title XVIII program. Among them are (1) the requirement for 3-day hospitalization, (2) physician certification and (3) the requirement for utilization review. In order to be eligible to participate in Medicare, a facility must have a utilization review program. Extended care facilities have spent countless hours and money to develop those programs as they were required to do. However, Intermediary Lettr 257 (and Letter 371) on custodial care may well destroy the Medicare program, if it has not already.

Without consultation with providers of service, the Social Security Administration issued Intermediary Letter 257 defining custodial care. This definition was completely unrealistic. For example, let us assume that a patient has been in an extended care facility for 30 days. The Utilization Review Committee certifies that he needs additional benefit days. At the end of an additional 20 days, the patient is discharged from benefits under the program by the Utilization Review Committee. Under the instruction to the Fiscal Intermediary contained in Letter 257, the intermediary may review the record of this patient at any time after discharge and determine that all or part of this patient's stay of 50 days in the extended care facility was custodial and the intermediary then must disallow benefits and payment. The facility is left in the position of attempting to collect from the patient as a private paying patient.

It places the Medicare beneficiary recipient in the untenable position of not knowing at any time whether the care received under physician certification and Utilization Review Committee approval will be paid for by the Federal government. More over, it places the provider of service in the position, at any point, upon admission or at discharge, of not knowing whether payment for services rendered will ever be made by anyone despite the patient being admitted to the

nursing home after discharge form a hospital upon certification of a physician and being discharged upon orders from the physician.

This places the Fiscal Intermediary and the Social Security Administration over the physician and the Utilization Review Committee on which there is at least one physician and substitutes an agency regulation and the decision of a clerk for the medical decision of the physician and other members of the Utilization Review Committee.

In requiring the establishment of Utilization Review Committees to review medical illness of Medicare patients, Congress certainly did not intend for medical decision seriously arrived at to be retroactively overridden by a clerk in the office of a Fiscal Intermediary attempting to interpret Letter 257 hastily conceived. The utilization review regulations were promulgated after some 18 months consideration by knowledgeable people in the profession, consultation and consideration by HIBAC, and publication in the Federal Register asking for comment. Letter 257 attempts to amend this without complying with the procedures of Title XVIII or of the Administrative Procedure Act. Curiously enough, Letter 257 was just published in the Federal Register day before yesterday—although SSA has enforced this regulation since September 1968.

The Medicare Act provides that custodial care shall not be paid for in the extended care facilities. Neither is custodial care to be paid for in hospitals. However, HEW has done little or nothing to curb custodial care in hospitals nor to save the program several million dollars by requiring timely transfer to extended care facilities. Ten to fifteen percent of the cases that come to extended care facilities from hospitals are no doubt custodial cases, and should not be paid for. The reason that they are custodial cases is that they stayed too long in the hospital. This is costing the Medicare program far in excess of what it should cost. The intent of the legislation was that the patient would stay in the hospital only as long as hospital care was deemed necessary, and that they would be transferred to an extended care facility, which would be far less costly to the Federal government.

SSAs action against supposedly custodial cases in extended care facilities, may save a few thousand dollars and deny a beneficiary his benefits, whereas a better administration of the Medicare Act would save millions in hospital costs. The law requires utilization review process in hospitals. Utilization review in some instances probably is not working perfectly because SSA has not made it work, but, it is working. HEW can exert pressure on hospitals and on the fiscal intermediaries to force the discharge of patients from hospitals when they no longer require hospital care.

Secondly, in connection with "custodial cases", when the physician directs the transfer of the patient from the hospital to an extended care facility a clerk in the office of the Fiscal Intermediary may decide, some 2 or 3 weeks later, that the case is of a custodial nature and deny benefits to the person on a retroactive basis.

The clerk is, in effect, practicing medicine which is contrary to the Act. SSA has exerted pressure on the fiscal intermediaries to engage in these practices which clearly violates the Act. Originally, there were many cases of post-cataract operations which the Fiscal Intermediary held were custodial care, but later they reversed this determination.

The Social Security Administration more recently again has reversed itself, and now is taking the position that post-cataract recovery in ECF's involves only custodial care and will not be reimbursed by SSA. An aged person who is transferred 4 or 5 days after a cataract operation to an extended care facility, and who has the sutures removed in the extended care facility, needs observation by a nurse or a nursing staff, and needs constant nursing observation for several days. In short, the Social Security Administration, is denying benefits that the beneficiary has a right to expect in an extended care facility and is increasing costs by forcing longer hospital stays. SSA now takes the position that observation and the judgment of a nursing staff may not be reimbursable under the Medicare Act.

BETTER PHYSICIAN'S CERTIFICATION REQUIRED

Many physicians believe that the form of physician certification being used by the Social Security Administration is meaningless. They contend that the physician should be certifying to a detailed diagnosis which required extended care facility care. If this type of certification were required, physicians would

be far less likely to execute a certificate in borderline cases. It seems incongruous that the Social Security Administration would ask Congress to abandon the physician's certification in admitting a patient to a hospital, would refuse to be strict in custodial cases in hospitals, and, at the same time, would refuse to adopt a meaningful certification of cases in extended care facilities but be so willing to deny *retroactively* countless cases where extended care facilities have given the case.

THE "AMBULANCE CURE"

There are countless instances where the physician has transferred the patient from the hospital to an ECF only to have the Fiscal Intermediary determine that it is a non-covered case. The patient, seriously ill, has been miraculously cured (in SSA's opinion) by an ambulance ride from the hospital to the ECF. This has become a nationwide joke and is called the "ambulance cure."

THE "AMBULANCE RELAPSE"

The "Ambulance Relapse" puts the physician in a dilemma. He realizes that if he had left the patient in the hospital, the benefits would have been paid for without question. It would not be custodial care but covered care. The physician gets angry and frustrated after several such experiences and sends the patient back to the hospital.

One would think that the hospital would reject the patient, knowing that the ECF was told the patient's care is now non-covered. Indeed not, the hospital accepts the re-admission of the patient and is not only not questioned by SSA but is paid in full. This phenomena is known as "ambulance relapse." The "ambulance cure" is possible only when the patient is going from the hospital to the ECF. On the return trip, the same day or even later, when the patient is going from the ECF to the hospital, it is "ambulance relapse." All of a sudden, like a mirage, SSA makes the patient's "uncovered care"—his custodial care—become "covered care" and not "custodial care."

SOCIAL SECURITY ADMINISTRATION'S MEDICARE PAMPHLETS

The Social Security Administration, in the past, has issued pamphlets to the public which led the average citizen to believe that the benefits of Medicare were unlimited.

LENGTH OF STAY IN HOSPITALS HAS NOT DECREASED

With the action against extended care facilities, one might anticipate that the Social Security Administration had reduced the length of hospital stay in order to control that part of the Medicare program which costs the most. The opposite has been true. The comparison of hospital stays of ECF patients by and large has increased in 1969 over 1968. Hospital stays of ECF's patients is averaging in excess of 25 days. This is in contrast to the average length of hospital stays of 14 days of these patients who go directly home. The reduction of hospital stays will have the biggest single effect on reducing costs. This will also aid in the so-called custodial care "cases in extended care facilities." Extended care facilities will then receive patients before they become custodial. Likewise, patients should be moved out of the extended care facilities as rapidly as possible.

ANCILLARY SERVICES AND SUPPLIES

As stated earlier, Section 1861(v)(1)(A) provides that non-Medicare patients shall not bear any of the costs of Medicare patients. However, the Social Security Administration by design is forcing non-Medicare patients to bear more and more of the costs of Medicare patients by the spurious logic that any additional nursing or other services required of an extended care facility somehow will benefit the non-Medicare patient even though they neither are needed nor desired by the non-Medicare patient.

The Social Security Administration is attempting indirectly to force on class of service for Medicare, welfare and private paying patients which is has no authority to do, directly or indirectly. SSA issued a proposed letter in which it purported to prohibit extra charges for such ancillary services as spoon feeding, incontinency, and the like. Since all patients do not require these services,

extended care facilities and nursing homes did not charge patients for these services if such services were not furnished them. The Social Security Administration stated that if the charge for spoon feeding was an extra $1.00 a day, and the basic rate for room, board and general nursing services was $12.00 a day, then the extended care facility had to adjust its rate to $12.00 plus $1.00, or $13.00 a day and charge all patients $13.00, otherwise the Social Security Administration would not pay the $1.00 a day for spoon feeding.

Recently, the Social Security Administration has gone much further and said that catheter, cylsis, oxygen and tube feeding have to be included in the overall per diem rate. Most per diem rates are calculated for care of the "average patient" which is the only fair method. Patients receiving extraordinary services such as those recited above require more nursing care, more supervision and more licensed nurse observation than the average patient. Any patient who receives such extra care and service should be charged for it whether they are Medicare or non-Medicare patients and we should not expect patients which do not use such services to contribute to the cost of such care for them.

MEDICAL SOCIAL WORKER

SSA recently has taken the position that medical social service must be included in the per diem rate. The majority of private patients and many of those on welfare have families or close friends who care for their social needs, and do not want and do not need social work services. The remainder of the welfare patients are supposed to be served by a social worker assigned to the Welfare Department. While it is true that this service should be made available on a special fee basis to those who want it and need it, those who do not should not be made to pay for it for others. This is another waste of Medicare funds which, at the same time, increases the basic cost of care provided by the extended care facility.

THERAPY

The Act reimburses for physical, occupational and speech therapy. No one denies that such special therapy should be provided under the Medicare program to those who need it and for whom it will help rehabilitate and make a more useful life. But HEW has pushed physical and occupational therapy to an unwarranted degree. Admittedly, there are several examples in which extended care facilities have abused the Medicare program by making arrangements with therapists for excessive use of therapy. But HEW has encouraged this just as they are now pushing the medical social worker.

COMPARISON OF 10 PATIENTS—HALF OF WHOM WERE DENIED BENEFITS

Below is a description of ten patients, five of whom were held to be covered care and five of whom had almost an identical diagnois, but were rejected. In each case, a Form 1453 (Admission and Billing Form of SSA) was filled out in regard to each patient and forwarded to the Fiscal Intermediary. A clerk in the office of the Fiscal Intermediary then reviewed this form and made a medical judgment as to whether this patient's condition allowed the patient Medicare (ECF) benefits. If the clerk allowed Medicare benefits on the basis of the hospital diagnois, then this clerk arbitrarily wrote in the number of days to which the patient was entitled to have care in an ECF. Each of these cases is documented in the "ANHA Master List of Documents." Form 1453 for each of the ten patients is contained in the last 10 pages of such master list.

I. Comparison of Patient A and Patient B (Rheumatoid Arthritis)

Patient A.—Medical Record 69–E–734 was admitted to ECF 19–5126 on August 27, 1969 with a primary diagnois of Rheumatoid Arthritis and secondary diagnois of Chronic Hepatitis of 5 years duration after a hospital stay of 30 days. This patient has been designated by the Fiscal Intermediary as covered case subject to Utilization Review Committee.

Patient B.—Medical Record #69–E–676 was admitted to ECF 19–5126 on June 6, 1969 with a primary diagnosis of Hypertensive Cardiovascular disease and crippling Rheumatoid Arthritis after a 65 day stay in the hospital. Although this patient had the identical diagnois as Patient A, his case was rejected by the Fiscal Intermediary on July 2, 1969 as a non-covered. This case did have an assurance of payment until June 25, 1969. However, the form was not received by the ECF until July 2, 1969 causing a period of 8 days of care which had to

be paid from some other source—if there was some other source which usually is not the case.

II. Comparison of Patient C and Patient D (Cataract Extraction)

Patient C.—Medical Record #69–E–667 was admitted to ECF 19–5126 on May 28, 1969 with a diagnosis of Senile Cataract O.D. (right eye), Intracapsular Cataract extraction I.D. (right eye) after a 10 day stay in the hospital. This patient was considered covered care by the Fiscal Intermediary.

Patient D.—Medical Record #69–E–677 was admitted to ECF 19–5126 on June 9, 1969 with a bilateral cataract extraction (both eyes) after a 16 day hospital stay. Although this patient had a cataract extracted from both eyes and the same diagnosis as Patient C, his case was rejected as a non-covered, while Patient C who had an extraction from only the right eye was allowed.

III. Comparison of Patient E and Patient F (Cholecystomy)

Patient E.—Medical Record #69–E–654 was admitted to ECF 19–5126 on May 16, 1969 with a diagnosis of Post-operative Cholecystomy. This patient had a hospital stay of 18 days and was considered covered care by the Fiscal Intermediary.

Patient F.—Medical Record #69–E–673 was admitted to ECF 19–5126 on June 9, 1969 after a hospital stay of 13 days with a diagnosis of Post-operative Cholecystomy for chronic cholesysitis. This patient was rejected as non-covered care by the Fiscal Intermediary even though he had less hospital days than Patient E.

IV. Comparison of Patient G and Patient H (Colitis)

Patient G.—Medical Record #69–E–694 was admitted to ECF 19–5126 with a diagnosis of Chronic Renal disease and colitis after a 14 day hospital stay. This patient was considered covered care by the Fiscal Intermediary.

Patient H.—Medical Record #69–E–725 was admitted to ECF 19–5126 with a diagnosis of colitis with cerebrovascular insufficiency; severe diarrhea alternating with severe constipation. This patient had a hospital stay of 9 days. The patient was rejected by the Fiscal Intermediary as non-covered case.

V. Comparison of Patient I and Patient J (Generalized Arteriosclerosis)

Patient I.—Medical Record #69–E–643 was admitted to ECF 19–5126 with a primary diagnosis of generalized arteriosclerosis; (CVA recent). This patient had a hospital stay of 12 days and was considered a covered case by the Fiscal Intermediary.

Patient J.—Medica Record #69–E–680 was admitted to ECF 19–5126 with a primary diagnosis of G.I. bleeding; generalized arteriosclerosis, old fracture left femur. This patient had a hospital stay of 23 days and was rejected as non-covered care by the Fiscal Intermediary even though his records show that his condition was much more severe than Patient I.

Based on the preceding comparisons, it becomes apparent that it is unsatisfactory, to say the least, for a clerk in the office of the Fiscal Intermediary to determine the coverage of care on a piece of paper submitted with form 1453 to the fiscal intermediary. A physician would not attempt to "guess" the number of days of ECF care that was needed without examining the patient.

Based on the information on the Medical Abstract, a patient can be denied benefits by a clerk in the Fiscal Intermediary's office which have been certified to as being medically necessary by the attending physician. This patient has not yet been subject to the Utilization Review Committee's review. There is both a duplication of paper work which places a real burden on the administration forces of an ECF and Fiscal Intermediary; one can deny benefits which the other has not even acted upon. Assurance of payment was to be exercised in doubtful cases, but the Fiscal Intermediary made the ECF report on every case or be denied payments if they assumed their judgment and the admitting physician's judgment was bad in their opinion. The Fiscal Intermediary has become the Utilization Review Committee and the payor.

Senator Moss. We thank you very much, Mr. Mosher. That was a very knowledgeable and complete statement.

Of course in your position as president of the American Nursing Home Association you had to face up to a lot of these problems and therefore you had some very pointed recommendations to give us.

I agree with the opening part of your testimony, particularly when you said that licensing and upgrading goes clear across the whole Medicare field and we should not select our nursing homes or any other particular care facility. They all ought to have that same licensing. That is commensurate with their purpose.

I am very happy to have you detail for us in the record this real problem we have of overutilization of the hospital facilities, the circumstances of being unable to utilize the nursing home care without the risk of extra cost. Obviously this must be dealt with if new savings and defined incentives for the patients, for the family, physician, and for everyone to move to the proper kind of facility are going to be developed. It is ridiculous to have patients stay on in a hospital when they can be as well cared for and perhaps better cared for in the nursing home.

So I appreciate having your remarks. I do not know that I have any detailed questions. I made some notes and I am going to read your testimony. When you supply in detail a written statement, that will come in and I am sure it will help us very much as we try to come to grips with the problem as it fits the Federal Government here.

Does the staff have any questions?

Mr. PATTON. Mr. Mosher, I have one question. I believe you indicated toward the end of your statement that you were hopeful that Medicare could be revised so as to avoid the situation of overcharging by you to compensate for reimbursement deficiencies under Medicare. I was wondering, if that is a practice, how extensive is the overcharging of private patients? I understand what you mean. You mean through higher charges to the private patient. I was wondering if you can indicate to what extent that is done by the nursing homes, and if so if you feel that that is appropriate?

Mr. MOSHER. The answer to the first part of your question is as old as the medical industry. In all health care doctors have traditionally charged those who could pay more a higher price for a given service. Hospitals have always had welfare patients. Nursing homes have always had welfare patients. So it is as old as the institution that we have in this country.

Therefore, when I say overcharge I don't mean you go out to Nick, Joe, or Pete and just have a higher price. One level of patients pays more in order to compensate for welfare, for Medicare and for whatever might be in effect. This is universal. I don't think there is any question whether it is equitable or not.

Mr. PATTON. I take it you are hopeful of remedying this situation by amending the law so as to increase payments to cover all costs and not just basic cost.

Mr. MOSHER. That is right, a total situation. We now have one whole group of patients that you can talk to, one guy that pays the bill. We have very good cooperation working at the State level within the financial capacity of the State. We made tremendous improvements in the program. Up until a year ago we were getting from the States regardless about $3 a day and then we got $4 a day from the State taking care of a welfare patient. Now $300 a month is below the recognized level of cost for a patient.

If you are trying to do this on welfare, I defy anybody who made testimony in this room today to do a much better job on $3.50 a day. I don't care what job they hold, it just is not in the cards.

Senator Moss. Thank you very much, Mr. Mosher, for your testimony and your response.

Mr. MOSHER. Thank you, Senator.

STATEMENT OF MR. PRESTON

Senator Moss. We will now hear from Richard Preston, president of district 5, Florida Nursing Home Association.

Mr. PRESTON. Thank you, Senator.

I think Mr. Mosher has covered in large part the Medicare program and the Medicaid program which is just currently affecting the State of Florida. Certainly, I will be the first to agree that the beneficiaries of Medicare are not going to get their fair shake and really do not have an insurance policy as such under Medicare. Even when the doctor recommends that a person go into a nursing home from the hospital, he will not necessarily be covered. Certainly with private insurance, Blue Cross or what have you, if your doctor feels you need hospitalization and you have proper coverage, as a rule you can count on it that you are going to get it from that particular insurance company. This is not the case currently under the Medicare program.

