NURSING HOMES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON NURSING HOMES

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-SEVENTH CONGRESS

FIRST SESSION

Part 2.—Walla Walla, Wash.

NOVEMBER 10, 1961

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NOTE.—Six hearings on nursing homes were held and they are identified as follows:

Part 1.—Portland, Oreg.
Part 2.—Walla Walla, Wash.
Part 3.—Hartford, Conn.
Part 4.—Boston, Mass.
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NURSING HOMES

FRIDAY, NOVEMBER 10, 1961

U.S. SENATE,
SUBCOMMITTEE ON NURSING HOMES
OF THE SPECIAL COMMITTEE ON AGING,
Walla Walla, Wash.

The subcommittee met at 10 a.m., pursuant to notice, in the court room, Federal Building, Senator Wayne Morse (chairman of the subcommittee) presiding.

Present: Senator Morse.

Also present: Congresswoman Catherine May, U.S. Congresswoman from the State of Washington.

Committee staff members present: William G. Reidy, staff director and specialist on health and medical care; Miss Dorothy McCamman, expert on social security; John Guy Miller, counsel for the minority.

Senator MORSE (presiding). The hearing will come to order.

This is an official hearing of a subcommittee of the U.S. Senate's Special Committee on Aging. It is one of a series of hearings being held by similar subcommittees in over 30 cities throughout the United States within the next 2 months. Everything that is said here will be recorded, printed, and distributed to all Members of the Congress and to thousands of State legislators and scholars concerned with the problems that confront our older people here in the United States.

This hearing and those which I held last Monday in Portland and on Wednesday in Eugene are important to each one of us. This is our opportunity to get our views on the record; our opportunity to let all the people who help write our Federal laws know just what the people in the West believe to be the problems that confront people growing old in our part of the country; what you think can be done about the problems besetting our older people and their children now; what can be done to see to it that these same problems do not confront the youngest person at this hearing this morning when he reaches the biblical three score and ten.

When we speak of the aging, we speak of ourselves. What we may do to, or for, or with those of our fellow citizens who are already aged we do, not for them, but also for ourselves. What problems we solve for them, we solve for ourselves. That which we leave undone for them, may well be left undone for us.

This hearing is your chance to participate in the lawmaking process of our Government. The facts presented here, the ideas and opinions expressed here will be carefully studied and weighed against those voiced in other parts of the country. All will be carefully analyzed and those which seem of national import will be translated into legislation and sent to the appropriate Senate committees.

That is why I insisted that hearings be held here in Walla Walla, in Portland, and in Eugene. I want the voice of the West to be heard in the Halls of Congress. That is what these hearings are for.

This is how we shall proceed. Since I am chairman of the Subcommittee on Nursing Homes, this morning's session will be devoted largely to the testimony of expert witnesses discussing the nursing home picture here in Washington. Are there enough nursing homes? Are they of the right kind? Do they provide all the services needed? Can the people who need them afford them? What has been done in Washington about nursing home quality which can be shared with the Nation, of which you can be proud? What improvements can be made? Have you too much or the wrong kind of legislation? Do you need new or different legislation to assure your younger people who some day may need care in nursing homes that in their time of need it will be available?

These and similar questions we hope will be answered here this morning, and we shall seek answers from all who are here in a position to know; from State officials responsible for supervising nursing homes; from nursing home operators; from people whose job it is to try to find a nursing home bed with the needed services for an indigent or a middle income person; and from people who have to worry about where the money is coming from to pay for nursing home care.

When we have heard from these expert witnesses and we have finished hearing from them—and I am sure their testimony will be of great value to us—we shall hear from representatives of such groups of senior citizens as have asked to be heard. They, of course, are also experts and in a very real sense on this issue.

This afternoon, we will hold a so-called townhall meeting of senior citizens where I hope the real experts, the older people, will speak for themselves as to what their problems are and what can be done about them. I hope, too, that out of their experience and wisdom they will tell us what we, as a people and as a nation, should be doing to make sure that these same problems do not exist 20 years hence.

In closing this opening statement, I want to say that the testimony given here today will be brought to the attention of the two fine Senators of your State, Warren Magnuson and Henry Jackson, and to all the members of your congressional delegation, and we are very honored to have associated with us in this hearing this morning your Congresswoman, Congresswoman May. I want Congresswoman May to feel perfectly free at any time to participate in these hearings in her own way, because, although they are conducted under the Senate, they are nevertheless congressional hearings, and the findings of these hearings and the reports of these hearings, Congresswoman May, will be made available to the people in the House, as well as to my colleagues in the Senate. I have worked with your delegation on these problems and many other problems for many years. I have been in the Senate for 17 years, and I want to say that it is always a pleasure to me to cooperate with the delegations in Congress elected by the voters of Washington year after year.

Also with me today are Mr. William G. Reidy, our committee staff director and specialist on health and medical care. As I said to my own constituents in Oregon in our two hearings, I want to say to my friends in Washington—and Mr. Reidy can close his ears because he is a very modest man—but I want you to know that we are all indebted to Mr. Reidy. I have worked with him for many years in the Senate, and he has been one of our experts and staff professionals on the committee, of which I am a member, that has jurisdiction over these aging matters and health matters. He is one of the best qualified professional experts in the legislative phase of this subject that I have ever worked with in my years in the Senate, and I want, in behalf of you people here and in behalf of the people of Washington, to express our gratitude to Mr. Reidy for the great assistance he has been to the delegations from these two States. He sits on my right.

On my left is Miss Dorothy McCamman. I should publicly scold her, as I have privately. She has no business being here this morning for she was suffering from a fever and chills last night, I am advised, and I told her that certainly, since this is a health meeting, she ought to stay in the hotel until she gets well, but she is that kind of a dedicated public servant who doesn't want to let anyone down. She is our expert on social security. She handles a good deal of our social security problems, and may I say that in my years in the Senate I find that my heaviest mail, mail in regard to which I get the most letters, is mail dealing with social security. I think that is an interesting commentary, and Miss McCamman has been very helpful to us in handling our social security matters.

As I have told him, as I apologize to him, he should be up here on the same level with us, but physical facilities prevent it, we also have with us as counsel for the minority, Mr. John Guy Miller, next to Miss McCamman. I want to say, as I said in Oregon, there is no partisanship on this committee, although Mr. Miller represents the minority. I want to give you my word that, as we tackle these problems in the Senate Special Committee on Aging, which includes the health problems, I have never seen any sign of narrow partisan politics. It doesn't mean we always agree, but it is always interesting to know that there is the usual disagreement on each side of the table, disagreement among the Democrats and disagreement among the Republicans, and there is usually a coalition of agreement when we get through with the debate, with some Republicans joining the Democrats, and vice versa, but the approach—and that is the important thing, I think, in that it helps restore the confidence of the voters in government—the approach is a nonpartisan approach on these matters that are so close to the welfare of the people of this country. Mr. Miller is the staff member representing the minority. He has cooperated with us and been very helpful to me as chairman. I wanted you to know the identification of the members of this staff and my sense of gratitude toward them.

Before I call on the first witness, I would like to insert in the record of the hearing at this point what I think is a very interesting and helpful article that I read in the Walla Walla Union-Bulletin since

I arrived in Walla Walla this morning. It is an article that appeared in the November 9 issue entitled "Population Projection Here Given," and I think it is interesting to note the statistics in this article dealing with several classifications. The age classification is of particular importance to this committee, but all the other classifications, I think, also in one way or another, bear on the general problem that confronts this area, and I would like to insert this article in the record at this point.

(The article referred to above follows:)

[From the Walla Walla (Wash.) Union-Bulletin, Nov. 9, 1961]

POPULATION PROJECTION HERE GIVEN

Walla Walla County can have a minimum of 51,000 population or a maximum of 64,100 by 1980, Robert Clark, of Clark, Coleman & Associates, told members of the regional planning commission at a Wednesday meeting. The population projections were part of a year-long study to develop a comprehensive plan for the county.

Walla Walla City's minimum population could be 30,600 by 1980 and the maximum 39,000; urban population, 44,800 and 58,600.

Clark stressed that the attitudes and desires of the people in the city and county would have a great deal to do with the area's future.

Getting Walla Walla County on paper in statistical form, so far, has required more than 12 months' work, compiling a report of more than 50 pages, use of dozens of graphs, maps, and charts.

GROWING, DECLINING

Of major importance, the study shows that one age group, known as the labor force, are declining rapidly in the county and the age group of 65 or over—both men and women—is increasing just as rapidly. At the present rate of increase, the community could, by 1980, become a city of retired persons.

Other age statistics shown by the report: the age group 5 to 14 years is increasing; 15 to 19 is about the same and 20 to 44 is declining; 45 to 64 is about the same as previous years.

Loss of the labor force age group is of major concern, the study indicates, because potential industry and business look at this factor before locating in a community.

The study shows that the public school enrollment will increase from 8,212 students in 1960 to 12,750 in 1980. Elementary schools will have 6,900 students; junior high schools 3,050, and high school 2,800. These figures do not include parochial schools.

SHARE IN GROWTH

From some standpoints the report is not an optimistic one, but from others there are indications that Walla Walla County will participate in the substantial growth that will inevitably come to the area during the next 20 years.

Clark, Coleman & Associates, who conducted the survey, based their predictions on Walla Walla County's percentages as related to a 3-State-area, to a 29-county area, and to the 5-county economic area of Walla Walla, Benton, Franklin, Grant, and Umatilla Counties.

"We have no crystal ball to gaze into in making population predictions," Clark said, "so it is necessary to base future figures on what has happened in the past."

Historically, he said, Walla Walla has been the dominant city in a fairly large area. However, this is no longer true. Walla Walla's percentage of population in the 5-county group has decreased considerably over the past 10 years and future predictions must be made on the basis of lower percentages because the other counties have grown faster than Walla Walla.

The population predictions do not consider the possibility of war, major disaster, or a major industrial boom.

In the future, the services offered by banks, physicians, attorneys, hospitals, and others will be of major importance from a growth standpoint and keeping Walla Walla an important city.

QUESTION MARK

Retail trade, Clark said, has a large question mark in front of it. The potential is here but it requires much work and study on the part of merchants and businessmen to realize the potential. In the percentage of retail trade done by the city as compared to the whole of the 5-county area, the city is slipping, he said.

The county has some resources of significant importance, the study shows. However, the area lacks natural balance and as a result the economy leans heavily to one side.

From an economic and industrial standpoint, agriculture will continue to play an important role. There will be growth in the food-processing industry. All aspects of water resources should be fully developed. The Snake River dams will add materially to the industrial potential of the county.

Potential industries for the county include those dealing with fertilizers, chemicals, adhesives, and plastics.

Production of wood charcoal from logged wood wastes which are available byproducts of the timber industry in the Blue Mountains is a potential industry, the study indicates.

In a survey of existing industry, 47 percent of those responding indicated they located here because of market convenience; 42 percent because the location was convenient to raw materials. Forty percent anticipated expansion of plant facilities during the next 5 years at an average investment of $100,000.

Senator MORSE. I will call on the first scheduled witness after I have called on Congresswoman May. I want Congresswoman May to make any statement she cares to make.

STATEMENT OF HON. CATHERINE MAY, U.S. CONGRESSWOMAN FROM THE STATE OF WASHINGTON

Congresswoman MAY. Senator Morse, staff members, and those of you who are interested enough in this very important national problem, I should like to say, as a Member of Congress from this district, that we, in the State of Washington, are both pleased and proud that the Senate Special Committee on Aging has seen fit to hold hearings on the subject of nursing homes in our State because we feel that our record of accomplishment in this State is one that should be known throughout the Nation. You are going to hear from expert witnesses on this later on, and I would like to say that few other States, if any, have shown so clearly how high standards of nursing home care can be produced through effective combination of enlightened community leadership, intelligent State and local government action, and private initiative, working together to meet the needs of the people.

Our churches, our proprietary nursing home operators, the medical profession, voluntary associations, and State and local government agencies have demonstrated in the State of Washington that cooperative efforts can meet the major needs of older people at the State and community level with a minimum of Federal Government participation. I think that Washington's nursing home achievement record is outstanding in at least three major respects: the number of acceptable nursing homes and the number of nursing home beds; second, the high level of professional care provided patients in the homes; and, third, the pioneering efforts to strengthen rehabilitation in nursing homes thereby providing a maximum opportunity to return to the most meaningful living situations for our elderly citizens that are possible.

While the number of people requiring nursing home care is a small percentage of the older population, it is extremely important that adequate care be available to them. The fact that the average person in

a Washington nursing home is approximately 79 years old emphasizes that quality professional services must be supplemented by tender, loving care. There is evidence to support the opinion that this essential ingredient has been inherent in the care provided by most of our State's nursing homes, both proprietary and nonprofit. It should be noted too, I think, that the nursing home program in Washington has substantially reduced the cost of hospital care for older people in the State and without denying them the benefits of necessary care. It would be hoped that other States, having seen what we have done and accomplished in the State of Washington, would see fit to develop comparable programs. It would seem that, if we can do it, so can others.

The State of Washington leads the Nation in the number of nursing home beds for each thousand persons. With three times as many beds per thousand as the national average, Washington has far more proportionately than any other State. Actually, the Public Health Service in January 1959 reported that we had 4.34 nursing beds per thousand. This contrasts with 1.54 per thousand in California and 2.43 in Colorado, both of which States exceeded the national average.

The quantity of nursing home beds tells only a part of the story. Even more important to the people in our State is the professional care which these homes provide. In a recent study of those nursing homes serving "heavy care patients," it was found that the patients received an average of 112 minutes of personal care per day. Registered nurses supplied 28 minutes of this care and licensed practical nurses 18 minutes, and the U.S. Department of Health, Education, and Welfare has stated that this is the highest ratio of professional nursing care per patient in the United States.

Since the adoption of the Nursing Home Licensing Law by our legislature in 1951, there has been a steady improvement in the quality of nursing home plants until the present high level has been reached. It was during my years in the legislature here, those early years right after the law was passed, that I was privileged to participate in the raising of these standards at different levels. This improvement has reflected also the cooperative efforts of the health department, our fine nursing home operators, physicians, and others at both State and local levels.

Now, one point I want to make very clear is that it should not be assumed that the success of nursing home development in Washington, in providing quality care at lower cost, has left our people complacent and satisfied with our progress record. We are still looking for new ways to provide optimum care to older people at lower costs. Discussion is already underway aimed at possible development of home-care programs in this State, which may permit more older people to be adequately cared for in their own homes. There is no question but that, medically and socially, it is best to retain older people in their own homes and in their own communities wherever it is practical.

It is possible that pioneer efforts in rehabilitation training programs for nursing home personnel may play a part in this laudable objective. This rehabilitation education service affords another example of the forward thinking and acting record of Washington, and we are going to hear more of this in detail from one of our wit-

nesses this morning. Beginning in January 1959, this project was given recognition by the Gerontological Society at its meeting in Detroit in November 1959 and by the American Medical Association Conference on the Aging in San Francisco last January.

The project here, as we in Washington know, sponsored by the State department of health, the State division of vocational rehabilitation, the State department of public assistance, has the technical guidance of the University of Washington Schools of Medicine, Social Work, and Nursing, and its objectives have included the following:

(a) To determine potentials of older patients of such facilities for improved self-care and vocational rehabilitation; (b) to provide appropriate rehabilitation services; (c) to reduce dependency and to determine if a larger number of chronically ill persons can be helped to achieve a greater degree of independence; (d) to make it possible through these services for many such persons to be discharged to their homes or to a community situation; (e) to engage, whenever possible, through provision of rehabilitation services, in productive work in a workshop or community situation; and, (f) to develop demonstration and teaching techniques and materials to facilitate the expansion of this type of program into other geographical areas of the State.

I might say that the eagerness with which operators and administrators of nursing homes have seized on the opportunity to improve their services, is indicated by the fact that 31 homes requested the services of the project team in the first 6 months of the project. These homes, with one exception, served from 40 to 270 patients. I am informed that success with the program has increased the number of participating homes substantially above this figure.

I think this type of program is especially important because it emphasizes efforts to keep our older people as fully involved in the life of their family, community, and Nation as possible. For the vast majority this means, of course, maintenance of good health that they already have. But even for those who become ill, either acutely or chronically, we should never give up, never assigning them to the scrap heap. Some of the results produced through rehabilitation in nursing homes here and elsewhere show that surprising results can be achieved with patients who a few years ago would have been given up for lost.

We do not want to have that happen to our older people because, above all they have shown their desire to remain active, independent, contributing of their wisdom and knowledge and experience to their community, and it is our hope that the Rehabilitation Education Service of the State of Washington can make a substantial contribution to our understanding of how we can return the chronically ill to optimum participation in meaningful living. Thank you.

Senator MORSE. Thank you very much, Congresswoman May. I think your statement is an excellent introduction to these hearings today, and I thank you very much for participating with us in these hearings.

Our first witness this morning will be Dr. Robert Hall, appearing in behalf of Mr. Hegland, director of the State department of public assistance. Dr. Hall is the assistant director of the department of public assistance in the State of Washington, in charge of the division of medical care. He graduated in 1942 from the University

of Chicago Medical School, then went directly into the Navy. He has been a resident of the State of Washington most of his life. Prior to becoming assistant director, he was in private practice in eastern Washington for 12 years.

Dr. Hall, we are delighted to welcome you to the witness chair. You may proceed in your own way.

STATEMENT OF DR. ROBERT HALL, ASSISTANT DIRECTOR IN CHARGE OF MEDICAL CARE, WASHINGTON STATE DEPARTMENT OF PUBLIC ASSISTANCE, OLYMPIA

Dr. HALL. Senator Morse and Congresswoman May, members of the committee, ladies and gentlemen, I would like to apologize for Mr. Hegland, for his being unable to be here, as he is at a regional meeting in San Francisco. So, he was unable to make it.

We were a bit uncertain as to just what this committee might want to know. So, we have tried, with the private nursing home industry and the department of public health, to coordinate our story so that there would be a minimum of overlapping and we could make the most efficient use of our time.

We of the department of public assistance would like to present to the committee: (1) A method of certifying nursing homes; (2) a definition of adequate nursing home care; (3) classification of patients; (4) classification of the nursing home; (5) an analysis of the nursing home caseload; (6) a cost study by which we determine the per diem rate of pay.

The people of the State of Washington have been providing nursing home care for their senior citizens for more than 20 years. The paper you have before you says "15" and actually it is something over 20 years, and now this is a part of a very comprehensive medical care program.

The Washington State Department of Public Assistance has a very keen interest in the nursing home problems of this State since at the present time approximately 70 to 75 percent of the nursing home beds are occupied by recipients of public assistance.

Recently we have, in cooperation with the nursing home industry, worked out a contract with each individual nursing home in which we attempt with some success to define what we expect to be included in the nursing home care which the State is purchasing. We also include criteria for the classification of homes and patients. These two items, the classification of homes and the classification of patients, form the basis for the payment of care provided. We feel that since this contract is unique, being the first one, as we understand, in the United States, and based on many years of experience, it may be to the committee's interest to review this contract in some detail. In so doing, we will explain points 1, 2, 3, and 4; that is, certification, the definition of adequate nursing home care, the classification of patients, and the classification of homes. In your folder you will find a copy of this contract, from which we will read parts and leave out some of it, beginning with the part, "It is hereby agreed by and between the parties hereto," and so forth——

Senator MORSE. May I say, Doctor, that all of this material in your folder will be made a part of the record, including the contract.

Dr. HALL. Fine. Do you want me to read this, or to make it as brief as I can?

Senator MORSE. I leave it up to your pleasure.

(The prepared statement of Dr. Hall containing exhibits A, B, and C will be found on p. 237.)

Dr. HALL. I think some of these points bear repeating. Some of them, we will go over briefly. The home agrees to provide nursing home care in accordance with the present rules, regulations, and policies of the department and schedule I, which is attached to the contract, to those recipients of public assistance accepted by the home for such care, the home reserving at all times the right to refuse to admit or continue to care for recipients whose care is found undesirable by the home, and this is a right of the home, to choose the patient, and we also reserve the right of the patient. Nothing in this contract will be construed to prevent a recipient exercising his right to request and be moved when authorized by the department from one nursing home to another.

The home agrees also to provide reasonable information to justify the rates of payment. This is paragraph 2, and this we will cover under the cost study. They file with us fees and rates that are charged for additional service that we don't list, such as shaves, haircuts, personal laundry, which we do not consider to be a part of the nursing home care.