Senator, I will go into a little defense. I think that the nursing homes in this county and in the State certainly today have been attacked. I think everyone who gave testimony had something good to say, but I think if the tapes are gone over most of it has certainly been far from 100 percent for nursing homes.

This is unfair. I mentioned at the hearing that we had several weeks ago that Senator de la Parte was conducting that we certainly have bad apples in every industry, as I think the Senator recalls, on several occasions where one or two of his Senate colleagues were under investigation. Certainly, the newspapers of the country did not condemn the entire United States Senate, and I feel this is the way it should be handled in the nursing home industry.

I will be the first to admit that not everything is peaches and cream in every nursing home or in any nursing home—this is an impossibility, as it is in any business. I think the Times articles,* as Senator de la Parte indicated, really started the investigation going. To my knowledge I am not aware they were instrumental in having investigators come to St. Petersburg, but this is what it did come to.

We witnessed this morning when Representative Fleece had a witness appear before this group some very bad accusations against nursing homes in Pinellas County. It is just unfortunate, I think, that several of the administrators, probably in this room, that at one time or another employed this gentleman, did not have a chance to cross examine him under oath. I feel the witness's testimony might well be thrown out. We, as an association, will be forwarding my letter, if it is all right with you, Senator, regarding this man's capabilities as far as an expert witness.

Let us go back to the series of articles which instigated the first Senate hearing. Again, the two reporters that worked in the area's nursing homes set themselves up as experts in the health care field. We

*See appendix 4 for newspaper articles from the St. Petersburg (Fla.) Times.

just do not feel that anyone coming in off the street, so to speak, can make these judgments and make them as sound medical judgments. Some of us who have been members of the association for a number of years certainly have a lot to learn.

There was one medical doctor in town, Dr. Quicksall by name, who requested time at this hearing. Unfortunately, the time has not been given; he was not allowed to appear because of the shortness of time before this group. I talked to him at length about three or four nights ago and he was very upset about the Times articles. This particular medical doctor did not say anything against nursing homes in this community. He has from 60 to 70 patients in the nursing homes in a number of areas in Pinellas and said as far as he was concerned that, by and large, the care given in these nursing homes was certainly good. Again, we do have isolated cases.

Unequal Newspaper Coverage

Getting back also to some of the testimony after the series of articles in the Times. During the series of articles people were writing their viewpoints to "Letters to the Editor." The ratio was probably around 4 or 5 to 1 in disfavor of nursing homes. However, in a nursing home which has 50 beds, not large by today's standards, we have a number of the staff that wrote in—this was on their own, we knew nothing about it until afterwards. We also had a number of patients' relatives that wrote in—all in favor of nursing homes in the area and the care that was given. These letters were never published. They all received little cards stating, "Thank you for your viewpoints but we are unable to use this." We feel this is not fair coverage, that both sides should have been given equal opportunity.

Also, if we had been given advance notice, possibly witnesses could have been at this hearing, as was the case this morning. I think any nursing home administrator in the area could have brought in relatives—not too many patients, naturally. However, we would have one or two patients certainly in any nursing home that could have come up and testified as to quality of care and so forth. So I feel that it has been completely out of line.

I think the whole process of aging, by the general public and, again, the reporters that worked in these nursing homes, is certainly not completely understood. Accusations were made as far as the use of restraints, which is common practice in nursing homes in this country when there is a doctor's order. This was never checked into. They didn't question, "What is the reason for this?"

There were many accusations made, say, that take some time to find out reasons, just like the matter of senile patients. There was a quotation in the newspaper from a patient as to the lack of care in a nursing home. It was brought out through the investigation by the State board of health that this particular patient had been judged incompetent over a year before.

Now, someone who knows a senile patient, knows also that they fall in a good many categories. They can be completely lucid at one time and way out in left field at another. If someone does not understand that, certainly they will take what the patient says as gospel truth.

This has always been a touchy matter in nursing homes with relatives or friends—they have not seen how in 5 or 6 years they have changed. There are certain problems that have arisen that they do not understand. In most cases, the administrator will take time out to explain why they have got to be restrained in a chair, if this is the case. So, again, I think a lot of it is misunderstanding the problems that exist in a nursing home—the problems of aging.

You certainly have to have rules and regulations in any industry. I will say I think we have an abundance. We may have the most rules and regulations of any industry in the city. If the current rules and regulations are enforced, they are certainly adequate to insure good patient care in nursing homes.

I will say licensed, because we have a problem in this State, and many other States in the Union, where there is a very unfortunate existence of unlicensed nursing homes being operated for profit, much more profit than any licensed nursing home because they do not have to have adequate staff. These should be investigated first. There are a great many we bring to your attention, Senator, as a problem not only in Pinellas County, but statewide and national.

Locally, the county board of health is responsible for the existence of nursing homes, but has been unable to close the unlicensed ones up because, as yet, there has been actually no pinpointing as to whose responsibility it is. These are the boarding houses of yesteryear that are not licensed as nursing homes, not required to have any staff whatever, and when you talk about the disadvantages as far as lack of care, this is a good place to start looking.

Grandfather Clause

It was mentioned several times, as far as the law is concerned, that there is a grandfather clause. That seems to be upsetting several of the State senators and they comment on the possibility of making a change in this. I would suggest to you that abolishing completely the grandfather clause, especially with the way the rules and regulations change from year to year, could well put all nursing homes out of business. There have been instances in the last several years where the nursing home took 9 or 10 months to build from the time it was started. By the time it was completed, it was out of conformance because of rules and regulations that had been put in since the start of construction.

We feel in this case certainly this nursing home should not be denied a license strictly because of unrealistic rules and regulations that have been put in in the interim. In Pinellas County most of the nursing homes are approximately anywhere from 10 years old or younger—most of them are younger. So we do have good facilities, but probably in 60 percent of those, there are some physical plant deficiencies that they could be closed because of them. When we have spent $500,000 or $300,000, whatever the case may be, and built according to code just a few years ago, we feel we should be able to continue to operate. This is why we feel that some sort of grandfather clause has to be in.

I think in the first hearing I referred to, which Senator de la Parte conducted, the different teams that were sent out into the county to inspect, after the series of Times articles and accusations by the large

newspaper, were questioned under oath. I think if you will take the time to go back and read the testimony in that particular hearing of all of these state board officials, that you would draw the conclusion that these accusations were isolated instances. This is the word, under oath, of the health teams that came down to Pinellas County to inspect.

Adequate Pay

Another area I think that we keep hearing about is adequate pay, the fact that employees in the nursing home business are not adequately paid. The wage currently in this area, nationally as well, of $1.30 per hour will go up to $1.45 per hour in February 1970 and $1.60 per hour 1 year thereafter. So the wage level of the rank and file staffing of the nursing home is going up.

I mentioned at a couple of staff meetings to my own staff in my own nursing home that I would like to pay $2.50 an hour or $3 an hour, but then I would go broke. No. 2, the rates for the patients would rise. So we would price ourselves out of business. It has to be done on a very, shall we say, planned and deliberate, positive, upward increase as far as pay rates are concerned. Of course, I am happy to increase every time. We, as an industry, naturally have to go slow on this.

As far as saying that you are going to get better help just because you are going to pay them $3 an hour, I think this is a fallacy, too. I think in the construction business the laborers are getting $4, $5, $6 an hour in some places, and the quality of the buildings they are building is less and less desirable. So you cannot buy quality just by paying x number of dollars per hour. We have found in the past the girls we had working for us a number of years ago for $1.25 an hour, if they were good then, they are good now. If they didn't work good then, they are not good now, regardless of what we are paying.

Summing up, as far as my testimony at this hearing, I would like to say that I am very happy to have had the chance to speak in behalf of the nursing homes. Again, we do have problems, Senator; I think we are doing our best to iron them out. It has been an extremely fast-growing industry. I think if you look back 15 years ago at the nursing homes in this country, look today at the nursing homes in this country, believe me, there is no comparison. The quality of health care has gone up in that 15 years astronomically.

As far as the future is concerned, I think the help shortage certainly is nationwide, and this is the problem. You gentlemen are going to have to look at the problem, the State boards of health are going to have to look at it, and the problems hopefully can be worked out in time. I hope we can work together, and as administrators in nursing homes we certainly do our best to work with you. We do not like to be constantly lambasted when we feel it is unfair, but sitting down and trying to talk and work problems out, we think this is good.

Thank you.

Senator Moss. Thank you, Mr. Preston, for your statement. I think it is entirely appropriate that you have had this opportunity to state the case as you see it from the side of the nursing home operators. Certainly I don't want the record to be unbalanced as you felt it might have been without your statement. Even though other witnesses did preface their remarks by saying kind things about the operators in the

nursing homes, perhaps there was an overemphasis on the failures in the nursing home field.

I agree with you fully on the tremendous advance and change that has come in the last 10 or 15 years. It was not long ago that the nursing home was simply a place kept by an older couple or older lady in a large house and people were allowed to come and live there until they died and that is about all—a custodial place and a place to go when no one else would bother. I agree we are making considerable progress, but I think we all agree that much remains to be done. That is what we are talking about in this hearing.

I am pleased to have your testimony. If you care to amplify it at all in writing at a later time, say within the next 30 days, of course you may do that.

(See appendix 1, item 1, p. 221.)

Now we have sat right through lunch hour and beyond trying to complete this hearing because we have a limitation of time which we have already exceeded. I have other commitments which must be kept. Because we do not have more time we will not be able to hear all of the people perhaps who might have testified before us and might have liked to be heard.

I announced in the beginning, if you recall, that if any person who was not going to be heard wanted to make a statement for the record it could be written on this form which is provided and which the staff people will have at the doors, it is still available. You can write that down and sign your name and it will be put in the transcript to be made of these hearings. It is this form here.

(See appendix 3, p. 236.)

I point out also that the record of this hearing will be kept open, as we say, for 30 days. We are going to have other hearings in other cities. By saying that I indicate that any person who has a contribution to make, has something that they would like to have put in this record, would like to make a contribution to it, they may send that to us in writing. Just send it to the Committee on Aging, Washington, D.C., and it will be included in the record.

Those who testified here this morning may wish to clarify or amplify some point they made, or in view of statements that were made by others if they want to make some addition to their statement, this will be possible by putting it in writing and sending it to the Committee on Aging and identify it with this particular hearing so that we will know where it will be in the record.

After the record has been completed it will be printed and anyone who wants to receive a copy of that can send a postcard or a letter to the Committee on Aging in Washington and when the record is printed we will see that a copy will be mailed to you if you want it. Those who testified will automatically get one without sending in a request, but anyone else may do so.

One final announcement. For those professional people who have reason to want a copy of the written statements that were filed with us today by people who testified, we have a few of those and a member of the staff will be at the door and will give you a copy as long as those copies last of any of those written statements. There may be some who need it right away.

I do appreciate the very fine hearing we have had. We have had a series of excellent witnesses. We have accomplished our purpose I think in coming here to get a picture of the situation in Florida and more broadly of important issues which affect the whole country in this field. We have received some excellent suggestions as to what needs to be done on the Federal level to rectify some of the problems which have become very severe in the field of care for the elderly.

You have been a very good audience and you stayed here a long time.

I accept all the apologies about the cool weather but I can tell you that it is nice to see the sun shine down here in Florida.

The hearing is now adjourned.

(Whereupon, at 1:40 p.m., the subcommittee adjourned, subject to the call of the Chair.)

APPENDIXES

Appendix 1

ADDITIONAL INFORMATION FROM WITNESSES

ITEM 1. LETTER FROM RICHARD PRESTON, PRESIDENT, FLORIDA NURSING HOME ASSOCIATION TO SENATOR MOSS

FLORIDA NURSING HOME ASSOCIATION,
February 7, 1970.

Senator FRANK MOSS,
Chairman, U.S. Senate Special Committee on Aging, New Senate Office Building, Washington, D.C.

DEAR SENATOR MOSS: I am enclosing a letter from one of our patient's relatives and a post card which was received from the St. Petersburg Times by one of our nurses. Both of these, I think, are pertinent, as they pertain to the part of my testimony stating that the St. Petersburg Times gave unfair coverage during their investigations and did not present the nursing home side. Literally hundreds of such letters were written and sent to the newspaper—yet, less than a handful were published.

* * * * * * *

I would hope, Senator, that you would take the time to check all the testimony given at the investigation conducted by State Senator de la Parte, and especially the testimony of the County and State Boards of Health people who made on-the-spot investigations of Pinellas County nursing homes. Many of the accusations made by the St. Petersburg Times reporters were just not true and were proven to be fallacies.

If you desire any more information at any time on nursing homes in this area, please do not hesitate to get in touch with me.

Sincerely,

RICHARD PRESTON, *President.*

Enclosures.

Re nursing homes.

To: The editor St. Petersburg Times.
From: Nora Kemp Albaugh, 1601 63d Avenue South, St. Petersburg.

I have read with much interest all the recent articles on "Nursing Homes". Since October of 1964 my husband and/or I have visited one and for a part of this time two nursing homes at least 345 days of each year. We have visited at all different hours of the day. We have been to these for family but I have personally visited others in at least twelve different homes in the city on quite a few occasions. I agree that some homes should be investigated but I also know that not all homes deserve the blanket criticism leveled. Two homes in the city have been a special blessing to me and my family in a time of need.

One of the first articles mentioned that doctors say 80% of the people in nursing homes could be cared for by their families and in the article of Nov. 25 Sen. Louis de la Parte of Tampa is quoted as saying, "Thank God, there are some families who find a way to take care of their own aged." I resent these statements and they do not make me feel one bit guilty to have a family member in a home now. Most of us are not physically or emotionally equipped to care for the aged, infirm and senile persons we are responsible for. You may not always be happy with every aspect of patient care in any nursing home but they also may not be very happy with you. No one person can give 24 hour care as the

home is equipped to do plus providing skilled care, companionship, crafts, entertainment, church, beautician, shower baths, proper diets, etc. A private home is not equipped for all these things.

I taught school for quite a few years and I can tell you the young are twice as easy to deal with as the old. If you haven't tried either do so sometime. I am grateful each day for the Richard Prestons and their staff at the Whitehall Convalescent Home here. No one is perfect, but these people run a good home and I am most appreciative of the service given to the member of my family there. I could not do the same at home.

NORA KEMP ALBAUGH.

ST. PETERSBURG TIMES,
St. Petersburg, Fla.

MRS. PHILIP A. TAGUE, JR.
330 79th Avenue,
St. Petersburg Beach, Fla.

Thank you for your letter to The Forum. We regret that we are unable to publish it.

We like to hear from our readers and hope you will write again.

The EDITORS.

Appendix 2

STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT BY HEALTH PLANNING COUNCIL OF THE JACKSONVILLE AREA, INC., JACKSONVILLE, FLA.

BACKGROUND

Any appraisal of the nunrsing home situation in Duval County, Florida, necessitates a description of the county's demographic characteristics as well as a summary of the growth and development of nursing homes and extended care facilities the past five years.

The county, a typical southern community with a readily definable power structure, experienced a great amount of growth during the 1950's and early 1960's, with a present population of 525,000. This growth was due mainly to a considerable net in-migration of relatively young, unskilled and uneducation white people from the neighboring southeastern states. The black segment of the county constitutes about 30 percent of the population and is mostly native to the area. Expansion of this black segment in the past 20 years was the result of increasing numbers of births over deaths.

Duval County is a major insurance center in the Southeast. It is a seaport city and the location of a relatively large number of paper mills and related industry which employs largely unskilled or semi-skilled personnel. There is little of what one would consider "sophisticated industry" in Duval County.

Duval County is atypical in respect to other Florida cities in that the aging (65 years or older) constitute 6.5 to seven percent of the population whereas the state average for older residents is 13 percent of the population.

A relatively indepth study of nursing homes in Duval County was made in 1964 by the Health Planning Council of the Jacksonville Area, Inc. At that time, there were 22 licensed nursing homes catering primarily to white patients and three licensed nursing homes catering primarily to black patients—their total bed complements were 870 and 117 respectively, for a total of 987 beds. There were five licensed homes for the aged for whites and four licensed homes for the aged for blacks—with total bed complements of 67 and 51 respectively. At that time, four nursing homes with 60 beds and over represented over 40 percent of the available beds. The other 60 percent of beds were in homes with less than 60 beds. In the county, 17 licensed nursing homes were in converted dwellings and represented 41 percent of the total 987 licensed beds. The general physical condition and state of repair of these converted dwelling type nursing homes ranged from good to very poor.

In 1964, 63.4 percent of the nursing home beds were individually owned and operated. These homes were operated by proprietary corporations and two were operated by non-profit church affiliated groups. The church affiliated homes represented eight percent of the number of homes in the County and 15.4 percent of the available beds. One black home of 52 beds was operated by a non-profit community corporation.

A licensed practical nurse (LPN) filled the requirements of the "Nurse-on-Duty" during the evening and night shifts in most nursing homes. It was generally known that most of the homes in Duval County having 60 beds or less employed only one registered nurse (RN) with the remaining requirements filled by the LPN's and aides.

The study included information as to the financing of these patients, and the findings revealed that 80 percent of the patients were on either the county or the state welfare roles.

Most of the recipients were in one of the four categorical federally aided programs: Old Age Assistance (OAA), Aid to the Blind (AB), Aid to the Permanently and Totally Disabled (APTD), and Aid to Dependent Children (ADC).

The majority were recipients under OAA. The state vendor payment at that time was $100.00 per month to the nursing home for patient care, plus $10.00 per month for the patient's personal expenses, and up to $20.00 per month for drugs.

Few of the nursing homes accepted state welfare patients for the vendor payment of $100.00 monthly except the black nursing homes. If patients had no other source of income, the Department of Public Welfare requested the County Welfare Department to supplement the vendor payment. The County was authorized to supplement the state payment up to $200,000 per month, but because of a chronic shortage of funds, this supplementary payment averaged around $50.00.

For indigent persons who required nursing home care and were not eligible for state welfare, i.e., those who did not meet the five-year residency requirement or who were not permanently disabled, the Duval County Welfare Department paid up to $175.00 per month and supplemented up to $200.00 per month. These figures were maximums and the actual payments were probably lower due to the shortage of welfare funds within the county.

In conclusion, nursing homes for white state welfare patients who were supplemented by the county were accepted at $150.000 monthly and homes which accepted patients from county welfare only, received about the same amount. The black homes would often accept patients for the $100.000 state vendor payment only, which was on the average $25.00 per month less than in the white nursing homes.

In 1964, the greater percentage of nursing homes charged $250.00 monthly. Others catering to a more affluent clientele charged $350.00 or over. Homes with average monthly charges of $200.00 or less contained 27.9 percent of the available beds, whereas homes with monthly charges of $250.00 or more represented 72.1 percent of the total available beds.

The most critical nursing home bed shortage existed for the indigent welfare case. With a few notable exceptions, the status of nursing homes in Duval County, Florida, was extremely poor—both in respect to physical facilities and quality of care rendered.

CURRENT SITUATION

In August of 1969, five years later, another study was made of nursing homes. There were 20 nursing homes licensed with a bed capacity of 1438. Of these homes, only eight were in converted dwelling type homes with the expectation that most of these would be phased out by 1971. This compared with 17 converted dwelling type homes out of a total of 25 homes in 1964.

Theoretically, all of the homes had integrated, but in reality, integration was limited mostly to Medicare patients. Two black homes still served the majority of long-term welfare nursing home patients. The population during the five-year period had more or less stabalized at 525,000.

Despite the current average occupancy rate of 73 percent at the time of the study, there were 310 new nursing home and extended care facility beds under construction. Another 500 beds were in various stages of planning. Since this report was made public, a number of proposed projects were delayed indefinitely or completely abandoned.

Of the 20 licensed homes, 13 were operated by individual proprietors and represented 682 beds or 47 percent of the total 1438 beds. It is anticipated that eight of these homes (of converted dwelling variety) with a 159-bed capacity will probably be closed within the next two years.

Four of the homes with a 486-bed capacity were owned by syndicates and represented 34 percent of the county's capacity. The remaining homes were under non-profit sponsorship and represented 270 beds or 19 percent of the total. (Another 310 beds in non-profit homes are now under construction).

Only eight homes were certified for Medicare patients. Three of these certified homes were individually operated; two were operated by philanthropic groups and three were chain operations. Their total bed capacity was 1036 or 72 percent of the total available beds. Since then, a number of these homes have reduced the number of beds which were certified for Medicare. This was done mostly by the non-profit and single owner operators who had no choice but to serve the long-term patients because of scarcity of Medicare customers.

Two of the chain operations catered heavily or almost exclusively to Medicare patients as did two individually operated homes. The other four eligible homes were serving only 21 percent of the Medicare patients.

An evaluation of occupancy rates revealed that only 1051 patients utilized 1438 beds or 73 percent. Of these patients, 178 were certified for Medicare, or 17 percent of the total number of nursing home patients in the county.

Homes concentrating their facilities for Medicare patients had the lowest rates of occupancy. A 233-bed "Medicenter" facility had only 41 patients and another 100-bed individually owned facility had 64 patients, whereas the philanthropic homes were filled to capacity. The substandard homes (converted dwellings) rarely had any vacancies.

Approximately 800 or about 75 percent of the patients in nursing homes are indigent and under a welfare program with a rate of reimbursement from $250.00 to $300.00 monthly.

The higher price homes or those that cater mostly to the Medicare patients are charging $450.00 to $550.00 per month.

In comparing the changes in the status of nursing homes in the five-year interval between studies, the overall physical facilities are much better than they were in 1964. However, it must be pointed out that there still exists a wide range of facilities. The indigent and welfare patients in the main still occupy the inadequate physical facilities, excepting those fortunate enough to reside in one of the non-profit sponsored homes. However, there exists a large surplus of beds in good physical plants which are not occupied because of the costs which few nursing home patients can afford.

An evaluation of the quality of care in Duval County nursing homes follows.

COMMENTARY

1. The expansion of nursing homes and extended care facilities

The expansion of nursing homes and extended care facilities during the past five years in Duval County was undoubtedly the result of the Medicare program which began in 1967. This trend to building new facilities to meet anticipated needs for more and better quality beds was followed by the proprietary as well as the non-profit groups. An added stimulus to the expansion of non-profit and church related facilities was the availablity of federal grant-in-aid funds (Hill-Burton) for the construction of and expansion of these facilities.

The unprecedented growth of facilities no doubt reflected the anticipation of increasing utilization of beds resulting from the Medicare and Medicaid programs.

Primarily, the growth of nursing home chains reflected anticipated profits from a "new industry" to be financed largely by federal funds. The nursing home stocks became glamour issues and were eagerly sought after in the market place. The promoters of these chains realized handsome profits on the stock market without any real concern for the proper operation of the homes themselves or any real interest for the welfare of the patients occupying these facilities.

2. Cost and delivery of services

The cost of nursing home services has risen at the same rate proportionately as that of the hospitals. It reflects the escalating and spiralling cost of labor and goods used in the nursing homes as well as the high interest rate for funds borrowed for building programs. State licensure requirements no longer permit the conversion of residential dwellings into nursing home facilities and thus additional facilities can only be designed from plans approved by the State. Increased costs of construction results in increased cost of operation.

3. Lack of quality control within nursing homes and extended care facilities

There has been *little effort* on the part of official bodies to spell out guidelines which would enable the licensing authorities to evaluate the *overall true care* of the patients within these facilities. The tangible physical facilities can obviously be measured but efforts to develop mechanisms to insure the quality of the other dimensions of human needs—social, emotional, medical, and recreational outlets—are left to chance and the sensitivity of the investigator. These conditions can very often lead to the accelerated vegetation of the nursing home patient.

4. Relationship of the nursing home and the hospitals

There is only one major hospital with 370 beds in Duval County which has an active and positive program for continuum of care from the acute care facility to the nursing home or extended care facility. But even then, there is no follow-up on the quality of care in the nursing home or what happens to the patient. Furthermore, it can be anticipated that motivation and pressure for transfer of the patient to the extended care facility will largely be dependent on the demand for hospital beds. With the doubling of general hospital beds in the county ex-

pected by 1971, the occupancy rate of hospital beds may be the determinant as to the rate of transfers to the extended care facilities.

5. Shortage of adequately trained personnel

There exists in Duval County, as in most other parts of the country, a severe shortage of adequately trained paramedical personnel. The expansion of nursing home facilities plus Medicare personnel standards of training has undoubtedly added to the severity of the problem. To add to this complex problem is the unwarranted and poor utilization of skilled personnel. A number of facilities operating at a relatively low rate of occupancy still require skilled staff which could perform as adequately in a facility with an occupancy rate of close to 100 percent. Thus, this scarce staff effort is diluted and also can have a demoralizing effect upon many who are employed within these grossly unoccupied facilities.

6. Access of minority groups to nursing homes within Duval County, Florida

A study by the Health Planning Council in August 1968, after the first year of Medicare utilization revealed that the black community hardly utilized this program. In the analysis, it was believed that the cultural factors no doubt played a major part in their reluctance to utilize the facilities under the Medicare program. Entering an all-white nursing home was an alienating experience which most blacks preferred not to attempt.

Another significant factor was that most of these patients did not have their own private physicians but had been dependent upon the clinical services of the county hospital. Regulations governing the Medicare program are, for the most part, based upon the assumption that the patient has his own physician. The absence of a private physician had curtailed the use of the extended care facilities and thus the continuum of care was interrupted for most blacks.

7. Overbuilding of nursing homes

Overbuilding of nursing homes is a definite reality in our county. This has occurred largely for reasons which were mentioned in Commentary #1, namely for investment purposes. Under-utilization of beds results in lessened income and the resultant economizing measures employed in a desperate effort to remain in business, results in poor services to the patient.

There is social and economic waste in building unneeded or ill-utilized facilities. Whereas, in other sectors of the economy, bankruptcy is never a pleasant experience, in the nursing home setting it may be a traumatic experience for many patients who may have to be transferred once again.

8. Lack of planning

One of the most obvious and damning conclusions is the almost complete lack of sensible planning by the nursing home industry during the past five years. The individual operator has probably been the greatest offender in failing to investigate before he invested in a new facility. He appears to have been either grossly misinformed or anticipated unrealistically his profit potential from the Medicare program. He also over-estimated the number of potential patients who would be eligible or interested in entering a nursing home facility.

It appears that planning for health facilities, now a voluntary process, may have to become a more authoritative service within the purview of the state licensure process.

ITEM 2. STATEMENT FROM LOIS N. KNOWLES, ASSISTANT DEAN AND PROFESSOR OF NURSING, THE J. HILLIS MILLER HEALTH CENTER, UNIVERSITY OF FLORIDA

I. INTRODUCTION AND NEED TO CONSIDER THE NURSE'S VIEW

Mr. Chairman, I am Lois N. Knowles, Assistant Dean and Professor of Nursing at the College of Nursing, University of Florida, Gainesville, Florida. For the last nine years I have been involved with the nursing of older persons in activities that include teaching, nursing practice, research, publication, and consultant work in geriatric nursing. I am currently a member of the Committee on Nursing Standards of the Geriatric Division of the American Nurses' Association, an Association committed to improving the quality of nursing practice for older people.

It is a privilege to represent the nursing profession and to present to you a

statement concerning present and future conditions and needs in the area of long-term health care for the aged, for the hearing record of the Subcommittee as a part of its study of "Trends in Long Term Care." I have reviewed the Hearings of the Subcommittee since 1965, and, while I do not pretend to have made a detailed review, I did notice that, until 1969, no nurses testified or prepared statements for the Subcommittee. Therefore I was greatly heartened by Mary Shaughnessy's presentation to you in July 1969.

II. THE NEED FOR ASSESSMENT OF THE AGED PATIENT'S HEALTH NEEDS

It is understandable that attention is now being focused on nursing home facilities and working conditions. It is also understandable that the design of long term nursing care facilities, such as nursing homes, has for perhaps too long followed small hospital design. But, now that some improvements and corrections have been made, it is perhaps not so apparent what is still wrong. The situation reminds me that Henry Ford, who made his first car in a garage, did not first make the garage and then make the car to fit it. Rather, he used the car to determine the design of the garage. At present, we are in a similar position in regard to our nursing homes and other facilities for the aged. We have buildings now, you see, and people in them, but the services people get are not yet consistent with the services they need.

The primary reason for this is that little attention has been paid to clarifying and communicating the product nursing homes offer—NURSING. First, by and large, the public has only a hazy idea of what constitutes good nursing, the essential component of the product they are buying. Not for long would a business survive in our society with such a misty fog obscuring both the *consumer's* understanding of the service he needs and the *provider's* understanding of the service he provides—or thinks he provides. Both the patient and his family and also the nursing home managers need to clear their thinking about themselves and each other. When the service wanted and the service offered have been clarified, the public and the nursing homes can then begin to communicate more clearly with each other.

In addition to this clarification, nurses themselves must begin consistently to make more comprehensive assessments of the nursing needs of their older patients, so that nurses' professional judgments can more effectively reinforce the health care being provided to patients in nursing homes. Those of us most involved with geriatric nursing must scrutinize the service offered, clarify the remedies we recommend for existing problems in long-term care for the aged, and communicate our thinking to other interested persons.

Nursing home personnel must evaluate themselves. It is at once baffling and startling to find that orderlies, state legislators and newspaper reporters are currently evaluating nursing home care. If persons outside the nursing profession are unhappy about conditions, you can rest assured that those of us within it, who are trying to improve the nursing, are even more unhappy. It is shocking for nurses to hear about physical abuse of institutionalized older patients. It is also shocking for nurses to find that some older patients cannot walk because they have sat too long in chairs, or that others are dying because of depression, apathy, and not eating the food placed before them. These are representative of the kinds of nursing problems which need attention at once. My statement therefore will be devoted primarily to ways to improve the product NURSING which is being bought by the public and by the Federal Government through its financial assistance to older people.

Ways to improve long-term care for the aged are:

1. Provide a device to use in assessing the patient's current and changing state of health and to help point up the kind of health care facility he needs;
2. Provide clear statements concerning the definition of nursing and its standards, and concerning nursing evaluation and functions;
3. Provide education for geriatric nurses relevant to work they will do in long-term care of the aged; and
4. Recruit a sufficient number of appropriately educated geriatric nurses to care for the older persons in our long-term care facilities.

In order to provide a convenient way for members of a Health Team to make individual and combined professional assessments of a nursing home patient's health needs, a computerized health history form is indicated, for use by the several members of the team.

III. THE COMPUTERIZED HEALTH HISTORY, AND NURSING FORM

A. Initial assessment.—Early assessment by means of such a form would identify the kinds of assistance needed by the elderly person and who can best provide them and would estimate how long he will need them. Such a Computerized Health History Form is presently being used in the Health Maintenance Research Project at Cathedral Foundation of Jacksonville, Inc., Jacksonville, Florida, which is directed by Mr. Charles W. Pruitt, Jr., Executive Director.

The use of the computer for this information is intended to assist in meeting manpower shortages, improve the quality of care, and provide better care to people who need it by saving the time of health personnel.

B. Periodic reassessment.—There is a great need for a periodic reassessment of older persons' health by the nurse, the social worker, and the physician, so that the patient does not become trapped in a facility or experience kinds of assistance not appropriate to his changing state of health or to changes in the availability of additional resource persons, agencies, or equipment.

C. Matching the older person's health, and nursing *needs with the appropriate health care facility.*—There is a need to clarify the separate purposes and functions of hospitals, nursing homes, homes for the aged and other facilities—so that they may be staffed appropriately and so that older people may know they have alternative living arrangements and so that older people may receive health services in accordance with their needs. I believe that the number of persons needing institutionalization could be maintained at the present number if a sufficient number of such living arrangements and health services were provided.

IV. NURSING DEFINITION, STANDARDS, EVALUATION AND FUNCTIONS

A. There is a need to *define* more clearly the meaning and activities of nursing so that the public, as well as nurses themselves, understand better the scope of the product they are buying or selling.

The Committee on Standards of the Geriatric Division of the American Nurses' Association has adopted Virginia Henderson's definition of nursing:

> "The unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will and knowledge. And to do this in such a way as to help him gain independence as rapidly as possible." [1]

The Committee has established standards based on this definition. I offer some examples of nursing activities which will result, in the opinion of experienced geriatric nurses, in a better quality of patient care than if these activities are not carried on. A simple example will illustrate. When a nurse assists an elderly person to learn to wear and use his hearing aid, she meets one of the standards of nursing practice. As you know, sometimes it may take several months or even years for the patient to adjust and to adopt this addition to his body as a part of his pattern of living. And, as you know, it is pretty well known that if a person loses contact with his environment he will withdraw, become apathetic, suspicious, "disengaged" mentally ill, and eventually will stop eating and die. In this example the nurse is needed to assist the patient to hear because he did not have the strength, will or knowledge, by himself, to learn to wear his aid.

The relevant question for us, here, is: How did the nurse learn to assist the person to wear the hearing aid? The example not only illustrates a specialized nursing practice; it also directs our attention to another problem: that nurses are still learning, largely, by trial and error to give this special kind of nursing care, since their formal nursing education often fails to include preparation in nursing problems of the aged chronically-ill. While such preparation is lacking these significant health problems may go unattended because the nurse does not consider them to be within the standard realm of nursing practice and therefore her responsibility.

B. There is a definite need for careful evaluation and re-evaluation of the nursing being done in nursing homes and other places where geriatric nursing is provided. The evaluation must be done by qualified nurses basing their evaluation on a standardized set of criteria. The Committee on Standards of the Division on Geriatric Nursing of the American Nurses' Association has formulated a

[1] Henderson, Virginia, *The Nature of Nursing,* New York, Macmillan Co., 1966, p. 15.

list of such criteria. A means for implementing these standards is by far this decade's most critical issue in the nursing of older people.

C. There is a critical need for better utilization of professionally-educated nursing personnel to ensure that those nurses available are used to carry out their proper functions. This problem points up the need to organize nursing homes (and hospitals) administratively so that the responsibilities of food service, housekeeping, and secretarial, pharmacist, and administration activities are delegated to appropriate parties—all of whom are under the direction of the administrator of the facility rather than the nurse.

The manpower shortage in health professions is well known. The greatest waste in nursing today is the practice of using professional nurses for non-nursing activities. This waste should be stopped at once. No one can afford it; least of all the patients in nursing homes and older people resident in long-term care facilities. Homes and facilities employing nurses for nursing activities and then using them for functions other than nursing should not be approved. Such a fact should be built into the law, not only for nursing homes and similar facilities but for hospitals also. The nurse who functions after five o'clock in the afternoon as a pharmacist cannot at the same time be engaged in nursing activities such as helping a patient to communicate, eat, walk or learn to go to the bathroom by himself. Basic knowledge of good management must be applied in nursing homes and other health facilities as it has been for many years in business and industry. We can no longer afford to waste scarce nurse power.

V. NURSING EDUCATION

A. *Continuing education for Nurses, to Meet Immediate Crises.*—The majority of nurses in charge of the nursing in nursing homes have been educated in nursing programs where most of their education and experience have been with acutely-ill patients. In spite of this fact, they have done an amazingly effective job of meeting the nursing needs of their older chronically ill patients. The difficulty of their job is due not only to deficits in their education but also to changes in the health needs of our population. The emphasis now is or should be—on keeping people from being institutionalized.

That nurses recognize the need for maintaining high levels of health of older people is demonstrated by the large attendance at three workshops conducted in Florida under the auspices of the Florida Nursing Home Association in the Fall of 1969 and at the 1970 Annual Clinical Session on Gerontological and Geriatric Nursing conducted by the College of Nursing and the Division of Continuing Education at the University of Florida in Gainesville. I believe that nurses in Florida and elsewhere are eager to learn better ways to care for the older patient. That geriatric nursing is becoming more recognized is evidenced by the fact that in 1969 over 22,000 nurses held membership in this Division on Geriatric Nursing Practice of the American Nurses' Association. Funds are needed for continuing-education programs for professional practicing and technical nurses. Such programs should include basic lists of activities essential to provide quality nursing of the specific nursing problem under study. Geriatric nursing assessment forms and standards may be used to identify such nursing problems.

Procedures suitable for the teaching of Licensed Practical Nurses and Aids also need to be carefully assigned and evaluated.

B. *Geriatric nursing educational programs for the undergraduate and graduate level and for technical and professional nurses.*—Although commendable, nurses' bootstrap response to the need for special geriatric nursing is an emergency response in a crisis situation and need not be perpetuated, if education in geriatric nursing eventually is included in all nursing programs on all levels (technical—Associate of Arts; professional undergraduate Bachelor of Science in Nursing; and graduate—Master's degree in Nursing.)

There is also a need to establish master's—level graduate programs in geriatric nursing. This nursing specialty is relatively new, and the current hesitancy in starting this formal program may be attributed partially to the presence of makeshift operations to identify the nursing problems of elderly patients and to find scientific knowledge to shape the needed nursing actions (practice).

Research in geriatric nursing is proceeding very slowly. Teachers qualified for research are more likely to be teaching undergraduate students in conventional nursing programs.