Then on the household items, the home agrees to furnish clinitest tablets, aspirin, mineral oil, body lotions, including alcohol, milk of magnesia, and antidiarrhetics. The home further agrees to provide reasonable care and attention for the safety of recipient patients as their mental or physical condition may require, which shall be in proportion to the physical or mental ailments of the recipient patients unable to look after their own safety, and the department agrees to pay: For group I care $6.38 per patient day; group II, $5.27 per patient day; group III, $4.66; group IV, $4.14.

Then we agree to classify the homes first, as I, II, III, and IV. These are on the basis of minimum staff requirements, which we will cover very briefly in a few moments. We also classify the patients and for this we use physicians and classification nurses.

Paragraph 8 of this contract merely states in a very complicated way that the department, in cooperation with the homes, does the bookkeeping and makes the payments by the use of our machines. Paragraph 9 designates the type of homes established by the department's rules, which we cover under schedule III. Paragraph 10, the home agrees to have a currently valid license. Now, the licensing in this State is done by the department of public health, not the department of public assistance, but we get into the act because we are paying the bills.

If you will now turn to the contract, we will define "adequate nursing home care," as we see it. Adequate nursing home care means responsible, knowledgeable, kind, and understanding care which includes: (1) medical supervision; (2) medications and treatments competently administered; (3) personal hygiene; (4) promotion of self-help; (5) meeting emotional needs and/or behavior problems; (6) safeguarding of personal possessions. We might also add as (7), and (8) a safe and comfortable environment. Here we do not have

the primary responsibility but we feel this is a proper function of the public health department. However, we do not exclude these two points physical plant and diet as a part, an important part, of adequate nursing home care.

We then, as you see, define in some detail what we mean by medical supervision, meaning diagnosis, reporting to the attending physician, doctor's orders, and so forth, and then again under paragraph 2, medications and treatments, we again define the home's responsibility, as well as we can, as to what they are expected to provide, and we continue on through personal hygiene, promotion of self-help, meeting emotional needs and/or behavior problems, and safeguarding of personal possessions, including money, and then under each of these paragraphs, we again detail as much as we can, and, as you can see, this is quite a comprehensive listing, but I think the remarkable thing is that these points have been agreed upon by the nursing home industry with little or no difficulty and the department of public assistance. I think it is a remarkable thing that such a detailed contract could be agreed upon by over 315 nursing homes, and through this contract, it has been our experience that nursing homes are just as anxious to raise the standards of care as we are and public assistance are. I think this speaks very well for the nursing home industry in the State of Washington. It is a remarkable thing that they have accomplished.

This contract has given the homes and the State a base which we can work on on our mutual problems. I am sure you must appreciate that, with some 9,000 patients in the homes, we do have some problems. I would not want to give the impression that all is sweetness and light. It is not. We do have problems, but we have a base on which we can work them out.

Now, briefly, I would like to cover the classifications of the nursing homes and how we do it, as shown in schedule II. This is the criteria. It is just a guide. These aren't the only things that are used or that we use in classifying the various patients. In other words, we have the amount of payment, the severity of the ailment, or the difficulty of care, and I think it is worth reading this in some detail.

(1) Hard and fast rules cannot be laid down for the classification of all nursing problems into four categories of care.

(2) Good judgment and interpretation will be observed by the department's screening personnel, which includes both physicians and nurses, when using the guide outlined below in the classification of nursing home patients. Classification decisions will be rendered in accordance with best professional judgment. Such judgment will be based upon information supplied by the supervising and/or attending nurses, the attending physician where indicated, the nursing home record, and personal observations made by the screener, and then, if you will notice, we have the group I patients in three groups, A, B, and C. Under group I, we have those confined to bed, helpless. These automatically get group I care. In status B, confined to bed, semimobile, additional problems must be—and then we list what these additional problems are; status C, semiambulatory, additional problems must be, such as complete incontinence, tube feedings, medications, and so on.

Then we go to group II where we try to define what type of patient, or at least give a guide as to what we consider in group II care, and then we do the same for III and IV.

Senator MORSE. I think, Doctor, this is a good place for me to ask for your opinion regarding the matter of patients confined to bed and patients who are not. We have been told that in some States payment to nursing homes is based on the patient's condition, and the result is, as alleged in some instances, that operators get paid more for keeping patients bedridden and less for getting them back on their feet.

In listening to you, I judge that in Washington you seem to have resolved this problem by paying in accordance with the type of service needed by the patient and made available by the home, and not leaving the payment to be determined in larger amounts or smaller amounts whether or not the patient is bedridden. Is that correct?

Dr. HALL. I wouldn't say, sir, that we are entirely without sin in this State. This has been a problem that we have had. However, with the recent project that Congresswoman May mentioned, I think there has been a change in the attitude of the definition of nursing home care in this State. We are now presently giving credit for a genuine rehabilitation effort being made in these homes with these patients. In other words, we do recognize ambulatory patients, although we do not say it in this thing, and special efforts are being made, and we would consider an ambulatory patient as a group I patient, and we encourage and try to encourage this sort of thing, and I think we have had very good cooperation from all concerned. This business of stacking them up as cordwood, bed after bed, we deplore. I think most of the enlightened nursing home operators in this State also agree to this. Does this answer your question?

Senator MORSE. Yes, sir.

Dr. HALL. We haven't entirely solved the problem, but we are working on it. Then we classify homes. Now, I think perhaps I could pause just a moment here and say that we will not pay for care for a group I patient in a group III home. In other words, if they have a group I patient, they must be staffed to give group I care, and we have these as minimum standards. There are some who object that they are too much, but I think not. The majority of the nursing home people feel that the staffing is not too heavy.

In a group I home, we have a registered nurse employed as a supervising nurse, and she is on full time for a 40-hour week, and the reason for this is to give continuity of care. In other words, if you have a nurse on Monday and a different one on Tuesday, and right on down the week, your care becomes chaotic because the nurses have different opinions on what should be done, but we insist that they have one nurse to be given the responsibility for the total care given in the home. Then we must have a registered nurse on evening duty; in other words, 16 hours a day of care. The other shift can be a licensed practical nurse, and they also must have a registered nurse available for relief duty, weekends and holidays. Then we use the term "sufficient additional nursing personnel to adequately care for the type and number of patients in the home," and this is rather a gray area and here we have some rough problems.

In the group II home, they are only required to have the registered nurse 8 hours a day, but again she must be full time for continuity of care. The other shifts may be licensed practical nurses and a licensed practical nurse for relief duty, and against sufficient personnel. Then in group III, we do not require a registered nurse. We

say that a licensed practical nurse shall direct all nursing care given in the home, who shall be full time, a minimum of 8 hours, and then another licensed practical nurse for relief duty. We have been criticized in some areas for this. Some people say we can't have nursing home care without a registered nurse. Well, I think you must be practical about these things. There are only a certain number of registered nurses, also there is only a certain amount of money that the State has, and our experience has been that many of the homes take it upon themselves to hire a registered nurse in these group III homes. In other words, they have a registered nurse as the supervisor even though we don't require it. Many of them do not. Then in group IV, it is again the licensed practical nurse. We have very few group IV homes.

Now, in both the group III and the group IV home, the patient is an individual who is up and perhaps needs just a little supervision as far as medication, or is confused at times and wanders, and that sort of thing. In other words, he is not an acutely ill patient although at times he can present problems and may very well become a group II during his stay.

This is the way we classify our homes—and I know that it must be confusing—but this is it briefly.

Then we would like to cover the cost study and the analysis of the nursing home caseload. The present rates of payment for the care of public assistance recipients in licensed private nursing homes are based upon a cost study, which is a very sophisticated study, conducted for the calendar year 1959, with the findings updated through 1960. This study was in compliance with the 1959 State senate resolution directing the legislative budget committee to conduct a study to determine how much the State should pay for each type of nursing home care, and the legislative budget committee, in turn, assigned the responsibility of the study to the department of public assistance. The 1959 legislature also earmarked a special appropriation to be disbursed at the rate of 40 cents per public assistance patient-day to those homes cooperating with the department in furnishing information concerning costs. Since the 40 cents did not represent an increase in rates over the previous biennium, failure to cooperate would result in a decrease of rates for the home involved. The 1959 senate resolution reflected the longtime concern of the Washington State Department of Public Assistance and the State legislature over the rates paid for public assistance recipients in licensed private nursing homes. Basically, the rates were established and altered by negotiation without reference to any firm framework of costs. The process was satisfactory neither to the department nor to the industry, and the results were subject to question in terms of equity both to the taxpayers and to the nursing home operators.

Legislative concern had been heightened by the steady increase in the number of old-age recipients in nursing homes despite the decline in the number of OAA cases. This subject is discussed in detail in the report, "Analysis of Increase in Nursing Home Caseload." In brief, the findings are that an estimated 20 percent of the discrepancy between the changes in OAA caseload and OAA nursing home caseload is due to the increasing average age of the recipients, 15 percent to transfers from State mental hospitals, and between 40 and

60 percent to increased costs of medical care, with the residual discrepancy attributable to social factors. In other words, as our OAA caseload goes down approximately 1,000 a year, our number of people in nursing homes goes up almost 1,000 a year.

Senator MORSE. On this one sentence, Doctor, what is it you said about the mental patients?

Dr. HALL. We now anticipate removal of approximately 1,600 of these people to nursing homes.

Senator MORSE. Can I take just a minute? I do not intend to say very much in these hearings because the important thing is for the people attending the hearings to do the talking, but you hear so many criticisms in this general field. When I hear something deserving of commendation, I like to take a moment to give the commendation. I am not at all surprised to find that the State of Washington ranks among the two or three of the most forward-looking States in the country regarding nursing home care, and you have to go through this analysis of your caseload and your cost analysis to understand why, but you have sought the facts and you have been trying to follow where the facts lead.

Furthermore, let me say that the legislature and all the people are entitled to this credit. We recognize that, if you are going to have decent standards, you are going to have to pay for those standards, and you have been willing in this State to pay more than is true with many States.

As I sit before you today as an alderman—that may surprise you, but I have been an alderman in the District of Columbia for many years since I serve on the District of Columbia Committee of the Senate. That makes me an alderman, because Congress runs the District of Columbia to its everlasting shame. Why in the world shouldn't the Congress give to the thousands of people in the District of Columbia the same rights of the first-class citizenship that you and I enjoy? I battled on this for years and we got it through the Senate four different times. Now, I hope we can eventually get it passed and give the people of the District of Columbia the right to govern themselves. However, I mention this because it relates to this problem. You know what we pay for nursing home care in the District of Columbia? A flat $100 a month. It doesn't make any difference what the condition of the patient is, and, therefore, we have nothing but the worst nursing home situation in America, the kind of a nursing home situation which you don't like to take foreign visitors to in the Capital of this Nation. I will be conducting some hearings early next year in regard to the nursing home situation in Washington, D.C. Some of the nursing homes seem a little concerned about it. They have no reason to be concerned about it. I seek to help them, not hurt them. I don't know a nursing home operator that wouldn't welcome financial help so they could operate high standard nursing homes.