C. *Need for a demonstration center for geriatric nursing teaching, practice and research.*—The lack of model Clinical Demonstration Centers is a definite

deterrent to effective practice, teaching, and research in geriatric nursing. The lack also hampers recruitment of nurses to geriatric nursing. There is a decided need for such centers where quality geriatric nursing may be learned and practiced. Such a Center should include patients who live in a residential care facility such as a home for the aged, so that those nursing activities needed to maintain the patient's health may actually be carried on. A pilot study in health maintenance is being carried out at Cathedral Towers, Jacksonville, Florida where an understanding is evolving of the function of the professional nurse and the cooperating social worker in a high-rise residential apartment facility for older adults with low incomes. However, the site of this pilot study is located 75 miles distant from my class in geriatric nursing at the University of Florida. If available, closed circuit television would help bridge distance gaps between classroom teaching and on the spot nursing in actual long-term care centers.

Besides live-in patients, Clinical Demonstration Centers also should include non-bed-ridden nursing home residents, as well as a Day or Night Center where aged persons go to learn to live with those additions and subtractions they encounter from disease or disability, as a part of the aging process. My example of helping a patient learn to use a hearing aid exemplifies what nursing students would learn in their work with nursing home patients and residents in day centers for older persons.

The goal of the clinical Demonstration Centers would be to enable nursing student and practicing nurses to learn how nursing staff members assist the elderly person to maintain his health and his usual life style for as long as possible and, after that, to assist him to die with dignity. This implies an eventual reduction in the number of institutionalized older persons. With more such Centers, the cost to society and to the individual of health care for the elderly should go down.

Geriatric nursing faculty and nursing interns and residents, could join undergraduate professional and technical nursing students, to create in the Center a dynamic teaching-learning operation. Faculty members could hold dual University and Center appointments if it were not a University-sponsored Center, so that their practice and teaching privileges would be assured and so that new knowledge could be more expediently applied to the health problems of aged persons. Such Demonstration Centers should be developed in practical ways so that they can be used to show nurses in privately-owned nursing homes how they too can improve the nursing care they provide.

In designing such Centers, closed-circuit television should be provided for teaching and learning purposes, so that nursing consultation and the presentation of nursing case-studies could be available to nurses in settings remote from nursing schools. Nurses working in nursing homes thus could keep in touch with the Centers and could bring nursing problems to the Center for assistance in solving them. Geriatric nurses in the Centers could also assist with problems encountered by nurses in residential apartment facilities and in day, evening or night senior centers participating in the closed-circuit system. The latter would serve the aged not only for recreational and social events but for rehabilitation in the widest use of the word, including the gamut of nursing services. It would be appropriate for some present nursing home facilities to become Clinical Demonstration Centers.

We should recognize that, since those persons who are institutionalized often are unable to get out into the community and to participate in community activities, the institution must expect to supply these activities and access to them. This provision is very expensive. Nursing home facilities which provide these services should be used only by those persons who have been judged by a multidisciplinary team to need it and the facilities need to be planned on a city, county, or even regional basis.

VI. RECRUITMENT OF GERIATRIC NURSES

As members of the subcommittee know, there is a tremendous need to recruit more nursing personnel to the field of geriatric nursing. Although a great deal of the shortage may be attributed to economic reasons such as low salaries, I believe that the currently prevailing negative attitude toward the elderly and the aging among an American public which includes nurses and potential nurses will be far harder to overcome. It is not "popular" or "nice" to be old in the American society—unless one enjoys unusual social prestige or a large share of the world's goods.

Implementation of the measures outlined in this paper would greatly assist in

improving attitudes toward the aged because Americans characteristically want to help people who need help and these measures would give them ways to do so. Geriatric nursing is now in the stage of psychiatric nursing twenty years ago. Many of the same tactics (such as recognition, status, money for scholarships, higher salaries, Demonstration Centers, etc.) would improve the lowly position of geriatric nurses, of whom so many more are needed.

VII. CONCLUSION

A computerized health history for the elderly, which includes a health and nursing assessment, is recommended as an expedient means of improving the quality and quantity of available nursing and other health care. The nursing of elderly persons may and should occur in many different kinds of environmental settings. Using nurses to assist in health maintenance in ambulatory non-institutionalized aged persons will reduce the high cost (in human potential and in money) of institutionalization for the aged. Periodic reassessment of individual patients, as well as of facilities, will be essential to ensure that individual needs and the services offered in the facility are matched as nearly as possible.

Standards for Geriatric nursing have been formulated. This advance should help direct nurses in improving their geriatric nursing practice, so different from the care they were educated to provide for acutely ill patients. Much is needed in time, money, and energy to implement these standards through continuing educational programs.

Course content in geriatric nursing has been recommended as an essential addition to the education of present-day nursing students. Graduate programs on the master's level are essential for the preparation of nursing teachers, practitioners, and researchers.

There is an urgent need for Clinical Demonstration Centers to demonstrate quality geriatric nursing. Some of the present nursing homes could be developed into such Centers. The amalgamation of academicians in the universities with professional nurses working in nursing homes, homes for the aged, and in day and rehabilitation centers for the aged is an obvious way to implement new knowledge more quickly to solve the problems encountered in nursing practice and to provide an avenue by which practitioners can bring to the attention of academicians geriatric nursing problems for study, analysis, and resolution.

Using nurses for activities other than nursing is wasteful and no one can afford for another minute to continue to violate this basic principle of management.

Currently recruitment for geriatric nurses is slim, due largely to American attitudes toward age and to the public image of nursing in nursing homes. This, as well as other problems of status, pay, etc., need attention before we can hope to attract more nurses to the field of geriatric nursing. Using some of the promotional tactics used in recruiting for psychiatric nursing would be helpful as a remedy. Providing Clinical Demonstration Centers would help promote quality nursing. Last, there is a need to recognize that the needs of the long-term patient consist primarily of NURSING needs. The cover payment for Medicare gives recognition only to those procedures ordered by the physician. I assure you they are only a small part of the health care that the ill, older person needs.

Mr. Chairman, thank you again for the opportunity to present one nurse's point of view on health care for the aged. I personally want to congratulate the Subcommittee on its intelligent, interested and helpful approach to the health problems of the aged, evident in these hearings.

ITEM 3. LETTER FROM MRS. BILLYE BOSELLI, EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, JACKSONVILLE, FLA.

VISITING NURSE ASSOCIATION,
Jacksonville, Fla., January 8, 1970.

Hon. FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care,
New Senate Office Building, Washington, D.C.

HONORABLE MOSS: I by no means claim any expertise on nursing homes. Rather the information the personnel of this agency has comes directly from patients who have been in one or several institutions. According to many, many reports

the terms "home" "personal" and "care" are euphemisms. Based on observation in many cases even bodily care leaves much to be desired. These complaints for the most part are aimed at the big, pretty, safe, impersonal, sterile, chain nursing home. The larger and more institutionalized they become, the less personal they become. The smaller nursing home which in truth is unsafe so far as the plant is concerned and are scheduled to be closed, do provide a more individualized personal service. Oddly enough we do not get complaints from these homes.

The nursing home resident has no voice and becomes dehumanized. Familes still have to be responsible for some care in feeding and providing sitters. Management people in big business lack knowledge about the needs of the sick and their personal care. Profit is first, the patient second. True, professionals are employed as administrators, but they are controlled by big business with a profit motive. Yet the trend in this State is larger, more expensive chain nursing homes. The trend toward more and more institutional care is obvious. Home care is being legislated out—as evidenced by the arbitrary restrictions placed on such services in July by medicare and the fact that such services were not included in Florida's medicaid plan. I do not claim that home care is a panacea nor that it is a substitute for the person who needs twenty-four hour care and protective services.

However, with twenty-five years experience in this field, I know that a large number of persons can be provided individualized, quality care outside an institution at less cost to the community, and the patients emotional, social and psychological being. The crux of the nursing home story as far as I am concerned is the fact that in situations where the nurse feels that nursing home care is the best plan, it more often than not is impossible to persuade a patient and/or their family to agree to it. These persons would rather die in a filthy, foul odored, cold or steamy room alone than go to an institution.

This should tell us something. Traditionally it has been the Visiting Nurse Association goal to teach families and patients how to provide the care which would enable families to assume responsibility for their own and keep the patient living within the optimum level of his limitations. Traditionally if the Visiting Nurse could, with teaching and supervision, keep a patient stabilized at home she had reached her goal. The new interpretation on the part of medicare now rules this out. Thus, without additional funding for home care agencies throughout the country it is difficult to foresee anything but more sterile institutions and of even greater concern more elderly persons in cheap, dingy rooms which are neither under the inspection and licensing jurisdiction of the Hotel Commission or the Health Department. There are too many of these already and if home care services cannot be provided and the patient has only the choice of an institution there unquestionably will be many more.

Admittedly I am home oriented and believe in helping families and the elderly to remain independent as long as possible but I am not blind to the great need for institutional care and the problems involved in such care. Until these institutions can provide more than just a bed however I think, the so called consumer of nursing home services is helplessly trapped and can expect little but rapid deterioriation. Contracts can prevent discharge and regulate charges; the ratio of R.N.'s and L.P.N.'s and other personnel can be established and maintained; the plant can be made to meet certain standards as are menus and the handling of drugs and documentation but I know of no way to adequately police or legislate good "care". One thing which is so desperately needed is *close* coordination of hospitals, nursing homes *and* home care agencies in the delivery of health services. Until this becomes a truly working situation each group will continue providing care which the other could and should be providing.

A decision should be made as to whether we really means to provide care to the elderly, sick, person regardless of his residence. Having made this decision then patients and those delivering health services should not be subjected to capricious and arbitrary rulings and interpretations such as those related to Medicare which lead to chaos, bitterness and neglect of sick people in need.

As one small example of the results of the above I enclose a copy of an analysis of this agency's case load for 1969 which was done when we, faced with a $120,000.00 deficit because of the "new" interpretation of skilled nursing and custodial care. This agency was established in 1944 and traditionally has provided nursing care to those in need of part-time service in the home regardless of ability to pay. We have a well trained experienced staff of nurses and home health aides to provide such services. Since the advent of medicare we have expanded our staff to meet this demand. Medicare has paid for services since 1966. Now, they will not and we find ourselves in the position of reducing staff by one-half with an increasing demand created by medicare.

In short, the continued expansion of sterile, chain nursing homes, governed by business men hundreds of miles away who motivated by profit is detrimental to the desired delivery of health services to the consumer. He simply is not getting what he or a third party pays for. The concept and attitude for restorative care of these elderly persons appears to be totally missing.

Institutionalization of any individual because of a lack of funding for home care agencies to provide part-time care which would enable him to remain in his own home is a false economy for tax payers and a psychological, social and physical crisis for the patient.

A really workable coordination of hospitals, nursing homes, and home care agencies in the delivery of health services is essential without it improvement appears dismal.

With the payment on the part of medicare, for home care services there seemed to be a positive move in the right direction toward comprehensive coverage. With the withdrawal of these fnuds the trend reverts to the impersonalized, sterile, institutionalized care without individualized planning or choice on the part of the consumer unless it is no care.

Sincerely,

(Mrs.) BILLYE BOSELLI,
Executive Director.

Enclosures.

EXHIBIT A.—VISITING NURSE ASSOCIATION FACT SHEET ON PATIENTS 65 PLUS, JAN. 1 TO NOV. 30, 1969

902 patients	Age and number
Average age	77.19
Living alone, incapable of self care	283
Living with another but unable to care for self or another	322
Living with working child and incapable of self care	111
Boarding home	26
Living with responsible family unit	160
Income:	
Less than $1,000	223
$1,000 to $1,499	141
$1,500 to $2,099	210
$2,100 to $3,099	160
$3,100 to $4,000	64
$4,000 plus	104
18,288 visits	**Number**
Projected coverage under revised interpretation:	
Medicare	6,772
Nonmedicare	11,516

	Visits		
	Patients	Medicare	Nonmedicare
Projected disposition without VNA services:			
OPD	319	2,151	4,630
OPD by ambulance	144	798	627
Nursing home	417	3,723	6,259
Boarding home	22		
Note:			
1969 to hospital or nursing home from VNA			230
1969 expired			76

FACT SHEET—1969 AND 1970 BUDGET AND STAFF

	1969	1970
Expense budget (in thousands of dollars):		
VNA	202	218
HHA	102	82
OEO	66	66
Total	370	366
Income projection (in thousands of dollars):		
American Cancer Society	3	3
Duval Medical Center	9	9
United Fund	67	73
Fees	15	15
Hospital coordination	7	7
OEO	66	66
Subtotal	167	173
Medicare:		
VNA (actual) [1]	74	[2] 46
HHA (actual) [1]	80	[2] 10
Total	321	229
VNA (projected)	101	111
HHA (projected)	102	82
Grand total	370	366
Staff (nurses and aides):		
OEO	11	11
VNA	19	20
HHA	[4] 22	[3] 5

	VNA	HHA	OEO
1969–70 administration staff:			
Professional	2	2	1
Clerical	2	1	1

[1] January–November 1969.
[2] Expected.
[3] 11 expected to be working after February.
[4] 5 presently working.

BUDGET AND STAFF

[Dollar amounts in thousands]

	1969	1970
Budget	$370	$366
VNA	−49	−137
HHA	+154	+56
OEO	+167	+173
Staff [1]	55	28
Nurses	19	11
Aides	34	17
Administrators	9	8

[1] 1969 budget, $370,000; 1970 budget, $229,000.

VISITING NURSE PROGRAM, 1970

Sources (estimates in thousands of dollars):	
ACS	3.3
DMC	9.0
UF	66.5
Fees	15.0
Medicare	[1] 46.0
Total	139.8

Expected situation	Nurses
Required for visits to dollar sources	11
Funded by dollar sources	6
Deficit (nurses)	5

111 (continue present level of service) [2]	208.4

Deficit (in thousands of dollars):	
Borrowed for 1969	6
Salaries thru February 1970	7
Indebtedness	25
Hospital coordination	+8
	30

[1] Expected.
[2] Nurses required to continue present level of service: 20.

VISITING NURSE PROGRAM—MEDICARE ONLY, 1969 AND 1970

	1969 (January through November)	1970
Patients	902	320
Not covered	582	
Covered	320	320
Visits	18,288	6,772
Not covered	11,516	(1)
Covered	6,772	

[1] OPD, $15 per visit; ambulance, $30 round trip; nonskilled nursing home, $200 per month from welfare.

Note: VNA cost per visit, $6.25; VNA cost per patient per month, $31.

HOME HEALTH AIDE PROGRAM, JAN. 1 TO NOV. 30, 1969 [1]

Total patients (HHA and VNA)	180
HHA patients not seen by VNA	[2] 76
Total hours (HHA and VNA)	22,925
Estimated covered under new policies	11,295
Estimated uncovered under new policies	11,630
Average age	79
Living alone and incapable of self care	36
Elderly couples unable to care for each other	27
Living with 1 child who works all day and incapable of self care	13
Income:	
Less than $1,000	20
$1,000 to $1,499	25
$1,500 to $2,099	15
$2,100 to $3,099	8
$3,100 to $4,000	2
Above $4,099	6

[1] Total expenditures through November, $73,669.
[2] All would have to be placed in nonskilled nursing home.

Appendix 3

STATEMENTS SUBMITTED BY 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 hearings on "Trends in Long-Term Care," in St. Petersburg, Florida, I would have said:

(The committee received the following responses:)

JUNE R. BIBLE R.P.T.

I request direction to the proper person either on this panel or within your agency for further discussion regarding the relationship of the patient of the quality of care within the hospital, E.C.F., skilled nursing homes, custodial care (intermediate) and their residence. It appears that the information offered here today plus additional data gathered within specialized services must be considered. By identifying the problems and either by further identification and proper utilization of existing health manpower plus those presently being trained in the field is essential. Also professional audit by peer review must be encouraged. I feel by these methods we can undoubtedly lower the cost to the program and simultaneously still raise the quality of care.

JEANNETTE GIACOBBE, ST. PETERSBURG, FLA.

L. Obtaining higher standards.

(a) Proper inspections by the Health Dept.

(b) Classification of facilities, nursing homes, restorium, etc., those patients needing extensive care or just custodial care plus a pill three times a day. The rates should be accordingly.

(c) Proper, safe area for the senile or just confused patient. Eliminating restraint.

(d) Therapy is too costly. But walking for a few minutes daily is as important as turning a bed fast patient every two hours.

(e) Food—health inspections at meal time not just 7 to 3—but the supper.

I am enclosing a copy of my husbands ideas. He is paraplegic and it took him a long time to write these thoughts.

He is a patient at the New Fern Restorium since August 1968. This facility was covered by the reporter of our "St. Petersburg Times." The account that this young lady wrote was as accurate as can be. Every word was truthful. This facility is still operating in the very same manner in spite of all the publicity.

Little wonder, Mr. Mosher is the president of the American Nursing Home Association.

1. Prohibit accepting patients just to fill empty beds unless there are the proper number of qualified aids and nurses to care for them properly.
2. Have a standard or exam to judge an aid before hiring them and consultation.
3. Only allow accepting patients in proportion to the number of qualified aids available to care for them.
4. Better discipline between aids and nurses. (Familiarity breeds contempt.)
5. Do not allow aids any other duties but patient care. (Eliminates confusion.)

6. Better preparation and serving of food, i.e., on time, hot and more variety.
7. Better facilities to get out in open air and sun, i.e., gently sloped ramps and doors easily operated.
8. Fully equipped therapy dep't. in each nursing home, qualified personnel, not just "eye wash".
9. Rooms large enough for more than one bed and furnishings, i.e., chairs, lamps, bureaus and clothes closets.
10. Allow inspections by proper authorities without notification. (If they're on the ball they will welcome it.)
11. Allow inspection reports available to the public at the office of inspection upon request. This should include all inspections, fire, building, and medical. In this way a person wishing to place a relative or friend in a nursing home would have a pretty good idea to which one they should visit.
12. Make available to each relative or friend a copy of State or/and local nursing home regulations or rules when admitting a patient.

MRS. OLIVE K. GRIMES

Nursing homes are a necessity. Nursing homes must be provided solely to answer that necessity. Nursing homes should not be private businesses, because private businesses are operating primarily for profit. Profit should not morally be made from the basic needs resulting from sickness of our people.

Therefore, the Federal Gov't should provide nursing homes (contrary to your own appalling apprehension) and bear whatever the cost is for decent care of our fellow beings in the time of their greatest need.