Now, I cite this in contrast to what you are doing here in the State of Washington. I shall go back with a recommendation to Washington, D.C., to at least try to take some benefit from the State of Washington on the basis of the testimony that you are giving, and don't think I'm not going to use these two documents, and I will make them officially a part of this record.

Dr. HALL. Thank you very much, Senator. I think I would agree that the people of the State of Washington are very proud of their record on nursing home care and medical care program. I think it is one of the finest in the land, and so I have heard since I have been on this job.

The department conceived the nursing home cost study as a twofold one. Although selective information was available, representative data were lacking on the characteristics and service needs of nursing home cases. In order properly to evaluate the results of the cost study, it appeared advisable to undertake a characteristic study of a random sample of public assistance recipients in nursing homes, and such a study was conducted in December 1959, on the basis of a 5 percent sample. The schedules were completed by registered nurses from the medical care division of the department. That is our nursing home section and classification nurses. In each instance, the nurse visited the nursing home, observed the patient, reviewed the patient's records and consulted with the charge nurse in the home. During the same period and for the same cases, a social characteristics schedule was completed in the department's county offices. Although not immediately related to the cost study, as such, the social characteristics study was designed to ascertain the relationship between the need for public assistance and the need for nursing home care, as well as to obtain information on the events precipitating nursing home placement.

The cost study proper had two major objectives. The first was to determine an initial rate structure that bore a reasonable and defensible relationship to reported costs. The second was to obtain costs in such a form that adjustments could be made in the future for changes in prices, wage rates, and staff requirements. The latter objective entailed a longer and more complicated schedule than the first objective alone. Since even a relatively simple cost study is costly to the department and the industry, the advantage of averting an additional study in the visible future was considered to outweigh the immediate disadvantages and the more comprehensive study was undertaken.

In developing the study plan, the department consulted not only with the legislative budget committee, but also with representatives of the nursing home industry. All parties involved were concerned that the results be valid, and the consultations were productive. The main, though not the only, problem areas were: Selecting homes to participate in the study; assuring the validity of the reported cost data; determining the extent to which cost breakdown is desirable from the standpoint of flexibility, where practicable, from an accounting standpoint; determining a reasonable return on invested capital; determining the allowances to be made for the unpaid labor of operators and families, including administrative allowances; allocating costs among different classes of care in homes providing more than one class of care; determining the adjustments to be made for changes in taxes, prices, and wage rates during and subsequent to the reporting period. The detail of these problems and the methods adopted in solving them are given in the report, "Nursing Home Cost Study."

This cost study was based on the calendar year 1959, and most of the homes included in the study cooperated with the department and

submitted schedules promptly. The department with considerable success made every effort to secure the voluntary compliance of the remaining homes. I might say that all homes cooperated, but we did have difficulty with a few of the smaller homes simply because they didn't understand what we wanted. Then we sent some of our own auditors out who did the accounting for them. In some cases, however, it proved necessary to revoke the 40 cents per diem payment in order to obtain the cost information. We did have a little trouble, but it was of a minimum.

Senator MORSE. Maybe you made it retroactive.

Dr. HALL. The main findings of the characteristics study are given in part II of the report, "Nursing Home Cost Study," and the main procedures and techniques used in the cost study, as well as a summary of the results, are given in part III. The schedules and instructions used in both studies are included in appendix A.

Some of the highlights of our characteristics study that will be of interest to this committee are: The public assistance recipients in nursing homes are predominantly a very aged group—as of December 1959, 53 percent were as least 80 years, 24 percent were at least 85, and 10 percent were 90 or over—62 percent of all the nursing home recipients were women; most of the recipients suffered from multiple impairments, and those most frequent impairments were strokes, other heart or circulatory disease, arthritis or rheumatism, debility and senile behavior disorders; only 26 percent of the recipients were always clear mentally, 34 percent were mildly confused, and 37 percent were seriously disoriented at least part of the time, and the remaining 3 percent were mentally retarded; 30 percent of the recipients were bedridden most or all of the time and another 10 percent were bedridden part of the time; 50 percent of the recipients had bladder continence all of the time, 26 percent were occasionally incontinent, and the remaining 24 percent were frequently or always incontinent; 62 percent had bowel continence all of the time, 16 percent were occasionally incontinent, and the remaining 22 percent were frequently or always incontinent; in general, the recipients needed and received a variety of personal services though relatively few required such specialized services as intravenous feeding and complex or extensive dressings.

Incidentally, the data on services proved invaluable in the cost study proper in helping to solve the problem of allocating costs among different classes of care.

The median costs for each class of care, as well as the breakdown by type of cost—for instance, food for patients, return on investment—are shown in the "Nursing Home Cost Study" report. We are convinced that our study has been a useful and objective tool in arriving at equitable rates. We have published our methods and results in full detail, not only because we are anxious to share our experience with other agencies, but because we welcome suggestions and constructive criticism, and I might add in an aside that we sent this cost study into every home in the State. Is that not true?

Miss MARSHALL. Yes.

Dr. HALL. We ourselves hope to refine our techniques further prior to the next rate adjustments. In short, we regard this study as a first rather than a final step in solving the problem of determining equitable vendor rates.

Senator MORSE. Doctor, this is a very, very fine and helpful statement to this committee. I have no questions. Do you have any further comment, Congresswoman May?

Congresswoman MAY. No questions.

Senator MORSE. Thank you, Dr. Hall. Our next witness will be Mrs. Gladys Broughton. Mrs. Broughton was educated and worked in Washington State. She received a degree in sociology and training in social work, both a degree and training at Washington State University, Pullman, Wash. She worked as a social worker for 2 years in Tacoma, Wash., and in Pasco, Wash., Department of Public Assistance, transferred to the American Red Cross as field director at the general hospital at Fort Lewis, Wash., and held this position for 4 years. This was following Pearl Harbor where she was in charge of all caseworkers and recreation workers for patients at this large Army hospital. She returned to the department of public assistance program as supervisor in casework services. She held this position for 17 years in the offices in Walla Walla and Columbia Counties until she retired in July of this year. She is a member of the American Association of Social Workers, a member of the American Association of University Women, and she is a member of the Council of Social Agencies, a member of Altrusa, the International Women's Service Club and Professional Women, and past president of the Walla Walla club.

I give you this account of the wonderful dedicated record of this next witness, and I want to say that such dedicated citizens as Mrs. Broughton, in my judgment, really give us a better understanding of what we mean when we say we live in a free society.

Mrs. Broughton, I welcome you to this witness chair.

STATEMENT OF MRS. GLADYS BROUGHTON, RETIRED SUPERVISOR OF CASEWORKERS, WASHINGTON STATE PUBLIC WELFARE DEPARTMENT

Mrs. BROUGHTON. Senator Morse, Congresswoman May, members of the committee, I think I am frightened.

Senator MORSE. Please proceed in your own way.

Mrs. BROUGHTON. I want to say first that I think it is a privilege to have worked with the State of Washington, and I, by no means, want to infer that my criticisms, and there are going to be some criticisms because I have worked with people and I know what it can be, and I only say it because I hope it can be helpful.

True, we have come a long way in nursing home care in Washington in my 21 years of experience. However, I think we do have to go further. The commodity we are discussing is people. What do they want and need? Do we always know? Is it costing too much, or not enough? Either or both ways. Are they getting the care? If not, why not? Are there enough beds for all classes of patients available? These are some of the questions which we should be thinking about.

I would suggest that we might think of the following six points:

(1) I believe we need closer cooperation between public understanding and the cost of adequate care as it affects the tax burden and other persons who might have nursing care. As to the efforts that are being made for their protection, do they understand what efforts are being

made, both the old person and the taxpayer? A thorough knowledge of good and not so good care. There are some very good nursing home patients being given care in the State. Others, I think, need improvement.

(2) I believe there should be a closer working relationship between the various departments with acceptance of each other's point of view and intelligent understanding of each department. May I say here that I think many times the right hand doesn't know what the left hand is doing, and I have felt many times that we didn't understand exactly what the health department was doing. We didn't understand what the medical care was always doing, and we were the people who had the commodity. We were the persons who were serving and had the people. We were having to pay for people when they came to us, and we didn't always have the answers, and I think there is a vast lack of this getting together.

Why, and how they function? Why? Well, then, we come to this idea that there should be licensing. I think that that should be in our agreement. However, I don't believe we all understand it, and I am sure the public doesn't understand it. Should I say we need better publicity? Education for the public is necessary because, after all, the public are your taxpayers, and I am a taxpayer.

(3) We need an adequate staff. I think an adequate staff is very necessary for cooperative planning, for ill people, by all these departments, and by an adequate staff, I mean persons wanting and liking to work with the real interest in the well-being of the patients, as well as with a supervisory staff and professional persons, which can also mean nurses and doctors. They all should have good training and proper education for their work. I am afraid there is too much emphasis on the money they receive and not on the care of the ill.

(4) I think there should be better planning and cooperation for the time the patient may be in our nursing home. There should be help from the family or friends or a social worker, as well as the doctor, as to what the patient can and should do. Maybe we should consider say "Half-Way Houses," or a home away from the nursing home, a home until the patient may return to his own home. I believe this plan is used in some places where the transition from the nursing home to another home is much more relaxed care, not necessarily in large institutions, but with much less cost and care for all concerned. I also think a boarding home with adequate supervision and yet more pay than the regular board and room cost actually should be considered.

I want to say that I think there is this vast lack. Dr. Hall talked about the class of boarders receiving nursing home care, and we have very few—in fact, in my locality, if I am not mistaken, since I retired in July, we have none, and we need them. It is at this point that motivation is important toward self-care. It is possible that this should be considered too. Too many persons think the nursing home is the end of the road for them. It may well be if they are not encouraged to help themselves and do what they can in what they can do. I believe that, since I have left the department, they have started a plan of rehabilitation, which I think they should be commended for. Can a family or friends be of much help? I think there is too much dependency on public or private agencies, as well as on doctors and nurses.