Money is not the problem for this great country of ours. Service is the problem—and the Federal Government is the only agency that can provide service without profit.

I would also like to commend you for your "Anti-Smoking Campaign" efforts. May I suggest that you direct some of your efforts to "the rights and comforts of the non-smoker." I want to see smoking outlawed in all public places. Let the smoker smoke in private as much as he desires, but stop him from polluting the air I have to breathe.

DR. GEORGES GRIMES

In addition to my wife's remarks I also suggest that we have government hospitals for civilians, with doctors employed on a salary basis. This system is successful for the Veterans—it could be successful for the rest of us too.

The time is fast coming when we must recognize the awesome and disgraceful facts that the cost of all health services have soared above other expenses. Do you ever stop and think how unfair and immoral it is for the health professions to be allowed to profit so outrageously on the misfortune of their fellow men? They will not put controls on themselves so the (our) government must. Service is the answer.

L. M. GROWNEY

Too much overbuilding of nursing homes in Pinellas County.

Too much F.H.A. where not needed. Turned down by private financing, but approved with F.H.A. 50 yr. mtges.

MARGARET B. GROWNEY, ALHAMBRA NURSING HOME

It is my great concern as to Medicare's determining "Skilled Care." They term as "custodial" people who must be turned every hour, cathoders must be cared for cleaned and changed, must be fed and kept clean, these people require constant care but not by an R.N. (it usually takes two aides to help each). It would be impossible for families to care for them. Home care is too expensive and scarce. We keep a ratio of 1 aide to each 4–5 patients, we cannot do this under $16 a day. We opened in April and have never shown profit. A custodial home, charging less could not give the proper care—it is impossible. Medicare should cover this

type person. If they are moved to "welfare" homes it is impossible to give care these people require. We cannot keep welfare patients and it is sad to see them moved from top care to low care. I will lock doors before lower care and we have not even made costs since opening in April. We have had patients flown to us from New York where they paid $35 a day for a double room and no care. This is a national problem. We invite you to visit us and see our problem.

MISS NANCEY HARTLEY

In order to do "rehabilitation" you have to have education for staff and need teams to go throughout the county. The Jr. College has programs to prepare technicians and a pilot program for health care managers (assoc. degree and evening courses for present ng. home administrators). It is almost impossible to recruit people into programs where the salaries and status are so poor.

Hospitals continue to want to have individual expensive educational programs and ng home people are put in blind alley jobs and are the people who need educational upgrading in more than just one skill. Hospitals do not cooperate with extended care facilities. One hospital had empty beds while Medicare provided funds to ng homes and the hospital laid off much personnel (including R.N.'s). Then the ng. homes didn't take in more patients and the hospital days extended and the hospital had to go looking for highly skilled people—even hospitals pay more than ng. homes so the workers in health fields get discouraged and go into other fields. Comprehensive health planning has become a political football and until we get education of health personnel in educational agencies the manpower needs will not be available to give care. We must supply education for manpower on a county-wide plan.

The problem in certain counties has to do with the lack of defining in technical and vocational level of education. This stems from state allocations of funds. M.D.T.A. funds for a rerfresher course had been held up for 9 mos. We have at the college 150 names of R.N.'s who want to take the refresher course waiting for the Federal Government to release M.D.T.A. funds. Then we need to compete with moneys to educate upholsters, carpenters, etc. These are the every day problems in the training of manpower for health and affect all patient care.

ELEANOR C. HOGAN, R.N., PINELLAS PARK, FLA.

Nurses aides should be better trained—even licensed—better salary, not just some one coming in off the street with no training.

As for a Mr.' deGraff's statement, air conditioning is mostly for the active help, most aged people do not like air conditioning—go to nursing homes in midsummer, most men have coats on and women have sweaters or robes. As to his remarks about the liggle (convenient) package of soap for the enema, the old method of nubs of soap in a big jar works just as well.

Most old folks on relief are not wanted by the family if there is any family, or cannot be cared for by the family when they get to the point they cannot live alone. Some get to the point of being just "vegetables." These should be cared for in a State institution to make available more REAL nursing home cases.

LORNA BOONE HUTTMAN

1. Excellent bringing this hearing before the public.
2. Begin on time!
3. Have speakers talk to audience rather than to you Senator Moss.
4. How much does the Government pay the Insurance Co.'s, who act as intermediaries, in connection with nursing homes in Medicare?
5. How about doing a little research work in the European Countries on aging. Scandinavian countries started in this field in 1910 or thereabout, from here it spread to England, France, etc.
6. Please, please have S.S. & Medicare made *simple!*

I was much impressed with your sincerity and the sincerity of those on hearing panel. It has given me hope for the future of our Country. To hear these speakers one is inspired & feels that they are really interested in the problem of the aging. May I say—God bless you all.

MRS. CLARA MATSON

I had no way to take care of my brother, bord 3–21–87. I had to put him in Beverley Manor Nursing Home. His mind went bad about one month before he needed help. The 2d after he was there he ran off, trying to find my home. He got lost, didn't have hardly any clothes so some man brought him home and he was nearly frooze. So they got it in for him. Also because he didn't know realy what he was doing, if they could not take any one in that condition they should not have taken him. So it is a long story just what he went threw. He got worse every day, never called a doctor, never asked me to call, as I was under impression a doctor visited a couple times a week. So yesterday I ordered one. He was dieing, might be dead as of this meeting, as I am writing. So last night about 8 they got him in Mourod Park hospital. We entered the nursing home at 3 p.m., Dec. 24th, by my inforcing it. I could go on and on. Prayers has keep him alive so far. Brothers name, Chester A. Kingham, he is a veteran honorably discharged.

ROBERT L. PARBY, EXECUTIVE DIRECTOR, PRESBYTERIAN HOMES OF THE SYNOD OF FLORIDA

I have met several times recently with groups in Manatee County who have, for some years, endeavored to organize a facility for the care of the low income elderly, generally members of a minority group. At one time, at their request, contact was made with the local office of the F.H.A. to seek construction funds for a non-profit nursing home. We were informed that the only lending program would probaly require 8% interest. Even though Hill Burton funds were to provide 50% of the capital investment. The debt service would be prohibitive when added to other costs of service in relation to the ability of the person or supplemental government program to pay costs. This is considering the cost of construction of a nursing bed of from $6,000–$10,000.

I would like to suggest an experimental program utilizing self-help, volunteer services and modular and/or mobile home construction. This would involve creating a village as close to a city as practical, with the well aging living in independent mobile homes (not necessarily new) with a centralized facility of modular construction which would provide food service, nursing services for both in an out-patients and utilizing different levels of care to encouage each resident to maintain dignity and usefulness to the degree possible for each day. Briefly, the well aging would rent a space for a mobile home for about $40 a month, would buy a mobile home from savings or pay a debt service of from $10 a month up. Meals could be purchased at a cafeteria cost of 40¢ to 60¢. The levels of long-term care at the present level of inflation would cost from $150, in the centralized area to a maximum of $450. It is our opinion that a broad base of 1,000 well aging paying $40 a month for space would generate enough cash flow to subsidize long-term care over the amount allowed by Federal programs to the actual cost.

In addition, motivation is such an important factor in compassionate, personal understanding of each individual, the non-profit sector both government and private, need to innovate and set the standards as they have done throughout our great history.

CARL SETJE, PRESIDENT, CHAPTER 386, NARCE

We are vitally concerned with H.E.W.'s Intermediary Letter #371 and its devastating effect on Medicare patients who are on Extended Care and which we understand is spilling over into Hospital Care.

While we once advised our members who come under Medicare that they might well transfer from High Option Health Plans to Low Option Plans, we now have our doubts. For instance Blue Cross-Blue Shield of Florida has what is known as Complementary Coverage for those covered by Medicare. Since this progarm only pays for those items Medicare does not cover, we can only assume that these people have no protection whatsoever should Medicare reject their claims. Time is of the essence, if we are to help the living. We urge immediate action on liberalization of these restrictions.

MRS. PEARL SPRINKLE, R.N., GULFPORT, FLA.

Since I have a large stake in nursing homes in Pinellas Co. as a member of the nursing home inspection team, at the county level, the following corrections should be noted in the testimony and following comments should be made:

1. Our inspections are always unannounced.
2. The series of newspaper articles have done untold harm in the following ways:

a. To patients—many read the papers and we observed many crying over the articles and the unexcusable cartoons printed.

b. To homes—the infractions found were infinitesimal compared to numbers of homes and beds and showed little understanding of how a nursing home functions.

c. To many fine, dedicated people who work in nursing homes, this department has worked long and hard and was just reaching some success in interesting many competent professional people in working in nursing homes.

ADAM SURTAL, ST. PETERSBURG, FLA.

My name is Adam Surtal, a citizen living in St. Petersburg. I am 76 years young, sound of mind and in the best of health.

Today's subject for discussion is to resolve the problems visitors do find objectional in treatment and services or lack of which are given to the aged in some nursing homes.

In the past several years I made it a point to visit and cheer up those so unfortunate to be residents in nursing homes. My friends are no different than most in advanced age who find fault; also gripe even under favorful conditions. Where there was a lack of service help or the food given at a particular period of the day are not factors to comment about.

I have a more important subject of complaint besides normal care and diet meals. My gripe is one in which the tortures suffered by disturbed patients is to bar the use of any device of restraint; some are bordering upon the kind of instruments of torture used during the 16th century upon mental and confused victims.

The chain of that period had a leather cover over an iron chain and secured with pad locks. There are counterparts of this innovation of chain even having some refinement by being manufactured by using a canvas base. The use of a modified straitjacket; without sleeves; also a trade named device called "Posey" belt are in common use in most nursing homes on confused residents.

There is to my knowledge no city in this fine country where it is permissible to injure, torture, practice cruelty, use a short rope or chain on any animal. Yet human beings who are in advanced years have to endure the cruelty of man because the proper care of such individuals requires extra help to service the needs of each.

Senator Moss, please take the first small step and visit, without fanfare, some nursing home where the practice of chaining unfortunates is a daily chore. You will witness first hand how through the use of drugs these confused patients are sitting in a 75 to 85 lb. chair with a locked chain around the waist. These folks are real zombees they do not know or think or complain. The chain is in use for the greater part of the 24 hour day; in bed or chair except when necessary for human waste.

May I describe these torture chains in the eye of a mechanic by points of manufacture and breaking point of the bond; also how much weight dropped will separate the material.

The first is a modified straitjacket manufactured without sleeves. This jacket is made from durable nylon cloth into which is incorporated several strands of ¼" nylon cord which is braided. These ropes have a fixed non-slip steel lock which when tightly drawn requires a 40 to 50 lb. pull to open. The breaking point on the braided ¼" nylon rope will test a weight of 150 lbs. on a 4 ft. drop.

The next is a trade named restraint called "Posey." This canvass chain is the most cruel type of device to use upon the sick in nursing homes. There are two parts to this canvass chain, one of which is locked to the bed, the other part goes around the sick patient. In direct center of the first part there is sewen a six

inch canvass fabric where when the second part is entered the combined height at this point is one inch. Can you imagine the pain the spine has in store after several hours.

The "Posey" canvass chain is manufactured entirely in a cotton braided base its measurements is 1¾" by ¼". All gromets are made of extra heavy brass and so is the lock buckle which may be opened or closed by a special key. The break point or separation of the fabric can test on weight of 500 lbs. on a 6 ft. drop.

Honorable Sir there is no difference in the kind of material being used in any restraint device to change its name from being a real chain.

Please Senator Moss take stock of your age; even though you are now in perfect health the day is not far off when you too can find yourself a victim of social progress.

MRS. D. G. HARRIS WILLARD, R.N.

There is so much politics involved that a human being doesn't have a chance either as a patient on Medicare or Medicaid, or as a Registered Nurse trying to care for these people to the best of their abilities (for which they have been well trained), as the nursing homes set their own policies, and pay only for L.P.N.'s, and aides and orderlies, and order the registered nurse to "Push pills and keep your mouth shut or you will not hold a job in this area". In other words blackballed as an R.N.

Yet, this same R.N. has a family to raise and support via her education and lacks the right to work due to standing up for her principles of practice against the administrators of these nursing homes, who do not have the same compassion, the same knowledge of nursing care, the same obligations, or the same qualifications and availabilities of the registered nurse, for the administrators are only out to pass inspections of buildings, foods, etc., and at the minimal rates so that they can make money. In other words when you take the greed of money out of these places, and substitute good care by good qualified help, then and only then will you be helping the patient, and without the heavy costs to the government and to the patients' families. It is not lack of personnel in these places, but a definite lack of qualified help, as the administrators will not fit the qualified help into their so-called budgets. So, the patient is at the mercy of the unqualified help, the administrators make money for their backers and themselves, at the expense of the patient as well as at the expense of the government.

For example, patients are placed under welfare and Medicare, and then the patient-guest, who is a private care patient, so-called is placed differently so that medicines are given out, the private patient is to receive meds when ever they ask for it, not by the Doctors order (as per professional stds.), and the welfare Medicare patient receives only the amounts that are covered by the Dept., paid to the nursing home and to the pharmacy which sends out (under contract) the meds the welfare affords—emergencies are ruled out—no money to cover any extras, so the R.N. is told not to try to be heroic, in other words, let the patient die, for it makes more room for another, so more money for the home. It is a pathetic mess, and one that needs help from qualified medical personnel not from business administrators. In other words, let the office of the administrator tend to the business end of the home and the professional help take care of the medical end of it, thereby giving the kind of care that is due the patient and what the government is paying for.

Example: Many an orderly wears a white Doctors coat, thereby fooling the patient. Aides wear white uniforms and yes, even plain white caps, and they know nothing of the workings of the medical profession, and most of them are uneducated, as to patient care.

Practical nurses, even in training, wear uniforms like the R.N.'s try to take over the same duties without the knowledge of the R.N., and get like a robot, routinely do this and that, and soon feel that they know what the R.N. knows, so take over, and are kept on the job while the R.N. either quits or is easily let go. Her reason for quitting a place, is the one fact that her knowledge of the patients needs and the knowledge of professional ethics are not needed by the administrators, for they cramp the administrators style or prestige by bringing the true facts out to the public. Today when an R.N. is hired in a home, it is for Medicare purposes only, for the Law states that you must have an R.N. on duty from 7 a.m. to 3 p.m., what about the other 16 hours of a 24 hour period when patients need the qualified help????? Well, that is easy for the Administra-

tor, for his director of nurses is supposed to be (on paper) on 24 hour duty, on call, so to speak, so the home is covered to pass for Medicare inspection, and which inspections are known as to date and time way in advance so that the home can get covered with qualified help temporarily until after inspection, and the home is in the clear as to admonishments, then the R.N., whose name has been used for the time of inspection, is easily let go, with the same worded note, "Your services are no longer needed." This seems to be the password of the administrators here in Florida, at least the west coast of Fla., who tend to be "all out of monies, not for the benefit of human life." They do not seem to understand that without the first patient and a qualified personnel, their wouldn't be a nursing home business, and yes that is exactly what a person is used for today, a business.

Even some nursing homes exploiting children, who are unfortunate to be either mentally retarded or crippled or children of wealthy parents, who do not care, so the homes BUY these children by lots, like herds of cattle being sold to the highest bidder. Shocking? Yes, but what are you going to do about it? When the R.N. questions as to the childs therapy and meds, etc., the everyday care of the child, which she knows the child is not getting correctly yet the foundations and the parents as well as Medicaid are paying for their care. she is told that "This is none of your business", in other words, push pills and shut up or you won't have a job at $20 or $30 per shift, yes and each home varies on this also, so usually the R.N. working at her profession to keep a roof over her family's head is let go, and may or may not end up on welfare herself and her children have to go without, for she can't afford them, then when she tries to take a different kind of job to make an honest dollar, she is ignored as to being hired for the anticipated employer suspicious that there is more to her changing her job or position in life as they are forever being told that there is a shortage of qualified R.N.'s, when actually there is not. Take a survey of the registered nurses in this country, and find out why only so many are working at their profession that they had trained in hard work and at their own cost out of dedication and compassion for her fellowman, and love of people with the desire to truly help a human being to the best of her ability. Several of us have the answers or reasons but are never asked for what we think it will take to do a good job to benefit the patient and apparently we are not given the opportunity to speak out.

Just as I have tried for most 10 years now to have these things looked into as I was shocked at what I saw as to nursing of a patient herein this area of so many elderly people. I wrote several times to the welfare (HEW) in this State as well as to Washington and to the Presidents up to Pres. Nixon (whom I haven't contacted as yet for I am waiting to see if I will hear anything from Dr. Robert Finch to whom I have written three times without any answers). It has been only through Mike Richardson and Peggy Vlerebome the two young journalists who took an interest to get these things brought to the public's attention as well as the attention of our government. The investigation for my own knowledge are my own observations while working in six different nursing homes here in Pinellas County, and one in West Pasco County and one in Hillsborough County as well as the Masonic Home in St. Petersburg, Fla. Whenever I opened my mouth as to "constructive criticism", I was immediately let go. or if I saw that the administration was in like Flynn (politically) I quit on my own, with no harsh feelings, or letters of personality clash, which is the other reason normally used by administrators when they no longer want you in their employ because you have observed too much, and you are therefore detrimental to their place of business. I am far from being "always right", however, I am the kind of person who is called a do-gooder by some as I have always tried to help people, at my own expense (not at someone elses) I don't make any money at this, but at least I do feel that I have been able to help some people. Compassion and dedication to a good cause seems to be the leading trait in my little family, and so we are broke and tired as to financial situations, but happy in the knowledge of knowing that we have done a little bit to help someone else to help themselves, and that feeling of happiness or joy or pleasure is worth far more than any monies can buy.

We don't seem to have a life of our own, for we are always, involved with other, contrary to the majority of routine families, that we see everyday in lifes workings. Yet, even we have a basic routine in our household, private unto ourselves so that we can try to cope with the next days happenings whatever they

may be. Every one tells us that we are wrong to involve ourselves with others welfare and that we should look out for ourselves first, in other words be selfish unto ourselves, but we wouldn't be ourselves as human beings if we changed our way of life, or what we think life should be. We can only pray for God to give us the courage to face the facts of life, and carry on to best of our ability. You may think that I am talking foolishness, but am sure that if you checked into it you would find it to be the truth, for instance, my oldest daughter runs an office for a large company, for only a take home pay of $247.00 per month, just enough to pay the mortage and utilities and her needed gas to get to and from work; the rest of the time (after her 10 to 12 hrs. of work per day) is spent as Sec. of the Literacy Council (volunteer teacher of same), and as a singer in the Chancel Choir of our church, and as a Sunday School teacher of 9th and 10th graders, as well as a baby sitter and a volunteer counselor. I could not afford to send her to college, which she still wants to do, but can't afford it herself, so her many qualifications and abilities are given tirelessly without money compensation.

My middle daughter, also with excellent traits and abilities, but without a college education saw fit to quit her job at the Times (newspaper-accounting dept.) and got married so that she could go with her husband to Europe and work as a volunteer medical secretary at the Army base where her husband is stationed, plus helping out in U.S.O. and forming a Boy Scout group, of which her husband is Scout Master and she is a Den Mother, of Cub Scouts although she has no children of her own; plus baby sitting for the Colonels family in her spare time, and helping with EM wives club. My youngest daughter is a senior in H.S. and hopes to graduate in June, hopes to get a job and hopes to make enough money to afford her room and board at college, as she has set a goal for herself in the College of Health Related Professions. Since the age of 12 yrs. (now 17 yrs. of age) she has cared for children in private homes and at summer camp and swimming pool of a club during the summer months. She was a straight A science student award winner, First Vice Pres. of Keyettes, service club sponsored by Kewanis, and worked with the crippled and mentally retarded (still does). She has held office in the youth council as has her older sister. She also has held office as Inter Club Council Secretary, MYF. Is at present 2nd Vice President of Keyettes Inter Club Council, President, Student Council Pirates Cove, Senior Superlative, pep squad, hostess, usherette, mixed chorus; Chancel Choir, Certificate of Merit for Student Government Day, City of St. Petersburg. FHA award winner, amongst other activities, plus designing and building floats for parades and home comings. etc., plus Delco Sorority, Secretary, Sgt. of Arms etc.

She has a beautiful outlook on life and has always wanted to be a Pediatrician, but knows that we cannot afford that opportunity for her, so states she will settle to be a Physical Therapist for now if we can swing it somehow through a student loan or through the Navy at Bethesda to help her get a start in college then if she can earn enough she will go on to Med school. She had hoped to go to Tufts Pre-Med, but had to bypass that dream, just as her sister had had to bypass Hematology Research and related labs, as we had no monies for her to pursue her dream of becoming a Medical Technologist (not technician). It all seems such a waste of talents and potentials for the sake of that dollar needed to educate our children. There are many of we parents who come from large middle class families and without all that we have today as to monies and facilities, our parents were able to give us an education, if we so desired it, or we worked summers to gain more money and to afford education without being pushed into it. Many of my family were without college educations, but were smart as to intelligence and so made a go of life at least able to work at a decent job to have money enough to educate their own children, yet I am a R.N. and without funds to pay bills and cannot afford to live or give my daughters a college education nor can I or rather am I allowed the right to work, unless I will close my eyes as to what I see wrongfully being done to geriatric patients and without a good record of long employment in one place, others are skeptical of giving me a job, for they do not understand why I do as I do, and I never ask as to the rate of pay for I will work any hours any day and anywhere I can truly help someone, but when I see that no accomplishments can be gained from my being in a place, I leave of my own free will. So, have a poor employment record which is detrimental financially to me and mine.

I know that I alone cannot solve lifes' problems, it is foolish for any human being to think that he or she can, but at least, if given the opportunity, I can help and in my helping others I am helping myself and giving some meaning to my life as a human being in God's world, of which we all are a part. We don't live and let live, we try to help and help live, just like the Literacy Program "Each One, Teach One."

My ambition is to investigate the needs of the patients and see that they get what they need, even if their need is just a kind word, or a listening ear. It all takes time and money for transportation, but it can be done with a handful of people who really care, at least it is a start, and not a big expense to our Government. This business of doling out monies at requests and having it go down the drain in some elses' pocket, is ridiculous, but everything seems to be politics and it all depends upon what ball team you are on as to whether you live life or just exist as a human being. When people start telling it like it is, rather than hiding it or covering up for others mistakes, then and then only will there be understanding and worthwhile living. So much stated is taken "out of context" by others. To me, it isn't a generation or a communication gap, it is strictly an "UNDERSTANDING GAP."

Appendix 4

NEWSPAPER ARTICLES FROM THE ST. PETERSBURG TIMES, ST. PETERSBURG, FLA.

The following series of articles appeared in the St. Petersburg Times, St. Petersburg, Fla., on Sept. 28–30, and Oct. 1–2, 1970:

[From the St. Petersburg Times, Sept. 28, 1969]

Their Assignment: Soiled Sheets and Bedpans

For three weeks in late August and early September, Times reporters Michael Richardson and Peggy Vlerebome worked in seven licensed nursing homes in Pinellas County.

They carried bedpans, bathed and fed patients, and spoon-fed elderly men and women unable to feed themselves.

They changed stained and soaked bedding of patients who have lost control of body functions.

They stood the lonely vigil of all who work the 11 p.m. to 7 a.m. shift, arose before sunup to work the 7 a.m. to 3 p.m. shift and ended the patients' day on the 3 p.m. to 11 p.m. shift.

They helped lock elderly patients in their chairs by day and in their beds by night.

They talked to patients, doctors, nurses, aides, orderlies, maintenance men, cooks, and administrators—all of whom thought they were talking to another member of the nursing home staff.

They worked in large homes and small, new buildings and old ones—in family-operated and corporation-run businesses, in homes certified by Medicare and others that were not.

Before they went to work in the homes, Richardson did extensive research on the industry that is a billion-dollar business nationally, and on federal and state regulations pertaining to nursing homes.

In the four weeks since their last jobs, they did more research and contacted 22 homes requesting rates, applying for jobs or posing as husband and wife looking for a place for "grandma" to live.

They used their real names when they applied for jobs, but used the address of an unoccupied apartment on their applications. They told prospective employers they were college students.

Richardson, a newsman for five years, came to St. Petersburg in June from the Greenwood (Ind.) Daily Journal where he was city editor. Miss Vlerebome joined the Times staff in June after graduation from Indiana University.

The Times investigation was prompted by complaints from readers of poor care in nursing homes, including the unpublished manuscript of a registered nurse who worked nearly eight years in nursing homes throughout the Tampa Bay area.

Our Nursing Homes: The Inside Story

(By Michael Richardson and Peggy Vlerebome)

Abuse and neglect haunt many of Pinellas County's nursing home patients, despite high costs and a federal windfall to the big business of health care for the aged.

Rarely checked by public visit or government inspection, some nursing homes are dens of disgrace, despair and death. Some are adequate. A few are very good.

Americans—in sharp contrast to Europeans who generally care for the aged in their own homes—have one million persons in nursing homes, Pinellas County with its 54 facilities and 3,400 "occupied beds" is regarded as one of the nation's showcases in a growing nursing home industry.

41-304—70—pt. 2——8

But an eight-week study of patient care in Pinellas County revealed these facts:

For the majority, a nursing home is the last home. A survey shows that within six months after admission, 25 per cent of the patients die; 24 per cent face a serious physical or psychological crisis; while 51 per cent struggle to adjust and live 1½ to 2 years longer.

Cost of good patient care is prohibitive. Says a Tampa doctor: "If you can meet the bill, you'll get good care; if you can't, you've had it." The average cost of "good care" is $500 a month plus many extras. The room-and-board rate can range from $225 a month for almost no care at all to as much as $1,000 for Pinellas County's finest. (Two of every three dollars paid to nursing homes come from state or federal agencies.)

Unseen and subtle abuses confront the nursing home patient daily, hour by hour. Patients who "make trouble" for their caretakers are restrained by belts, straps, adult "high-chairs" and locked doors—often for hours at a time; or they are drugged into submission. Bedsores plague bedfast patients who are left in one position for hours. Urine-soaked sheets are left "for the next shift" to change, while the patient waits hours in discomfort.

Shuffling of patients from room to room, even from one home to another, is common and adds to patient confusion, doctors say. In St. Petersburg, eight lice-ridden patients were kept by a doctor in a private home he owned. When discovered by health inspectors, the patients were moved to a nursing home where up to 10 elderly persons were left unattended in a house across the street from the main part of the home itself.

These abuses occur despite a Florida health regulation that requires vigilant observation of any restrained patient, and thorough reporting of even "minor patient incidents." These rules are violated in most every home.

Perhaps the strongest public indictment is a physician's estimate that 80 per cent of nursing home patients "could be cared for in private homes by their own relatives."

Nursing homes everywhere are plagued by an almost incredible two-fold personnel problem. First, there is a shortage of nurses; second, the turnover rate among all nursing care personnel is high.

Department of Labor estimates indicate that the turnover rate for all nursing personnel approaches 60 per cent; aides and orderlies, 75 per cent; registered nurses, 71 per cent; licensed practical nurses 35 per cent, and administrative and supervisory nursing personnel, 21 per cent.

Despite high patient costs, employe wages hover around the federal minimum of $1.30 an hour. Nurses' aides, who make up two-thirds of the 1,841 nursing care workers in Pinellas County, average only $42 a week in take-home pay. A few orderlies make up to $55 a week.

Even nurses, who are responsible for the medical care, can expect to make a maximum of only about $120 a week after taxes. Licensed practical nurses make between $85 and $100 a week.

Homosexuals, alcoholics and drug addicts have been found working in nursing homes. In one St. Petersburg home, four orderlies were fired last month for homosexual activities in front of patients.

Training programs for "caretakers" (aides and orderlies) are virtually nonexistent at nursing homes. After as little as one day on the job, an aide may be responsible for the care of 36 patients.

State requirements on the number of nursing care employes a home must have per patient are usually met, although marginally. But on a given day a home will not have adequate staffing. One nurse reported she alone was responsible for the care of 122 patients at a St. Petersburg nursing home.

Doctors rarely see patients, and telephone prescriptions replace personal examination. One patient in a St. Petersburg nursing home, admitted in 1962, has been visited by his doctor only twice in seven years. Federal regulations under Medicare and Medicaid, however, require more frequent visits.

Visitors are the most pressing of all patient care needs. Says a Suncoast physician: "A lot of relatives and friends fail to visit; the patients are dying to have a conversation . . . This loss of an 'attending ear' is very important. The patients need a mental catharsis—that is, a mental cleanup job. They need that.

"If someone would listen to 'Aunt Nellie' for a half hour a day, it would give her something to live for."

A smattering of church-circle members periodically visits in nursing homes—but usually only to see church members. The sights and sounds of young people—delightful and desired by the aged—remain beyond the door of the average nursing home.

The public pays taxes, not visits. But those taxes bring local health department inspectors to nursing homes only once a year, and Medicare inspectors notify homes in advance of their twice-annual inspections, giving them time to spruce up.

Modern nursing homes—although vastly improved over some boarding house "snake pits" of 15 years ago—do not always live up to advance billings. The telephone book advertisement for a Pinellas County home said "electric nurse call system . . . completely air conditioned . . . planned recreation . . ."

But seven men crammed into an "annex" at the home had no nurse call system, electric or otherwise, and they sweltered in an unairconditioned room. The only recreation was for the few patients who could walk from their rooms to a television lounge or a porch, and back.

Even the simplest exercise for a "semi-ambulatory patient" (one who can walk with assistance) is a precious commodity. Few of these patients are given aid to walk—especially not if they have fallen victim to the need for a "posey," the belt-lock restraint.

"They are posey crazy around here," one aide said at a Pinellas home. "They put that posey on and these patients never walk again—for weeks, unless a nurse orders it."

Physical therapy programs—which are being set up more and more—do provide rehabilitation for patients, but they cost extra. At one new St. Petersburg home, after three weeks in homes, Times investigators found one woman who was "going home." She had received physical therapy treatment under Medicare payment and use of her right leg had been restored.

Little, subtle sins are frequent. Patient articles and clothing are misplaced, lost or stolen. A welfare patient complained that most of his clothes were missing, and an aide verified his charge. The clothes were not found, however. Later, they might "turn up" in the large chests marked "house shirts, house underwear, house socks." In the meantime, the patient would wear gowns at an extra charge.

The trauma of entering a nursing home goes untreated. A physician who specializes in geriatric patients explains: "When a patient goes in, he is automatically struck by the surroundings—a lot of old folks, some mentally ill, some agitated and others depressed, shouting or crying—and the smell; and he says, 'Am I going to be like this?' He feels shame, then fear and soon doesn't care, becoming inactive."

Yet there is virtually no psychiatric care available to nursing home patients.

Food in nursing homes rarely tastes good, if it tastes at all. Employes will not eat the "welfare food," as one patient called it. Properly prepared food kept warm is important, but a doctor notes:

"Any institutional food is not the best; it doesn't taste good and the patients become disinterested and don't eat. This is bad—soon they are not eating . . . Their nutrition and appetite is affected by lack of exercise, and their bodies suffer.

"Of course a doctor often has to prescribe low salt or bland diets, and this contributes to not wanting to eat. But I tell the relatives of my patients: 'Ask Uncle John what he would like to have to eat once a week—roast beef and home-fried potatoes—and BRING it to him.' Some nursing homes will not permit this practice on a regular basis."

Misleading and often meaningless "certificates" adorn nursing homes, but do not guarantee good patient care to an unwitting public. "Approved for intensive care," "accredited for convalescent care," "approved for Medicare"—all these mean little.

State licensing is the only government guide available, and there is only one independent accrediting organization in the country. The Joint Commission on the Accreditation of Hospitals (and nursing homes) approves just one Pinellas County home (in Clearwater) and only about 4 per cent of those in the nation.

"Let's face it," says the commission director of the nursing home division, "nursing homes are business; it costs to be surveyed by our accreditation—and many don't believe it is worth it."

Others couldn't pass the test. The commission's accreditation has been removed from three Pinellas homes in the last year.

Effectiveness in government enforcement is questionable. "We bend over backwards to get compliance with the rules," says a local health inspector.

Thirteen years ago, when there were about half as many homes and less stringent regulations, there were two inspectors. Now, there are 54 homes—and still only two inspectors.

Currently, in Pinellas, three homes are on "conditional" licensing, a device used by inspectors to insist upon improved care of facilities. Revocation of licenses, however, is rare.

Structurally, the majority of nursing homes are safer than 16 years ago when a Largo fire killed six persons and led to state legislation governing nursing homes. "We have eliminated many of the substandard homes in the last 10 years," says Dr. Wilson T. Sowder, head of the State Health Division.

But there are still homes that do not meet safety or health regulations. Patient beds, in older homes especially, are crammed into corners—in direct violation of health rules. A nurse in one nursing home was not informed how to open a second-floor fire escape until she had been on duty at night for three months. Another nurse then told her: "Sometime I'll have to sit down and tell you what to do in case of fire."

The nursing business has become a burgeoning industry—worth perhaps $100 million a year along the Suncoast. The facilities themselves, worth about $12 million in Pinellas alone, are but one facet. There are pharmacies, doctors, ambulance services, food services, utilities—and morticians—who feed on the growing business.

The advent of Medicare—which pumps hundreds of thousands of Federal dollars into Pinellas homes each year—launched a building boom in the nursing home field. New homes were built, others remodeled, because with Medicare a steady flow of the Federal dollar could be expected. Now chains of nursing homes are springing up—and the stock of these corporations is skyrocketing.

Ninety percent of all nursing homes operate for profit, but nationwide, taxes pay 2 out of every 3 dollars taken in by nursing homes. Medicaid, which has not yet come to Florida, paid $1.1-billion to nursing homes in other states last year, while Medicare paid out another $500-million.

But in recent months in Florida, Medicare administrators have tightened up on nursing home payments and clamped down on the number of patients admitted to nursing homes.

A North Miami Beach nursing home is charged in a government document with inflating its drug charges by 30 percent under Medicare. The Justice Department is continuing its investigation into the charges.

The federal crackdown indirectly affects all nursing home patients. When revenue drops, nursing home administrators admit they must pass the cost on to the patients or "cut the care—by a few nurses or aides." When there are too few nursing personnel, one administrator said, patients are drugged or restrained "to make less work."

Efforts are being made, particularly by nursing home chains, to improve care and surroundings for the aged. Bright colors, wooden rather than hospital beds and gay-looking draperies are being used to create a home-like environment. These efforts are not in the majority, however.

Still, too often, care is determined by costs.

"He needs a clean sheet," a new aide says of a patient.

"We'll wait till later, because he's on welfare, and well . . . you'll get to know which ones are," explains the "experienced" aide trainer.

"We've got to live down the reputation of the past," says a top official in one of the fast-growing nursing home corporations in Florida.

"One of these days, maybe we'll be looked on as professionals," laments a veteran St. Petersburg nursing home owner.

But the day is not yet here.

Too many nursing home owners and administrators have had almost no experience in health care generally, much less the specialized care of the aged. They are attorneys and purchasing agents and businessmen, not professional nursing home administrators.

A new Florida law passed this year is to require licensing of nursing home administrators—but the qualifications for licensing have not yet been established. A new state nursing home advisory council, which has not yet been appointed by the governor, will set up the licensing guidelines.

However, enforcement has always lagged behind legislation.

"The greatest enforcer is the private citizen, who visits these places and observes" a health official says.

Unfortunately, local inspectors rarely hear from anyone who will identify themselves.

"We won't follow up their complaint unless they give us their name and address," says the Pinellas County nursing home inspector.

Nursing Home Medicare Bills Under Review

Miami (AP)—Officials report a close review is being made of Medicare bills submitted by each of the 180 Florida nursing homes participating in the federal program.

The tightening-up procedure, intended mainly to assure that patients were eligible for Medicare, has caused delays in payments to some nursing homes.

Frank Moore, administrator for the life insurance company which is intermediary for the program in 160 of the Florida homes, said payments are rapidly getting caught up. "We are now only about 31 days behind," he said.

Three Florida nursing homes left the Medicare program temporarily. One of them, East Manor of Sarasota, has been back in good standing for some time and the other two—North Miami Beach Convalescent Home and the Samaritan Medical Center in Hollywood—"should be back under the program by the end of the week," Moore said.

The Social Security Administration in Washington said the case of the North Miami Beach home was referred to the Justice Department on Aug. 24 for collection of overpayments, not for prosecution.

Moore said both the North Miami Beach and Hollywood home had been very cooperative and both are providing good medical care.

Facts and Figures

Nearly 20 million Americans are over the age of 65, and half of those are 72 or older. One-third of St. Petersburg's population is past age 65.

One million people live in nursing homes in the United States, including about 3,400 in Pinellas County.

Of those in nursing homes and related facilities, 88 per cent are over 65; 70 per cent are 75 or older; 50 per cent are over 77; and one out of three is 85 or older.

Of nursing home patients, 50 per cent are confused all or part of the time. Almost half need assistance in walking and one in four cannot walk at all.