Of course, the above point now turns us in the direction to the other standards of people, and that applies to all persons. The social worker should know, if possible, about what plans a patient has or wants. But what of the person who does not have social worker care? What of the one who has no one to help, such as friends or family? What happens to this person? Are they to be left in nursing homes because of lack of proper planning? And I think that is awful true.

(5) I think from experience that one of the greatest needs is to have an adequate facility for all types of nursing home patients, as near the family or friends as possible. For most people, leaving their own personal belongings, their home, or whatever is uppermost in their minds, they think: What will happen to all this when I am ill? The water may freeze. Who is to pay the rent or the taxes? These are real fears to people (our commodity today), and their worry is not conducive to improved health.

The last point, and I think this is only another factor in the well-being of patients, and that is that they need someone to listen to their problems, someone who cares and understands. It is not always possible with an overworked doctor and the nurses aid, or even the social worker, who is, I think, an overworked staff. Does the public, even our Senators understand this need? Do they care? I sometimes wonder if we have forgotten how to smile—a smile of radiant acceptance and with it a feeling—that someone does understand and someone cares. In other words, a good listener. Wherever there are people, there will be problems, and so there must be intelligent planning, not only for them, but with them. Do we care enough to meet this challenge?

Senator MORSE. I want to thank you very much, Mrs. Broughton. I am pleased to report to you that, through the work of this committee, ably supported by our colleagues in Congress, we have made available Federal grants for States to use to demonstrate the value in what you refer to as Half-Way Homes. The funds are limited, but they are not all used. I would suggest that serious consideration be given, here as well as in other States, to try to set up some of these demonstration homes and see what can be done through this intermediate station between the nursing home and the home.

In some of our other hearings, there was a considerable amount of testimony in regard to the last point you made, this matter of loneliness, which, after all, involves the problem of mental hygiene.

Mrs. BROUGHTON. It certainly does.

Senator MORSE. In my own hometown the other day, Miss McCamman took me to an annual bazaar put on by the senior citizens, many of them rehabilitated, many of whom had suffered strokes, and I did a good deal of my Christmas shopping at this bazaar. I came away a better person than I was when I went in, but you can't be at that kind of a project without recognizing that you are meeting this problem of loneliness, to which you refer; this group of women, the senior citizens, getting together, making these articles, canning foods in a community senior citizens kitchen; the men, many of them learning to use their hands after a stroke, making toys, and that kind of community cooperation deals with this last problem that you raised in your statement. It is a very important one, and

there is no question about it, and I am very glad to have your testimony. It is very helpful to us, and I thank you very much.

Our next witness will be Mrs. Roxie Kendall, a registered nurse, member of Washington State Nurses Association, also a member of the Altrusa International Service Club. She has served as manager of Walla Walla County Infirmary, also known as Blue Mountain Infirmary, for the past 17 years. Before this, Mrs. Kendall worked as supervisor of the medical floor of Sacred Heart Hospital in Spokane, Wash., for 11 years and was head nurse at the county hospital of Stevens County, Wash., for 4 years. I am sure you will all agree with me that her qualifications are not only excellent, but, because of her qualifications, this committee is fortunate to have her as the next witness.

Thank you for coming, Mrs. Kendall. Will you please proceed in your own way?

STATEMENT OF MRS. ROXIE KENDALL, MANAGER, WALLA WALLA COUNTY INFIRMARY

Mrs. KENDALL. I don't want anyone to get the idea that I am not happy in my work because I like everything about it, about the Blue Mountain Infirmary, and I think I will just read my statement, and I think there are a few places I will make an addition.

The Walla Walla County Infirmary is a 57-bed, class I nursing home. The State health inspectors tell us we have a larger number of critically ill patients than they find in most nursing homes. Our patients come to us mostly from the hospitals in this community to recuperate from illness, surgery, or for prolonged terminal care. To give a few examples, I shall mention cancer, multiple sclerosis, strokes, cardiac diseases, asthma, and diabetes. You will find most any illness at the infirmary that is found in any medical department in a hospital. Also, you will find a good cross section of any community there.

It is our policy to not refuse any patient admittance if we have an empty bed, regardless of race, color, creed, or the amount of work involved in caring for that patient. I have seen the infirmary change from a shabby poor farm into a clean, homey, pleasant and, I think, quite efficient small institution, where sick people feel at home and are not ashamed to be there. The community, as a whole, is proud of the infirmary. Many clubs and organizations are generous in helping to make it a pleasant place for shut-ins. To mention some donations: television, radio, and intercommunication system with a record player, records, piano, movies, fountain, visiting and shopping service; and here I didn't mention what I feel is something that is extremely important, and that is our chaplain service, which is furnished us through the ministerial association in the community. However, let me stress, if any county or public institution remains good, there must be constant vigilance on the part of someone. There must be patience, and always a long-range program in effect.

We work hard and the remuneration, moneywise, is small, compared to other industries. In our State, nursing homes are exempt from the new wage and hour laws just enacted. It seems to me that, if wage and hour laws must be enacted, there should be no discrimination. They should be for everybody. I fully realize this would

increase the cost of patient care, but why should the worker be penalized? And I think, if I may insert just a little here, that we are asking the worker in a way to subsidize the cost of patient care when they are not paid the regular standard wages. Low salary is also conducive to constant turnover in staff, which is not good. The people doing this type of work, and doing it well, are performing a service to the public that cannot be purchased. One might buy some services, but not patience, kindness, and understanding this takes, because that is the person herself. Those people, who do not have these qualities, are absolutely worthless around a chronically ill patient. We accomplish a great deal in the way of rehabilitation with no trained help in that field. We keep our patients out of their beds just as much as possible. We work hard at keeping them busy with any little thing in which they show an interest. Recovery from illness is slow for these people, and we watch them from one step to another. Then suddenly they are up walking around, their minds are clear, appetite is good, they are sleeping well, they are continent, and medications are stopped. They still need help with many things and probably cannot live alone, but we have done all we can. We feel frustrated. We want them to go on to something, but we want something in which they will be happy. Otherwise, they will be back in the hospital, and everything that has been accomplished will be for nothing. There needs to be some link between us and the community.

The infirmary is county-owned with the State reimbursing the county for the net cost of operation. So far this year, this cost has averaged approximately $6 a day per patient. Economy is the constant watchword. It is difficult to plan for major repairs, replacements, and capital outlay without receiving criticism. I do not know how we could work and do a good job with fewer staff, but I am still told that we are overstaffed; but may I insert here, the Honorable Catherine May said that most heavy care homes are furnishing their patients 112 minutes of nursing care per day, and I think that is almost exactly what I am furnishing. The problems are too numerous, and, certainly, we want to be economical, but I do hope everyone remembers that we are dealing with real live people, and that we ourselves, and I mean you and I, may need some help and understanding some day.

Senator MORSE. This is very helpful to us. I have one or two questions, Mrs. Kendall. You may wish to supply them by way of a memorandum if you can't supply them from your own recalled knowledge.

And I might just say at this point in the hearing that I want each witness to know that you will have 30 days to file any supplemental statement that you may wish to file for this record. We are all working under a limitation of time in the hearings, but I shall keep the record open for 30 days, and we will receive from any witness any supplemental statements that they may wish to file. In some instances, we are going to submit to some witnesses series of written questions in the interest of saving time and ask them if they will help us out by filing within that 30-day period written answers to those questions. When we get to the senior citizens town hall meeting this afternoon, I want it understood that all those witnesses, too, have the very same privilege of filing supplemental statements, and those witnesses, who may not be able to testify because of lack of time, or those

witnesses that may not wish to testify orally, but would like to have their views made a part of this record, also have the privilege of filing statements during that 30-day period.

But in regard to your testimony, Mrs. Kendall, can you tell us how many registered nurses you have at your infirmary?

Mrs. KENDALL. I have myself, of course, and there is one head nurse on duty from 7 to 3, another registered nurse on duty from 3 to 11, and I have two part-time registered nurses who replace each of them.

Senator MORSE. And during the night, you have a practicing nurse?

Mrs. KENDALL. I have a licensed practical nurse from 11 till 7, and I am on call myself 5 days a week, and then a registered nurse takes the other 2 days of the week.

Senator MORSE. Well, as to this nursing allotment, is it true that you are overstaffed for 57 beds?

Mrs. KENDALL. I don't think so. I have never found out exactly, although I do not consider it overstaffed.

Senator MORSE. This is your total nursing staff? I mean, you have given us your total nursing staff?

Mrs. KENDALL. That's right, the registered nursing staff. However, there are aids and more classes of practical nurses besides that.

Senator MORSE. Do you have any nurses training program in connection with the infirmary?

Mrs. KENDALL. No. There have been times that we have had to bring aids in and train them, if we cannot find those who have had experience before, say in a hospital or another nursing home, but, usually, it is orientation, rather than training. Now, last summer, I brought two aids on my staff and put them to work for 2 weeks with a practical nurse, and by that time they were—well, they turned out to be quite valuable workers.

Senator MORSE. Do you find pretty good community cooperation among your service clubs and your women's clubs?

Mrs. KENDALL. Yes, indeed.

Senator MORSE. This is very helpful to me. If there is any additional information you would like to file with us later, please feel free to do so.

The next witness will be Mr. Edmund Jacobs, executive secretary, Washington State Nursing Home Association. Mr. Jacobs, we are delighted to have you with us. You may proceed in your own way.

STATEMENT OF EDMUND F. JACOBS, EXECUTIVE SECRETARY, WASHINGTON STATE NURSING HOME ASSOCIATION, PUYALLUP

Mr. JACOBS. Thank you, Senator Morse, ladies and gentlemen, and Catherine—Congresswoman May. She is an old friend of the nursing homes in our State and has worked very hard, when she was in the State legislature, in order to accomplish some of the goals that you have heard about this morning, and I want to tell you that your gain in Washington, D.C., is our loss.

I would just like to say one thing about the statement that perhaps the Blue Mountain Infirmary is overstaffed. As Mrs. Kendall enumerated the staff, it would appear that the only overstaffing is from 11 to 7, where the contract and the regulations will permit a licensed practical nurse to cover that shift. So, she does give 24-hour regis-

tered nursing care, where she could have a licensed practical nurse on that one shift. Most of the group I nursing homes in our State do the same thing, Senator, and the reason they do it is that the money, if there is money in the nursing home industry, comes from the private patients, who pay perhaps $100 more per month on the average than does the welfare. Therefore, in order to attempt to attract this private patient, you like to advertise 24-hour registered nurse care. So, it would be the rule, rather than the exception, that your group I homes in this State will have 24-hour registered nurse care, the same as Mrs. Kendall.

As far as Mrs. Kendall is concerned, she described what we like to think is a typical nursing home in our State. She is an excellent nursing home administrator, a very fine person. We are very familiar with her operation, and you could not have a better witness as far as care.

Now, we have an excellent nursing home industry in the State of Washington, and there are two main reasons for it.

Senator MORSE. May I interrupt you just a moment, Mr. Jacobs, so that we may make a comment on this for the record. Your testimony in regard to the advertising of the nursing homes, concerning round-the-clock registered nurses as an inducement for private patients, causes me to ask you: Is it desirable from the standpoint of the patients to have round-the-clock registered nurses available?

Mr. JACOBS. I would say it would depend upon the patients, Senator. If, as Dr. Hall explained, we have actually four groupings of patients within our State, certainly, it would be a waste of valuable registered nurse time to have round-the-clock professional nursing in your group III or IV homes where the patients don't need it, but it is most desirable to have this 24-hour registered nurse care where you have intensive nursing home care, where you take these people directly from the general hospitals. You have to be able to have nursing procedures immediately available. Medications are getting very, very complicated now, and some of them are quite dangerous if not properly used. Does that answer you, sir?

Senator MORSE. Mrs. Kendall said, I think, that the infirmary is in group I, and she listed it at 57 beds, and she listed the type of ailments that you will find in any hospital when she pointed out that they were the type of ailments that you would find in most general hospitals. I am certainly not a qualified witness. I just hope that I am a qualifying questioner. I ask: Shouldn't she have in that infirmary round-the-clock registered nurses?

Mr. JACOBS. Yes.

Senator MORSE. And if she does, she would be charged with being overstaffed with registered nurses?

Mr. JACOBS. No. Let's get this straight. I intended no criticism for her operation. She actually has the staff that I personally believe is required to take care of the kind of people she has, and, further, the group I homes in our State are taking a class of people like that that actually do require the 24-hour registered nurse care. The only reason you could say it was overstaffed, it is overstaffed in terms of minimum requirements, and only in that respect, not overstaffed as far as taking care of patients.

Senator MORSE. I'm glad I asked you the question, because I thought I had misunderstood you. I thought you made a comment that gave me the impression that it could be said the only place her infirmary was overstaffed was in connection with registered nurses. That is why I asked the question of you to see at what point she was overstaffed with registered nurses because, if we agreed that she needed registered nurses round the clock because it is a group I infirmary, I got a little lost with your comment.

Mr. JACOBS. It would be nice if we could have registered nurses around the clock in all our group I homes. The only reason it isn't required is that, frankly, we can't get the registered nurses. This is our problem. Now, there are two main reasons why we have a good nursing home industry, and I think we do have one. One is that we have a real tough licensing law. It was the first real tough licensing law in the country. It came as the result of a fire in a nursing home in which 18 people lost their lives, elderly people, and this happened while the legislature was in session, and the legislative committee visited the ruins before the smoke was all gone, and it wasn't long after that that we got a real tough licensing law. The law had been introduced in the legislature but languished in the committee until this fire came about and then it was passed.

Senator MORSE. Let me make a comment on that about the Washington Legislature, and let me make a very interesting comment on the operations of government. It is always said that we have to have a tragedy of some kind to pass legislation. It has happened before. In 1957, I conducted the hungry children investigation in Washington, D.C. I had no idea, when I started, what I was getting into. Senator Clark from Pennsylvania and I were the leaders of that investigation. You know what we found in Washington, D.C.? We found over 200 little boys and girls that lived out of garbage cans, and I mean that was their only source of supply of food. Sure, many of them were illegitimate and didn't know whether they had any parents, or whether they would know their own mother. It was a very deplorable condition and various types, but this was their only source of supply and within a stone's throw of the Capitol of the United States of America.

We brought that out in 1957, and I was making my plea then, not only for more funds, but for the elimination of some redtape in the handling of surplus food, and one of my colleagues from the southern part of the country asked me to yield when I was reporting on this to the Senate, and you will find it in the Congressional Record, that the Congressman wasn't friendly to my report. He asked me antagonistically and critically the following question: "Is it not true that most of these kids are colored?" and I paused long enough so that every eye was focused on me, and I said, "It is not true that all of them are, but most of them are; but let me say to my friend, they, too, are the children of God," and that is all I had to say. He sat down as though he had been hit by a baseball. One of my colleagues came over and said, "You can have any amount of money you want now."

But we had to have the Congress discover that we had that sort of situation existing in the District of Columbia before we could get the appropriations necessary, and that is why I made the comment that I made. I think the fault lies not only in this State, but in the Nation; the fault lies too often with the people themselves. They walk out

on their own responsibility of social conscience for these people that aren't as well situated as we are, and I want to say that I am proud that we are holding a hearing in a State in which the evidence has already shown that you have made great advancement, comparatively speaking, that many other States should have made with you many years ago.

Mr. JACOBS. Thank you. Now, this tough licensing law is one reason for our good industry, and the other one is the relatively high payment for welfare recipients. It doesn't make any difference whether you are buying nursing home care or beefsteaks, you are going to get about what you pay for. As the Senator remarked, in Washington, D.C., you pay a flat $100, and I imagine you get $100 worth.

Now, it looks like I have a whole lot here, as I read this over, and I am certainly not going to burden you with it all day. I want it in the record, because I think there is information there that might be good source material.

Senator MORSE. Your full statement will be printed in the record at this point.

(The prepared statement of Mr. Jacobs follows:)

PREPARED STATEMENT OF EDMUND F. JACOBS, EXECUTIVE SECRETARY, WASHINGTON STATE NURSING HOME ASSOCIATION

It is my understanding that one of the purposes of this hearing is to provide the Senate Committee on Aging with information on the nursing home industry here in our State of Washington and the part that licensed nursing homes in this State are playing in the care of the aged population of our State. I will sketch for you the history of the growth of nursing homes in our State and the growth of the Washington State Nursing Home Association, as the two parallel each other. In addition, I will attempt to touch on the quality and quantity of nursing home care available, both from the standpoint of physical plant facilities and the type and extent of nursing service. Finally, I will describe for you the program in existence between the industry and the Division of Medical Care of the Washington State Department of Public Assistance for providing nursing home care to our indigent aged.

Although nursing homes of one kind or another have been in existence in the State of Washington for more than 25 years, there is little recorded history or statistics available on the nursing home industry prior to the year 1951. The Washington State Legislature at their 1951 session, following a disastrous fire in a nursing home in Hoquiam, Wash., in which 18 aged patients burned to death, enacted a nursing home licensing law which provided that a nursing home advisory council should be appointed by the State director of health to promulgate rules and regulations for the licensing of nursing homes in the State of Washington. These rules and regulations were to "promote safe and adequate care and treatment of the individuals" in nursing homes and were to be adopted by the Washington State Board of Health and were thereafter to be filed with the secretary of state and, after an interlocutory period of 30 days, were to have the same effect as law.

The Washington State Nursing Home Association, which is a voluntary self-sustaining and self-regulating organization, came into being also in the year 1951 and assisted materially in developing the rules and regulations for licensing nursing homes with three members of the association sitting continuously since that time on the nursing home advisory council. The Washington State Nursing Home Association exacts high operational and ethical standards from its members and strives to provide the finest facilities and care in a homelike atmosphere where a feeling of social and emotional security is recognized as a patient need.

In the year 1951, when licensure commenced and with it came the keeping of accurate records, there were 298 nursing homes in the State of Washington, with a combined capacity of 7,648 beds. In November of 1955 these figures had climbed to 300 nursing homes with a combined capacity of 9,585 beds.

Obviously during the period from 1951 to 1955 many nursing homes in existence in 1951 had gone out of business and had been replaced by other and larger nursing homes. At the present time there are 334 licensed nursing homes in the State of Washington with a combined bed capacity of 14,222 licensed beds. During the period from 1955 to 1961, 77 new homes designed as nursing homes have been constructed with a total of 2,638 new beds. It is interesting to note that while there are over 14,000 nursing home beds licensed in our State, there are only 11,054 general hospital beds licensed in the State of Washington. I am sure your committee will find this to be a unique situation not found in most, if any, other States. An explanation is certainly in order. In most States you will find there are general hospital facilities, chronic disease hospital facilities, and nursing home facilities. We, too, have what, in most of those States, would be classified and licensed as chronic disease hospitals, but here they are licensed as intensive care nursing homes.

In 1951 there were 80 registered nurses employed in nursing homes in our State and no licensed practical nurses employed at that time. In June of 1954, there were 449 registered nurses and 442 licensed practical nurses employed in licensed nursing homes. In December 1958, there were 607 registered nurses employed in licensed nursing homes and 544 licensed practical nurses employed in these homes. In June 1961, there were 768 registered nurses and 608 licensed practical nurses employed in licensed nursing homes in this State. All of the figures quoted in this paragraph and the preceding paragraph were obtained directly from the Washington State Department of Health, Hospital, and Nursing Home Section, Smith Tower, Seattle 4, Wash. In a recent study of group I nursing homes in the State of Washington (heavy care patients), each patient received an average of 112 minutes of care per day with 28 minutes of this care being given by registered nurses and 18 minutes being given by licensed practical nurses. According to U.S. Department of Health, Education, and Welfare, these figures constitute the highest ratio of professional nursing care per patient in the United States.

At the present time there are 279,045 people over the age of 65 in the State of Washington. This is 1 out of every 10 citizens of our State. The average age of all patients in all licensed nursing homes in the State of Washington is 79 years of age.

The nursing home rules and regulations which were adopted require that every nursing home be inspected regularly by State and local health departments and the State fire marshal as well as the local fire department. Every licensed nursing home must provide fire protection based on national fire standards and each home is inspected several times a year. It is significant that not one licensed nursing home has had a serious fire since this inspection system has been in operation. Licensed nursing homes must pass equally demanding health inspections. These systematic, regular health department inspections pinpoint medical care, nursing care, records and reports, medications, food and food handling, heat, light, ventilation, water supply, sewage and garbage disposal, sanitary facilities, equipment, and furnishings—to name a few. One innovation which typifies the new era in nursing home care is the development of workshops for the staffs of these homes. These workshops cover all phases of nursing home activity and have been developed by the Washington State Nursing Home Association in cooperation with the Washington State Health Department and local and voluntary agencies. Over 950 nursing home operators and staff members attended the various workshops held in the various parts of the State of Washington during one calendar year, 1958.