Women outnumber men by almost two-to-one in nursing homes. America has nearly 25,000 nursing homes—about 15,000 more than there were just eight years ago. Pinellas County has 54 licensed homes with 4,567 beds—only about 72 per cent of them occupied. Florida has 285 nursing homes.

Nursing homes go by many names—restoriums, sanatoriums, convalescent centers and hotels, homes for the aged, manors and others.

Levels of care provided by each home vary—and each term confuses the public. There are "custodial" or domiciliary nursing homes which offer room and board and little else; skilled or "nursing care" homes that offer room and board and some nursing care, such as administering of medicines and drugs; and, finally, "skilled" or intensive care homes that offer care similar to nursing care in hospitals.

The nursing home industry is a billion-dollar a year business in the nation and is worth about $100-million in the Tampa Bay area alone.

Pinellas County has 1,841 employes involved directly in the care of nursing home patients, plus 926 other employes including administrators and food service and housekeeping workers—for a total of 2,767.

Despite the size and rapid growth of Pinellas' nursing home industry, there are still only two health department inspectors—the same as 13 years ago.

[From the St. Petersburg Times, Sept. 29, 1969]

(By Peggy Vlerebome and Michael Richardson)

A nursing home patients' sole caretakers are the aides, who are not paid well to do their job—nor paid to do their job well.

Aides are trained in the "learn-by-doing" method, and if patients are unhappy, uncomfortable, or dead as a result — well, that's one less to have to worry about.

That is the prevailing attitude of the most untrained, unskilled, lowest paid of the nursing home employes — the aide.

As inexperienced caretakers, we learned the following working in some Pinellas County nursing homes:

Don't make trouble for your fellow employes. This means you don't report that the only nurse on the 3 p.m. to 11 p.m. shift is not licensed in Florida. "She is a good nurse," the 11 p.m. to 7 a.m. nurse tells you.

Don't do anything you don't have to do. "The other shifts don't do any work, so why should we?"

If you discover a wet bed at 2:30 a.m., don't change it until 5:30, "so we don't have to do it twice," a nurse advised.

Don't use cups or utensils used by patients; "you don't know what you might get from them."

Don't touch a runny bedsore because you might get a staph infection. Let the other shifts worry about the patients getting staph infections.

Don't waste your time talking to patients. "They're so senile they don't know what you're saying anyway."

When you do talk to patients, talk as if they were children; don't ask if they have to go to the bathroom, ask, "Do you have to pee-pee?"

Don't spend a lot of time feeding patients who can't feed themselves; they won't know the difference.

If you have a headache, just ask the nurse for aspirin and she will give you some of a welfare patient's "and let someone else pay for it."

Don't change the top sheet unless it is really soaked as the patient will be charged extra for it. Presumably the patient would rather be wet and get a urine burn.

If patients "get in the way," strap and lock them in their chairs by day and their beds by night. Don't bother checking on them "vigilantly" as required by state law—a law unknown to most caretakers and ignored by the others.

If you have a patient who uses a catheter, "irrigate it when you get a chance" instead of every eight hours as required, a nurse said. Do it when you can—right or wrong.

But who can blame the aides for the poor care they give? In need of money and lacking any skills, they answer the newspaper ads with a call or a visit to the home and are hired on the spot or over the telephone.

They begin work as soon as they arrive at the home. They train under nurses bogged down with paperwork and aides who "have the routine down pat."

"There's nothing much to it after you learn to change sheets," a "seasoned" aide told one of us the first day.

To the aide, the patients' souls have died and their bodies will sooner or later catch up. This job is eight hours a day, five days a week, for the "going rate" of $1.30 an hour (the federal minimum); what happens on the other shifts doesn't concern her.

Somehow the aide knows she won't be fired unless she does something really bad like letting a patient fall—so if that happens she just doesn't report it.

She knows the home is short on help. The other aides tell her how many have come and gone. She doesn't know the turnover rate for aides is 75 per cent; if she did she'd realize that's part of the reason there is no training program.

But at least it is a job. If she doesn't like it at her first home, there are plenty of jobs at other homes. After two or three days, she can quit and get paid more somewhere else because by that time she will be "experienced." In time, perhaps she can work her way up to the top pay, $1.50 an hour.

If the aide can tolerate the stench of dried and soured urine and fecal matter, she might even enjoy her job.

She is given responsibility, and given it quickly: after one day in a home one of us was to be in charge of 36 patients. The aide has no superior except, technically, the duty nurse.

But the nurse is busy with paperwork most of the time, and the nurses are as unmotivated to provide good patient care as the aides—although they are the only trained employes among the "nursing care" staff.

Some homes also employ orderlies, who do the same things as aides, except they take care of men almost exclusively. Two-thirds of the nursing care employes in Pinellas County are aides, while there are only 64 orderlies—and 1,000 men patients. In homes which do not employ orderlies, the men patients must be bathed and dressed by women.

The remaining nursing care employes are nurses, most of them licensed practical nurses. Friction between them and the registered nurses is common.

The practical nurses used to do the work aides do now, and registered nurses spent a lot of time in contact with patients.

The registered nurse has more extensive and more intensive training than does the practical nurse, but with the shortage of nurses, both do the same things in a nursing home.

The registered nurses professionally resent the practical nurses for being able to do the same work but without the same training, while practical nurses resent the registered nurses for making more money for the same work.

The turnover rate among registered nurses is 71 percent, while among practical nurses it is 35 per cent. A registered nurse often finds a practical nurse with whom she works has been at the home longer—and in terms of seniority is "out-bossed" by her colleague.

Many nurses see their job as an executive secretary in a white uniform whose job is easier than in a hospital.

One St. Petersburg nurse, however, who prefers her nursing home job to a hospital job, stated it this way: "In a hospital you are so busy with paperwork and the patients come and go so fast you don't get to know them. In a nursing home you get to know them and watch how they respond to medication and get better."

Her opinion and motivation are rare in the nursing home.

But even more rare is the aide who realizes that patients are people with human drives and anxieties and who, because of their age, may have psychological problems and mental illness.

Most of all they need to be cared about, not just for.

Barely covered by a short and wrinkled cotton gown the 83-year-old man strains against the bar that keeps him locked in "his chair." His eyes blink with emergency, but no one answers their silent alarm. In a moment, he sinks back drops his head, and mumbles:

"What a life . . ."

What a life? He has not been bathed or shaved in a week. His toenails are so long he cannot wear socks and it hurts to wear shoes—but then, it has been weeks since he has been walked. His false teeth remain uncleaned in his dresser drawer despite the coming of a lukewarm meal.

He can no longer care for himself—he is old.

He has to go to the bathroom. But this normal body function, after months in a nursing home, has become more than an emergency—it is a crisis. In the moments that he waits for help, he mumbles "oh, not again." He knows the sting of a urine burn chafed by a wet gown and he doesn't want it to happen again. But it does.

Still, he sits, as he has for nearly six hours since dawn in his nursing home "home." Often, he leans forward to relieve the pressure on the bedsores on his back. Occasionally, he moves against the restraining adult high-chair—which is parked out of reach of his "call light."

His one consolation (?) is that he isn't the only human in that condition. He looks around "his room." There are others, sitting and staring, lying and staring.

His bed is one of 3,383 that the Pinellas Health Department calls "occupied beds" (not patients) in the 54 licensed nursing homes in this county.

The exact number is important—very important to the homeowners, their 2,700 employees, their stockholders, and to the federal and state government, doctors, druggists, ambulance drivers, food services, linen companies—and morticians.

"Here's your lunch," a voice interrupts.

He studies the tray, placed on his high-chair. The noon meal is usually the best, he says. There are thin slices of beef but no gravy, whipped potatoes but no salt, coffee with saccharin, bread with stiff edges, gelatin and juice. It is only half-warm.

But it is better than breakfast's half-scrambled eggs and cold toast.

"Are you going to eat?" the voice of a nurse's aide quizzes.

He nods quickly. Once, he shrugged his shoulders and the tray was whisked away. So he eats what another patient calls "welfare food."

Two hours after the meal was served, the tray is finally taken away.

In another 15 minutes, it would be "pill time"—one of three of four brief periods a day when he got a chance to see a nurse. He wants to talk to her about wetting himself, but as the nurse comes in, she speaks quickly about taking his pill.

He knows she is busy with other patients and he doesn't want to be a bother—so he continues to sit with the wet gown rasping across his abdomen.

Soon, another aide enters. "Are you ready for a nap?"

No, he isn't, but his protests have done little good in the past.

He would like for the aide to help him to try walking again—but she says she is too busy right now.

So he nods. He'll take a nap—at least he will get the wet gown off.

"Did you pee-pee? Your gown is wet," says the aide, cooing a reprimand.

He hangs his head and uncontrollably tears well in his eyes. He is ashamed, he says—and naked, without dignity. "I'm sorry," he sighs.

The aide goes for another gown, which she will have to mark down as an extra charge against his bill. She also picks up two disposable diapers and marks a 20-cent charge.

Returning, she places the diapers in the middle of the bed, then puts the fresh gown on him.

"Let's go," she commands.

The aide strains to help him rise. She urges him to help himself—but days without exercise prohibit him from helping.

She gently pushes him as he turns, then shuffles the two feet toward the bed. Again, they turn, and slowly and painfully, he swivels into bed.

"There you go," the aide says, expressionless, and she is gone.

In another two hours supper will be served, but he probably will eat in bed. And he will eat slowly—because soon, all too soon, after supper comes "bed time."

He dreads the nights, he tells a fellow patient—the long nights when there are fewer aides, when the moans of other patients knife through the shadowy hallway.

He talks with his "roommate" about how he would like to walk again, and how he misses "PT" (physical therapy). But the therapy had cost extra, and he could no longer afford it.

Supper comes and goes.

It is dusk outside.

Inside, it is "pill time" again—only minutes more before bedtime and the long night.

A woman poet, after years in a nursing home and shortly before her death, wrote:

"Fast now I sink within the night
"Alone! None other can assuage my pain.
"I yearn to reach the welcomed sight
"Of home and peace and parlor light
"I shall see them nevermore again."

Eighty six patients in one nursing home; 3,383 in Pinellas County; one million in nursing homes throughout America. A means to an end . . .

[From the St. Petersburg Times, Sept. 30, 1969]

(By Peggy Vlerebome and Michael Richardson)

"Whether a nursing home is a blessing or a curse depends on the rationale of the administrator of the home. It depends on the philosophy by which the home is run," Thomas A. Routh of the Hillsborough County Division of Welfare wrote in his recent book on nursing homes

The administrator is the man in the middle. He has subordinates, but if any thing goes wrong, he is responsible.

In the nursing home business, if something goes wrong patients may die—or live an existence which makes them wish they were dead.

The administrator may share the philosophy that Florence Lindruff, now a physical therapist with the U.S. Department of Health, Education and Welfare, proposed in 1957: "Perhaps it should be the credo of those working with the geriatric patient that living as long as we want to live is less important than wanting to live as long as we do."

But as head of the home, he has endless forms to fill out, supplies to order, bills to pay, and all the paperwork involved in a bureaucracy.

He must depend on his subordinates on the home management "team"—the assistant administrator, nursing supervisor, dietician—to keep the wheels running smoothly. In some homes, there is only one subordinate such as a nursing supervisor who doubles as his assistant.

As administrator he knows there is a 75 percent turnover rate among aides and orderlies, the untrained employees who provide the care. Even if he does the hiring himself, instead of the nursing supervisor, this does not guarantee good employees.

Nursing homes are not "personnel-oriented," laments Owen Beem, administrator of Pasadena Manor. An experienced professional administrator, Beem is trying to upgrade employees with training and higher pay.

Another administrator criticizes his colleagues for not checking the references of applicants, and notes that with employe shortages homes must sometimes keep what employes they have. "You can't bawl them out because they can walk out and get another job."

The administrator seldom has time to see patients. His office often is situated away from the patient areas, where his product—care—is marketed.

Were he to visit the patients in their rooms, he would see some of the abuses—as in one St. Petersburg home, where a plastic bleach jug is used instead of a sterile plastic catheter bag for one patient who uses the bladder-draining device.

But he is a busy man. In his daily schedule he must not only take care of piles of Medicare and other official papers, but also deal with grocers, druggists, ambulance services, laundries, morticians, medical suppliers and the public.

The administrator delegates a lot of power to the nursing supervisor, whose most important duty is to maintain a high level of nursing care. How she does her work determines whether patients are going to live or die; and if they live, whether they are as comfortable, healthy and happy as possible. If she does not do her job well, the blame falls at the administrator's feet.

A St. Petersburg registered nurse who worked 7½ years in nursing homes includes passages in her unpublished book about her contact with administrators of nursing homes in the Tampa Bay area.

At one home, the nurse complained, an aide on her shift not only had a key to the drug room (a state law violation) but also abused patients. The nurse said she reported the aide to the administrator, who replied in part:

"We are experiencing a temporary shortage of help. Gertie (the aide) can dispense medications and read charts as well as most nurses. That is why she had the extra key to the medicine room."

The administrator's comments on patients, specifically at medicine time, reflect an attitude in some homes: "Some patients are like petulant children. They refuse to take their medicine. When this happens we treat them like children. If they shut their mouths we merely hold their noses until they have to open their mouths to breathe . . . It is a little unpleasant but after a while they learn."

Another's comments about patient treatment are heard in home after home: "Mrs. G is senile. She is like a child. Treat her gently when she urinates and she will continue doing it. Gently punish her when she soils herself and she will soon learn not to do it any more." The "gentle punishment" from the aide had been name-calling and rough handling, the nurse recounts.

But in some homes, the patients are considered "family," as at the Candle Glow Nursing Home in St. Petersburg. Mrs. Reeta Elgland, owner, has some employes and some patients who have been there since she bought the home eight years ago.

In serving this "family," Mrs. Elgland said, she sometimes loses money for their benefit. "I haven't made money at this home for a year," she said, "but it has given me a good life, so now if I must give up some things for it, it's worth it."

Many administrators have experience from another industry, and the techniques learned there are valuable in running any kind of business. Some administrators hold law degrees, while others got their start working in homes owned by their families.

In 1963 only 10 percent of the nation's nursing home administrators were trained specifically in this field. Today, with college and university courses—including a two-semester course at St. Petersburg Junior College—and government agency-sponsored seminars, the number has increased, but not by much.

In their book "Where They Go To Die," Richard M. Garvin and Robert E. Burger write about a recent workshop for nursing home administrators from the nation's best homes. In a questionnaire, they were asked whether "anyone can do the job" if he or she has the right attitude.

"Only 38 per cent . . . said that skills are required over and above the 'right attitude'; 48 per cent thought that good will was enough," they report.

One St. Petersburg administrator who is a proven leader critizes his colleagues for not being personnel-oriented since the care is done by the homes' employes. "Management is part of the reason for turnover," he said recently. "They don't encourage employes to stay."

Employe labor unions, new to Florida nursing homes, "won't get in where management has regular merit reviews and pay increases," the administrator said. An attempt recently to have a union at The New Fern Restorium in St. Petersburg failed. There is a union at one Pinellas County home.

Abuse of the narcotics law by employes is another problem faced by administrators, but no one knows just how serious this problem is today. Blaming abuse of the law on careless administrators, a Clearwater policeman said recently that administrators "don't want to get a reputation" that might hurt their business "so they don't report it and they cover their own footsteps."

We've got a lot to live down about nursing homes," a St. Petersburg administrator says in explaining that the nursing home chain for which he works will be better managed than most homes.

[From the St. Petersburg Times, Sept. 30, 1969]

Nursing Home Growth Outpaces Government Control

(By Michael Richardson and Peggy Vlerebome)

Public taxes have made nursing homes a big business—but they have not guaranteed better care for the elderly.

As federal and state aid to the elderly increases, the nursing home industry booms. About $4-million a year in tax money is pumped into Pinellas County, where the number of nursing home beds has increased five times in the last nine years.

But enforcement of government rules has lagged behind money and growth.

The advent of Medicare—at first opposed by nursing home owners—brought with it a seeming "guarantee" of prospective income: Elderly sick patients would be leaving hospitals and moving to nursing home to "convalesce." Other persons who previously could not afford nursing care would be covered by the program.

The bonanaza was on. The number of licensed homes in Pinellas nearly doubled from 28 in 1960 to 54 today, and available beds climbed from 945 then to 4,567 now. Ninety per cent of the homes operate for profit.

Nursing homes are a prime investment item. More than 50 nationwide corporations have been launched into the nursing home ocean. Some of them have operations in Pinellas, including Med-cor, Care Corp., Beverely and Alliance Medical Inns. Nursing home stock has been known to sell at a price 100 times per share earnings.

The profit is there with revenue from government as well as private citizens—up to $1,000 per patient a year, one owner estimated.

Medicare alone means $2.5-million a year to Pinellas nursing homes and about $500-million nationwide. In addition, Pinellas homes receive $1.5 million out of $10-million annual payments for nursing home patients . . . as $100 to $150 per month for total patient care.

Drugs and supplies obtained "for the patient" can be purchased at wholesale cost—then charged to the patient at retail cost or above. For example, disposable diapers cost patients 10 cents each—but can be purchased for 2½ cents each.

The U.S. Justice Department is now investigating one Florida nursing home in North Miami Beach for allegedly charging an extra 30 per cent for drugs and therapy in its Medicare billings.

Some nursing homes see a need to eliminate federal and state "red tape." Home owners, administrators, doctors—even nurses—are reported bogged down with paperwork to obtain public assistance payments.

"You wouldn't believe it . . .

Now, Medicare through its "fiscal intermediary" (the insurance carrier, Aetna Life & Casualty in Pinellas) has cracked down on payments to nursing homes and on approving new patients for coverage.

"Covered care has been changed," says Preston. "They have also tried to make it retroactive as far back as one year."

The retroactive decision in particular has struck hard at the nursing home's pocketbook—whose monthly Medicare income can be $20,000 or more.

"Doctors are being overruled, and the utilization committee, which reviews Medicare, cases is being overruled," says Preston.

"It's to the point where it's impossible to get your benefits," he added.

"We're doubly concerned: we are not getting our money and the patient is not getting his benefits," he declared.

He said the Medicare action was "not only a cutback but a holdup."

Last year Medicare paid about $15-million to Florida nursing homes, Preston said, but the U.S. Department of Health, Education and Welfare "said this year to cut it in half."

While medicare troubles fester, other nursing homes are looking forward to Medicaid's arrival in Florida.

One Pinellas home owner commented on the fast-growing nursing home business here: "I really believe they're anticipating a windfall from Medicaid."