A project of interest has been undertaken for the last 2 years by the Washington State Department of Health in cooperation with the vocational rehabilitation people in our State and the department of public assistance. Using a Federal grant of $50,000 plus additional State funds from each of the departments involved, a team of occupational therapists, physical therapists, psychiatrists, social workers, and public health nurses have been going into various licensed nursing homes throughout the State and training the personnel therein in the latest techniques of rehabilitative care. Certainly the nursing home of the future will give more and more importance to rehabilitative care for our patients, assisting them to reestablish themselves as far as walking, feeding, and limited self-help and self-care are involved. Although this program is extremely worthwhile, it is fairly expensive as it involves many hours of labor on the part of doctors, physical therapists, occupational therapists, nursing aids, and other rehabilitative personnel. Although the department of public assistance contributed some personnel to the pilot study project, they have not had any funds whatsoever

available to pay for this type of rehabilitation by nursing homes generally, and it is highly unlikely that our State legislature will be able to find funds for this purpose without assistance from our Federal Government in the form of increased Federal matching funds for the medical care program or other subsidy on the Federal level. It would be the recommendation of our association that your committee study the results of this pilot study project which you have already financed with an eye to recommend extension of rehabilitative services to all of our aged infirm who can benefit from such care and treatment.

More and more people are finding their way into licensed nursing homes and many of these people are the responsibility of the State through the department of public assistance. In August of 1953 there were only a few more than 4,000 welfare recipients in licensed nursing homes; in July of 1958 this figure had risen to almost 8,000 welfare recipients in nursing homes and at the present time there are 9,119 welfare recipients in licensed nursing homes.

The increased utilization of nursing homes is due to several factors but three factors stand out above all the others. First, many people have been able to leave the old-age assistance rolls because of the liberalization of our Federal social security program, but these people are not able to afford nursing home care on their social security grant. Therefore, the OAA load decreases, but many of those people who have gone off the OAA rolls because of their social security pension, have necessarily had to go on the medical care rolls when physical disability struck and their social security pensions were inadequate to take care of their medical needs and, particularly, their hospital and nursing home needs. Second, since the advent of the nursing home licensing law there has been a marked improvement in the quality of nursing homes in the State of Washington. Not only are the physical plants superior with many new nursing homes being constructed and many new beds being added to older homes through additions and alterations, but also the standard and quality of care has materially increased. This betterment of physical plant facilities and improvement in overall nursing home care has made the licensed nursing home much more acceptable to potential nursing home patients and to their doctors to whom they look for advice. A program of education has informed the public generally that good licensed nursing homes are available for the care of the chronically ill, aged, and infirm person. This increased acceptability of nursing homes has encouraged many recipients of public welfare to enter a nursing home and seek nursing home care where formerly they shunned such care or were unwilling to avail themselves of nursing home care. Third, there has been a conscious effort on the part of the division of medical care to cut down the stay of welfare recipients in hospitals and to transfer welfare recipients into nursing homes as soon as their physical condition and prognosis would indicate that nursing home care is adequate. It is only because the standards of care in nursing homes have increased and because there are now professional nurses staffing nursing homes and available to give chronic care that the department has been able to transfer welfare recipients, who formerly required hospital care, into the licensed nursing homes. It is a conservative estimate that every time a welfare recipient is transferred out of a hospital into a nursing home the savings to the division of medical care and thus to the taxpayer of the State of Washington approximates $20 per day. We wish to reiterate that this is a conservative estimate. While hospital utilization by welfare recipients has decreased, nursing home utilization by recipients has increased in direct ratio to the hospital decreases.

During this coming biennium which started July 1, 1961, 1,800 patients will find their way from our mental institutions and homes for retarded children into nursing homes. The State has found that many of these people have oversome their psychotic problems but have no place to go or now have physical problems which make it impossible for them to return home. They can be taken care of in licensed nursing homes better than they can in mental institutions and in licensed nursing homes they will be eligible for $47.50 per month Federal matching funds while the Federal Government does not give any matching funds to patients in mental hospitals.

To review the cost of nursing home care since the inception of the medical care program, one must first review the so-called Moss-Adams cost study. This cost study was made in 1953 by the Washington State Nursing Home Association in cooperation with the Washington State Department of Health and the Washington State Department of Public Assistance. A questionnaire was agreed upon by the above-named departments of State government, the Moss-Adams Co., and association representatives, with the questionnaire thereafter being sent to each

member nursing home. This questionnaire was filled out by a licensed or certified public accountant retained by the nursing home, and paid for by the nursing home. The questionnaires were forwarded by the licensed or certified public accountants directly to the Moss-Adams Co. where a summary of all of the cost data thus accumulated was made by the said company. The questionnaire covered the 6-month period from June 30, 1952, and the summary of the cost study was accepted by the said State departments and by the association as being a true reflection of the cost of nursing home care at the time of the study. In addition to the various member homes paying their own accountant to fill out the questionnaire from the books of account of the home, the Washington State Nursing Home Association paid the Moss-Adams Co. $1,800 for their services in conducting and summarizing this cost study. As a result of this cost study, rates were established as follows: Group I care, $180 per month; group II care, $145 per month; group III care, $115 per month; and group IV care, $90 per month.

Group I homes are equipped to care for bedridden, seriously ill persons including patients recuperating from surgery or other hospital treatment. A minimum of three registered nurses must be regularly employed to cover the required nursing shifts.

Group II homes provide care for patients needing extensive nursing and bedside care. These patients are usually confined to bed unless lifted out, but may be capable of feeding themselves. A registered nurse must supervise all nursing care, which is generally provided by licensed practical nurses.

Group III homes, largest of all groups, serve patients who are ambulatory and usually capable of feeding and dressing themselves but still in need of medications and nursing care. All care is supervised by a registered or licensed practical nurse.

Group IV homes are designed for ambulatory patients whose primary need is for supervision and medications. All care is supervised by a licensed practical nurse.

In addition to the professional nurses listed above, all groups must employ nurse's aids and auxiliary help sufficient to properly care for the number and type of patients served.

Early in 1956, the department of public assistance, division of medical care, approached the association and asked for another cost study, stating that they did not believe the Moss-Adams cost study could be considered valid for the purposes of setting or adjusting rates for the care of welfare recipients in nursing homes at that time. As a result of this request, and in a spirit of cooperation, the Washington State Nursing Home Association entered into a series of meetings with representatives of the department of public assistance which culminated, some 8 months later, in agreement between the department and the association on a questionnaire upon which costs were to be reported and a set of instructions for use by the certified or licensed public accountant who would take the cost figures from the books of the nursing home and transfer them to the cost-study questionnaire. All figures taken from the books of account from the nursing homes in this manner were required to be reconciled with the Federal income tax return of the home for the calendar year 1955, which was the year for which costs were to be reported. A total of 188 licensed nursing homes in the State of Washington filled out the cost-study questionnaire according to the instructions and submitted the questionnaire to Ansell-Johnson & Co. of Seattle, certified public accountants. The Ansell-Johnson & Co. assigned an identifying number to each questionnaire as it was received, copied the information contained on the questionnaire onto a similar form, omitting the identity of the nursing home and substituting therefor the identifying number arbitrarily assigned to that home. In this manner, the costs of operation of the 188 homes were obtained without revealing the identity and individual costs of any particular nursing home.

Some attacks have been made upon the Ansell-Johnson & Co. cost study on the basis that the 188 homes reporting did not constitute a large enough percentage of the licensed nursing homes in existence at the time of the study. At first blush, this appears to be a valid criticism as there were 294 nursing homes licensed in the State of Washington as of the date of the cost study. In fact, however, only 227 of the 294 homes could potentially take part in the cost study and 188 homes out of 227 is, we believe, an exceptional percentage for a voluntary cost study of this type. The reason for the difference between 294 licensed homes in existence and only 227 able to take part in the cost study

is that, according to the records of the Washington State Department of Health (licensing agency) 67 licensed nursing homes either opened their doors during the calendar year 1955, changed hands as the result of purchase during the calendar year 1955, or went out of existence at some time during the calendar year 1955. In each case, there would not be a continuous operation of the nursing home involved for the full calendar year 1955 and thus they could not participate in the Ansell-Johnson & Co. cost study which required a nursing home to report its costs for the entire calendar year 1955. It is the feeling of the association that those attacking the Ansell-Johnson cost study on the basis of participation did so as a rationalization for their refusing to accept the results of the Ansell-Johnson study, which results clearly indicated that a raise in rates for nursing homes caring for welfare recipients should be granted.

The association believed that the Ansell Johnson & Co. cost study is a realistic basis upon which to figure the costs of nursing home care and submitted to the division of medical care of the department of public assistance and to members of the 1957 legislature a request for a rate increase based upon the summarization of the Ansell Johnson & Co. cost study.

The department of public assistance, in making their request for funds from the 1957 legislature, made no recommendation for a rate increase for nursing homes, although they did request a 20-percent increase for rates to be paid to private hospitals for the care of welfare recipients. As a consequence, the appropriations committee reported out the omnibus appropriations bill as well as the supplemental appropriations bill with what was obviously insufficient money for the department of public assistance to grant a rate increase for the care of welfare recipients in nursing homes in the 1957–59 biennium. The association took its problem directly to the legislators individually and to the Governor. Ultimately the legislature passed an amendment to the supplemental appropriations bill which granted a $2,225,000 rate increase to licensed nursing homes caring for welfare recipients during the 1957–59 biennium. This amounted to a rate increase of 40 cents per patient-day in all categories of care and was about 20 percent of the amount requested by the association for a rate increase.

In the year 1957 the division of medical care, in an attempt to cut costs, took laxatives, aspirin, rubbing alcohol, clinatest tape and tablets and some other household drugs off the approved formula for prescribed drugs, thus denying these household drugs to recipients in nursing homes. While this saved the State of Washington some considerable money, it worked a hardship upon nursing home patients who needed these household drugs and upon the nursing homes themselves, as these household drugs were necessary to the proper care of the recipients.

The liaison committee composed of representatives of the Washington State Nursing Home Association and representatives of the division of medical care of the department of public assistance, considered this problem and, after many months, finally agreed in April 1960 that the department would pay the sum of 7 cents per patient-day to those licensed nursing homes whose operators agreed to furnish six household drug items to welfare patients when prescribed by a physician and utilized by the home for welfare patient care. The items to be furnished were: clinatest tablets and tape, aspirin, mineral oil, body lotion, including alcohol, milk of magnesia, and antidiarrhetics. This agreement was reduced to writing and individual operators were required to sign the agreement prior to the effective date which was May 1, 1960. This agreement and the payment of 7 cents per patient-day have now been incorporated in the overall nursing home contract now in effect.