Building safety has improved substantially as a result of government action. As homes are built or remodeled, health and fire safety officials work with owners and architects to "build in" sprinkler systems, handrails and adequate lighting. These regulations can be set down on paper and checked.

Perhaps the best example of good rules enforcement in nursing homes is the observance of fire safety. Although a few potentially unsafe homes exist, most are newer and safer—and inspected often by fire prevention inspectors.

"We inspect about once a month, and if we find anything we write up a violation," says a fire inspector.

If the homes do not comply with fire safety standards, their annual license renewal is in jeopardy.

"Of course, there's a great turnover of personnel in these homes, and monthly inspections help us to be available to explain what to do in case of fire," the official at the St. Petersburg fire prevention bureau explained.

Frequent inspection is effective enforcement.

Rules concerning patient care, however, cannot be enforced on paper.

"No patient shall be abused, punished or neglected," the state regulation reads. But in countless cases we saw abuse and neglect go unreported.

How can health department inspectors check such incidents? Presently, they cannot, without public support. Nursing home personnel, seeking to protect their jobs, do not report incidents of bad patient care.

Local health inspectors are required to inspect homes only once a year. In Pinellas, over the last 13 years, there have been just two home inspectors despite the tremendous increase in the number of homes and patients.

Medicare inspections are required every six months—but nursing homes are notified in advance of the impending inspection.

But even with lagging enforcement, the U.S. Public Health Service reports one nursing home bed out of three does not "conform" to government standards.

In the absence of adequate inspections, nursing home administrators are left on their own to maintain the quality of patient care.

If costs go up, administrators—usually with no specific health care training—either pass the cost on to the patient or "cut the service, by a few nurses here, a few aides there."

A new Florida law, passed this year, will require licensing of nursing home administrators. A new nursing home advisory council will establish the licensing requirements but the governor has not yet appointed its nine members—five of whom are to be nursing home administrators.

[From the St. Petersburg Times, Oct. 1, 1969]

(By Peggy Vlerebome and Michael Richardson)

The best enforcer of laws governing nursing homes is the public, Robert C Hazelhurst, health department inspector has said.

He says he will investigate complaints from people who notify him, if they give their names and addresses.

But the public's contact with nursing homes is much like it is with funeral homes—in time of need.

There usually is not a lot of planning before having a friend or relative admitted. Sometimes only a few homes are visited by prospective customers after reading the advertisements in the telephone book.

What they see when they visit the home might be the same thing the ad said they would—but what they don't see might horrify them and scare them off.

What the public doesn't see, the public often gets, in a nursing home. And what they do see, they sometimes don't get.

Like the air-conditioned room in one St. Petersburg nursing home which is shown to visitors. The other rooms also have air-conditioning units—but the patient is charged $1 a day to use it.

Or the reassuring slogan of many homes, "24-hour nursing care" which often amounts to a few nurses busying themselves with paperwork, and several untrained aides.

What the public first sees inside the home—certificates in frames on the walls, carpeting, beautiful fabric-covered chairs in a handsomely appointed living room and patients sitting on the veranda—may well impress him.

The certificates on the wall usually signify membership in a nursing home association, but don't guarantee good patient care.

If among the certificates the visitor does not see the home's license from the county health department, he should demand to see it.

The carpeting and covered chairs are often for show; in at least one St. Petersburg nursing home patients are not even allowed in such areas.

And if the visitor encounters urine odor in the home, he should inquire about it. "There's no excuse for odor in the nursing home," a St. Petersburg administrator said. "You have to clean with a germ killer because germs cause odor."

Visitors should inquire about the food and whether there is a dietitian. Not only should they ask if salt and pepper, if allowed, is provided, but they should also ask for a tour of the kitchen and a look at the food.

The visitor should insist on seeing the entire home. A look into every room will not only answer but probably raise many questions in his mind.

In one Pinellas County nursing home visitors don't see "the annex" where a dozen men sit locked in their chairs and stare at each other all day.

And in another—one of the newest and with a good reputation—the old part of the building is not included in tours. It is in this wing where women patients, mostly on welfare, receive some of the poorest care we saw.

A prospective customer should ask if there will be a contract to sign and ask for a copy of it. Costs should be discussed so there is no misunderstanding after the patient is admitted.

The customer should ask what is included in the base charge; he should ask the charge on items not covered, and have both in writing. Among items to inquire about are disposable diapers, special diets, snacks, haircuts, manicures and pedicures, air conditioning, facial tissue, linen and changes of bedding, baths and shaves, to name some.

No visitor should leave a home until he has asked if there is physical therapy; if so, how often, how much it costs, who does it, and what it consists of.

If there is no such therapy, ask what exercise the patient has, depending on if he is ambulatory, semi-ambulatory or bedridden.

Then look for yourself and talk to the patients. What the administrator tells you about patient exercise and what really happens might be two different things. The administrator cannot be in the home at all times, and he must rely on another member of his management team to report to him on such areas.

Visit the home unannounced. Call the home a few days beforehand and ask what visiting hours are, as they vary from home to home.

It is hectic at shiftchange time—7 a.m., 3 p.m., 11 p.m.—and most homes prefer that visitors not come at those times or at meal time—7:30 a.m., noon, 4:30 or 5 p.m.

But there are advantages to visiting at those times. The visitor can see the employes as they come on and leave their shift, how many there are and their appearance. At mealtimes the visitor might get a look at the food.

No visitor should go to a nursing home without a copy of the State Board of Health rules for nursing homes and related facilities licensure. Free copies are available at the County Health Department, 500 Seventh Ave. S.

This set of rules contains many items the layman might otherwise overlook. For example, open floor space in rooms; a rule that handrails in hallways shall return to the wall; number of employes required, and the number of toilet facilities required.

This makes a handy checklist. But there is more to it—the rules say that patients shall not be locked in their chairs unless necessary and only with the permission of the doctor. This was abused in every home in which we worked.

Look at the patients. Are they smiling? Are many sitting in living rooms, or are they in their rooms? Do their eyes reflect despair? Are their fingernails well kept? Talk to them; are they happy? Do they have planned recreation or just television? Are there current magazines to read? Are there religious services for all faiths?

Far too frequently the only visitors are prospective customers, who often don't know what to look for. The power of enforcement of which Hazelhurst spoke is not used.

The public needs to visit homes not only to inspect them physically but, more important, to meet and visit patients.

"Just a 30-minute visit a day—or even a week—would give them a mental catharsis, a clean-up job," a Tampa doctor who works with elderly patients said with emotion.

There are church and social groups that visit nursing homes. Welfare department social workers visit welfare patients.

But they can't visit all 3,400 in Pinellas County regularly. More volunteers are needed to give patients a chance to socialize, to feel wanted, and to love.

Nursing Homes

(By Michael Richardson And Peggy Vlerebome)

Of The Times Staff

The absence of doctors in many nursing homes leaves patients without real medical attention. Instead, patients receive the homespun care of untrained aides and overworked nurses.

John T. has been in a St. Petersburg nursing home for seven years—but his doctor has visited him only twice. Some admission records in the same home show no evidence of the required physical examination upon entrance to the home.

A patient's only real link with the doctor usually is through the nurse who on occasion telephones a doctor to report symptoms, and usually receives a telephoned prescription order in return.

In more than 200 hours spent working in Pinellas County nursing homes, we saw not one doctor. When asked, nurses said the absence of a physician was the rule, not an exception.

Despite the fact that some patients suffer a trauma upon entering a nursing home and some develop serious psychological problems, psychiatric care for the nursing home patient is virtually non-existent.

The likelihood of death among the elderly doubles upon entering a nursing home, a major study declared, but doctorless nursing homes remain commonplace.

We saw one patient, who had developed a serious kidney infection, moved back into a hospital without a doctor's visit.

One nurse reported that a doctor would not come to a nursing home to pronounce a patient dead. The nurse said the patient died of a heart attack in the middle of the night and the doctor replied over the telephone:

"Then I pronounce him dead. Send him to the undertaker's and I'll fill out the papers in the morning . . . If any more of my patients die, just take care of them and let me know in the morning . . ."

The nurse was upset. "Fortunately, the patient had no relatives so I was spared the trouble of having to think up a story as to why the doctor was not there when, and if, they arrived at the home."

When it comes to the care of elderly in nursing homes, doctors are divided into two groups: those who almost "specialize in geriatric care" and build their practice around a certain number of elderly patients and those who have almost no elderly patients and seldom visit nursing homes. This distinction is a financial one—unless a doctor has many patients in a nursing home he loses money on visits. If he has several patients, it becomes "worth his while" to visit the home.

A Brandeis University researcher explained the phenomenon of doctorless nursing homes this way:

"The physician . . . has no traditional pattern of commitment to the extended care institution (nursing home) . . . .Thus a single facility may be visited by many physicians but none of them will be responsible for developing an organized and comprehensive care program.

"Thus the actual role of the institution is reduced to that of a boarding house rather than an intermediary institution with an integrated program of medical care."

The researcher, Norman R. Kurtz, a medical doctor continued:

"Neither can the (nursing home) administrator be counted on as one whose primary concern is a high quality of medical care for his guests . . . He has other problems to which he must give priority and not the least of his concerns is to run a profitable enterprise—at least it seems that people in the business are motivated by the hope of personal profit."

Medicare enables the elderly to leave a hospital after an acute illness and get cheaper care in a nursing home. But these homes have not yet been included in the doctor's accepted "chain of care" which links his office with the hospital, outpatient clinics and laboratories.

"Use of nursing homes as a custodial facility for persons nearing the end of their lives, or persons considered 'hopeless cases' has tended to alienate them from the medical profession," a major study said.

Doctors are said to be "acute-illness" oriented. The advanced age of the typical nursing home patient usually rules out dramatic recovery, and the poor mental attitude of the sick aged is discouraging to a busy doctor.

One of a group of Maine doctors who participated in a nursing home investigation admitted he found it unpleasant to work with patients "so unstimulating and so unresourceful as those who are rejected by their own families."

Another said he could not care for the aged beyond his professional abilities; he could not "arrange for more attentive families, more money and more hobbies."

The investigation's joint report concluded:

"Most doctors are frankly not interested in the care of the chronically ill and elderly in the nursing home environment."

This tragedy of the aged is compounded by nursing home "caretakers" who feel much the same way, even though it is their job to feel differently.

"When the doctor doesn't care, why should the nurse, the aide—or the patient?" one nursing home researcher asked.

All this could be changed by nursing home management if trained nursing care workers were employed, paid adequately and reasonable recreation and exercise programs were carried out, a Tampa doctor says.

He says most nursing homes fail to cope with the patient's major problems, which he says are:

A new patient's mind is often startled, dismayed and depressed upon entering a nursing home. He fears he will become like those agitated and depressed persons he sees.

A sense of abandonment and loneliness haunts him and he soon loses interest in life, because no one shows interest in him. "About 50 per cent of all the telephone calls to me are from old folks," the doctor says. "They say they have some physical problem, but what they are suffering from is loneliness—and they know a doctor is on call 24 hours a day, so they call just to talk to someone."

Nursing home food, even if "legal" and perhaps nutritionally valuable, isn't palatable. A patient loses interest in eating, which sharply reduces his physical abilities.

The fourth problem is inactivity, a lack of exercise. It is worsened by not eating, loneliness and psychological fears. Lack of exercise, too, breeds further inactivity. The doctor explains: "Inactivity is a two-fold problem: It adds to the mental slowdown, because the mind is not concentrating; and it speeds the deterioration of the bones—which makes it more difficult to move.

THE DOCTOR CONCLUDED

"The big mistake in nursing homes—all nursing homes I've seen—is a lack of activity for patients, no exercise. Some homes say, 'We let them play bingo or cards.' Well, many times that is not enough. You cannot just 'let them if they want to'—you must have someone to direct them, coax them—make them walk and exercise mentally and physically."

[From the St. Petersburg Times, Oct. 2, 1969]

(By Michael Richardson and Peggy Vlerebome)

In the evolution of health care for the aged, Pinellas County's nursing homes are better than their forerunners but not always what they need to be.

They are a purgatory—above hell, but by no means heaven—where good care too often is determined by the ability to pay.

The nursing home business in Europe would be a flop, for in England and Scandinavia family tradition maintains that the aged must be cared for at home.

But Americans have chosen to segregate the aged in nursing homes. Mother, daughter and aunt are out working—rather than remaining at home to care for grandpa.

Fifteen years ago, nursing homes were almost a national disgrace: There were fire-traps, rundown boarding houses, unclean badly cooked food, few nurses and unscrupulous landlords.

Much has changed.

Informed by newspaper and magazine investigations, the public clamored for government action. First came state and local laws, a tightening of building codes, required licensing, personnel requirements and patient care rules.

Government acted, if slowly, and some of the "snake pits" were closed down. But lagging local enforcement of state rules—and the elderly's inability to pay—prompted further action.

So, in the early 1960's the federal government stepped in—first with Medicare and more recently Medicaid. More money for the aged to pay for health care meant a bonanza for the nursing home industry. It also meant tighter rules.

New buildings had fire sprinkler systems, adequate lighting, handrails, better kitchen facilities; they were technically safer.

Corporations saw the potential profit in the nursing home business, and with design engineers and geriatric specialists, they built bigger and structurally safer homes.

Many of these improved homes were built in Pinellas County. Some of them have carpeted hallways, color televisions, spacious lounge areas, physical therapy equipment, modern kitchens and manicured lawns.

Moreover, some homes have taken the trouble—and expense—to staff the homes properly. A personnel-to-patient ratio above the state minimum is maintained in some better homes, and physical therapists, dieticians and recreation planners are employed.

In two older nursing homes here, there is a "family atmosphere," with aides and nurses who have worked there for years providing real care to patients.

At a Clearwater home, there is an effort to do "the little things" for patients. Two pots of coffee, a soft drink machine and cookies are available in a lounge area for between-meal snacks for those patients who can walk. Some St. Petersburg homes have made this provision, too.

A new St. Petersburg home is decorated in a more home-like manner with wooden furniture (instead of hospital beds), and bright-colored patterns in draperies and bedspreads.

It is not uncommon at one Upper Pinellas home for an aide to take patients shopping or to have a coffee break with them. A new facility near Largo is to be built not only with different degrees of health but with apartments separate from main buildings.

However, the chief product of the nursing home business—care—has been harder to improve than the facilities and the programs.

In any patient's room on any day in any modern nursing home, the care can be good or bad—depending on the training of an aide, the wages paid to personnel and the supervision by the home's management.

In "good" homes, we saw abuse and neglect, although less frequently. In "bad" homes, we saw certain patients receive good care—especially if they had visitors—but not often. Leak of encouragement and assistance for those patients who COULD walk—if helped—is a common black mark we found in all homes.

What can be done?

The general public—which had been willing to place one million Americans in nursing homes, including 3,400 in Pinellas—could act.

More frequent visits to nursing home patients is a first step. Scrupulous observation of a patient's care while visiting is another. Reporting abuse or neglect to the home's management—and to the health department—is a third action.

We asked the chief Pinellas nursing home inspector, Robert Hazlehurst, how much the public helps:

"Not much. Many of our calls are from griping employes; but we can't act unless the public gives us specifics, names and addresses," Hazlehurst explained.

Careful inspection of a home before admitting a patient may be the most important step in the public's action.

The Government could do more. Currently, Florida has only two fulltime inspectors for 285 licensed nursing homes. "We've never had the appropriations to enforce the law," Dr. Wilson T. Sowder, head of the state health division, told

The Times. "We've had to rely on local county health departments, and they have money and staffing problems too."

Hazlehurst said that recently his office had been bogged down in paperwork, to the point that, instead of inspecting as often as he would like, he was typing correspondence. (He and his fellow inspector, Pearl Sprinkle, must also check on unlicensed nursing home operations, homes for the aged, retirement centers and turn out considerable paperwork.)

Sowder also noted that the basic problem of care in private nursing homes is the cost.

"A few people are able to pay for above average care—but a great many are on the fringe, and cannot pay for what they really need," he explained.

The State welfare plan allows up to $120 a month for the indigent aged for nursing care. Unless an elderly person has adequate income from other sources he may not even get into a nursing home—or he may be forced into being a "welfare" patient who cannot pay for needed "extras" of therapy and clothing and supplies.

"You can inspect and regulate all you want," said Sowder, "but you've got to work with what you have—or they will end up in the street."

Beefed-up inspection forces to really "enforce the law" will require additional state money—and more tax dollars.

Government also could help the public by clearing up a confusing hodgepodge of names of nursing homes. "Sanatorium," "restorium," "convalescent center," "nursing hotel," "manor" and other combinations often mislead the public. Some states are requiring specific names for nursing home licenses, names indicating exactly the kind of care offered at the home. It could be done in Florida.

"Eventually that has to come about; we do earnestly hope it will," said Sowder.

More specific patient care rules could be enacted, as some other states have done, to require that bedfast patients be turned "every two hours" as is prescribed by nursing care professionals.

Training programs for nursing home employes could be required in order for a home to operate, or for a person to work in a nursing home.

Nursing home management could act. Training programs, staffing above the state minimums, better pay for employes and real recreation programs involving the patient could enhance the patient's life.

Of course, in the partnership between government and business, nursing home administrators are often caught in the middle. "They want better care, but they want it cheaper, too," one home owner said.

Self-supervision by nursing homes could be improved. A willingness to participate in an independent accrediting organization, such as the Joint Commission on the Accreditation of Hospitals and Nursing Homes, would indicate the management's interest in maintaining a quality home.

Harris B. Jones, nursing home director for the commission, explained the problem of independent accreditation. "This is a business; it costs money to bet surveyed. Some owners don't feel it is worth the investment, while others couldn't pass the survey."

Dr. Norman Kurtz, a Brandeis University researcher, told a new nursing home corporation seminar:

"The problem of quality control (in nursing homes) will not be solved without effort. It will not be solved without a great deal of resistance from those who are comfortable or see advantage to resisting change demands for quality care . . . neither should they be made by the faint at heart. Yet it is a problem which we must deal with and seek solutions to."

Thomas A. Routh, a training specialist with the Hillsborough County Hospital and Welfare Board, declares in his book, "Nursing Homes, a Blessing or a Curse":

"Nursing home administrators must have an overwhelming faith and belief in the fact that engaging in meaningful, purposeful activity is essential emotionally for all patients. They have to see and recognize the potential in the patient . . . if they are to help such patients."

With that attitude, Routh indicates, a nursing home can become a real "halfway house" where patients can look forward to a return to life, not the end of it.

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