This overall nursing home contract referred to above represents a landmark in the history of vendor payments by a State government to operators of licensed nursing homes. Not only is it the first such contract in the United States, but it also is a very comprehensive contract, setting forth in detail what the State is purchasing and how much it is willing to pay for the services received.

Though the department and association have not always agreed on some things, both agreed that a contract of this sort is necessary for the protection of the division of medical care, the patient, the nursing home, and the taxpayer. It is to the credit of both the department of public assistance and the association that when each side was invited by the other to submit a proposed contract, both submitted practically the same proposal. Minor differences were easily reconciled and the contract became effective on January 1, 1961. It is my understanding that representatives of the division of medical care of the State department of public assistance will cover this contract in detail at this hearing.

While the contract is acceptable, the rates for payment contained therein are

not satisfactory to the association at this time, and will have to be the subject of continued negotiations in the immediate future.

A third cost study was undertaken in the year 1960 with the nursing homes reporting their costs for the entire year 1959. Many months were utilized to develop the form upon which the costs were to be reported. Though it took a great deal of time, the final reporting form agreed upon was acceptable to the research and statistics division of the department of public assistance, the Washington State Nursing Home Association, the interim budget committee of the legislative council, the administrative assistant to the Governor in charge of budget control, and the legislative budget committee. I will not go into detail of the cost study, except to say that it is very comprehensive and generally was sufficient in detail to facilitate a breakdown of the many factors that make up the costs of providing care in nursing homes.

Both the actual completing of the cost-study data, and the summarization thereof, took longer than expected and it was not until late in December 1960 that cost figures were available. An adjustment in rates was made effective January 1, 1961, based upon the results of the cost study. Basically, the payment for groups 1 and 2 care remained the same, but the rates for group 3 and 4 care were raised. I am sure the Department has already provided you with factual data on the cost study, or will do so upon request.

We are not satisfied with the rates set as a result of the cost study. First, the summarization of the cost study was faulty in several respects and there was insufficient time to change the method of summarization before the rates had to be set. The department agrees with the association that the several areas will request further study and some revision of the method of summarization. We hope to be able to agree on changes to be made within the next 6 months. Second, the rates set as a result of the cost study reflect no profit whatsoever to the operator and the operators quite reasonably feel that they are entitled to a profit from this free-enterprise endeavor.

We have had excellent cooperation and relationships with the department of public assistance and have the highest regard for the personnel in the research and statistics division and the medical care division of the department with whom we will be dealing. We are confident that we will be able to resolve our differences and arrive at an acceptable rate for the care of welfare recipients in nursing homes.

We are, we think justifiably, proud of the excellent nursing home facilities available in our State and the high quality of nursing care which they provide. We are also satisfied that there is no person in our State currently in need of nursing home care who cannot receive it under our present extremely comprehensive medical care program. Persons on social security, for instance, who have a pension that meets their normal day-to-day living expenses are entitled to receive nursing home care with the division of medical care paying for the cost of such nursing home care over and above the amount of their pension. These people are classified as "medical indigents" or "medical onlys" with the State paying for the cost of medical care in excess of their social security grant which is considered as a resource. The same thing would apply to persons receiving annuities or other type of pension where the annuity or pension was insufficient to meet the cost of their nursing home care. We are very reluctant to see any change in the administrative responsibility for the medical care of indigents in the State of Washington, as we have devoted many years to cooperatively building with our State government a comprehensive medical care program of which we are very proud and which we feel provides excellent care to all who cannot provide such care for themselves. We very much appreciate the increased Federal matching funds which have been made available to the division of medical care from the Federal Government and we sincerely hope that any further assistance on the Federal level will be in the form of matching funds or subsidy to our State government in order that we can take advantage of the program now in existence and the administrative machinery which has been set up to make this program work, the cost of which administrative machinery the Federal Government is already sharing through matching funds. There has been talk of a national insurance program through our social security system or some other national administrative machinery. We here in the State of Washington are opposed to such a program for nursing home care. Because of the vast differences in nursing homes from State to State and the fact that the services offered range from virtually no professional nursing to intensive 24-hour professional nursing such as we have here, it would be extremely dif-

ficult to come up with a national contract for services and payment that would be fair to all citizens and nursing homes throughout our 50 States. Now, each State pays for what it gets; a uniform national program would either not pay some States for what they provide or would pay for services in some States that they would not be providing. Some time ago, we adopted a resolution which sets forth our thinking on this matter and I am attaching hereto a copy of this resolution.

The nursing home industry is now big business. There is one employee for approximately every 2½ patients in a nursing home. Oftentimes the nursing home is the largest employer in our smaller communities. Fifty percent of their cost is labor and for a 50-bed nursing home the payroll will run right around $5,000 per month. For the biennium starting July 1, 1961, the State of Washington has appropriated $34 million for nursing home care; another approximately $30 million will be paid during that period by private patients, making the nursing home business in the State of Washington a $30 million business annually.

The advances of medical science, the discovery of antibiotics and better rehabilitative and nursing techniques have added from 10 to 20 years to the life of our average citizen. These years however are not always good years and oftentimes the years are added following a serious illness. It would be wonderful if we could sandwich these added years in between the ages of 40 and 60 but, unfortunately, they must be added on to the end of our lifetime. People formerly died of a heart attack but now they live to be President of the United States. Pneumonia was formerly known as the old man's friend and you could expect a considerable percentage of our aged persons to die of pneumonia between fall and spring of each year. With the use of antibiotics, deaths from pneumonia have sharply decreased. People formerly died from the first stroke, now they may have several strokes before they finally succumb, and with proper rehabilitative services timely applied, people may recover almost fully from very severe strokes. All of this means that while we all may expect to have a longer lifespan, we must face up to the reality that we will probably spend a greater percentage of that lifespan in a medical facility than did our forefathers. This means nursing homes will be even bigger business in the years to come.

On behalf of the members of the Washington State Nursing Home Association, I wish to thank our chairman, Senator Morse, and his staff for making this time available to us. I will be glad to attempt to answer any questions you might have.

RESOLUTION

Whereas there is now pending before the Congress of the United States H.R. 4222, commonly called the King-Anderson bill; and

Whereas the said bill has been carefully studied by the legislative committee and the officers and board of governors of the Washington State Nursing Home Association, and discussions of the same have been held in open meetings of the membership of the Washington State Nursing Home Association, and the legislative committee, the officers and board of governors, and the membership are in agreement on this matter; and

Whereas it appears the King-Anderson bill would provide medical care and related services to all persons eligible for social security benefits, regardless of their previous contributions to the program and regardless of their present financial needs for such assistance, all of which is contrary to the original concept and purpose of the social security legislation which was intended to be actuarially sound providing benefits on the basis of contributions to the program; and

Whereas the enactment of the King-Anderson bill would most certainly raise the rate of contribution of the employee, which raise in rates of contribution would be tantamount to a direct income tax on such employees at a time when the wages of our laboring people are already heavily burdened; and

Whereas the enactment of the King-Anderson bill would, at best, furnish medical care only to those citizens of our country who are eligible for social security and would be of no benefit to the large segment of our elderly population who are badly in need of medical care but are not eligible for social security benefits; and

Whereas should the King-Anderson bill be enacted into law it would be necessary for the Federal Government to create large and complex administrative machinery to set standards for participating doctors, hospitals, and nursing

homes, some of which standards would necessarily be in conflict with existing standards in the various States, and to set rates to be paid for such medical care, which rates would also be in conflict with prevailing rates for recipients of public assistance in the various States and the passage of this legislation could result in lay people or government employees setting standards for medical care, treatment, and drugs and the restriction of doctors, hospitals, and nursing homes in the kind, type, and quantity of medical care, treatment, and drugs that could be administered and/or prescribed; and

Whereas there exists in many States welfare and medical care programs under the terms of which medical care is awarded to our indigent elderly on the basis of their need, with these States already having in operation appropriate administrative machinery to implement the said welfare and medical care programs, with such medical care programs presently receiving Federal subsidy by reason of the Mills-Kerr Act which has been enacted by our Federal Congress.

Now, therefore, the Washington State Nursing Home Association, whose membership consists of 183 licensed nursing homes representing almost 8,000 licensed nursing home beds in the State of Washington, does hereby oppose the enactment of the King-Anderson bill (H.R. 4222), yet recognize that there is a need for greater financial assistance to our indigent aged to provide them with medical care and related services, and do therefore respectfully suggest that, as an alternative to the King-Anderson bill, Federal aid to medical indigents through matching funds to the various State welfare and medical care programs be sharply increased from the general funds of the United States, thus reaching all of our indigent aged who are in need of medical care and taking advantage of already existing administrative machinery in the various States, the costs of which are already being matched by Federal funds. In this manner, the social security program will be preserved as an annuity program which was its original design and purpose.

Dated September 13, 1961.

(Signed) ROY J. MCDONALD,
President.

Attested:

(Signed) DOROTHY STILLWELL,
Secretary.

Mr. JACOBS. A little history on nursing homes in our State might be good perhaps. There have been nursing homes here for about 25 years, but very little recorded history prior to 1951 when our licensing law went into effect. Now, the Washington State Nursing Home Association, which I represent, came into being also in the year 1951. As a matter of fact, it was the health department in our State that asked that such association be formed in order that they could help implement the nursing home licensing law, which called for an advisory council by law. Three members of our association are on this advisory council and have been continuously since that time.

We represent in our State at the present time about 180 licensed nursing homes with somewhere around 8,000 nursing home beds. In the year 1951, when the licensure commenced, there were 298 nursing homes in our State with a combined bed capacity of 7,648 beds. In November of 1955, there were 300 nursing homes with a combined capacity of 9,585 beds. Ostensibly, we had gone up some 2,000 beds with only two new homes, but, obviously, many of the smaller homes and the homes that couldn't meet the standards set up by the licensing fell by the wayside and were replaced by larger and by new homes. At the present time, there are 334 licensed nursing homes in the State of Washington with a combined bed capacity of 14,222 licensed beds. This is very high, as has been pointed out by Congresswoman May. During the period from 1955 to 1961, 77 new homes, designed as nursing homes, have been constructed with a total of 2,638 new beds. If your committee holds hearings in Texas, you will find that in the State of Texas, according to the most recent figures we have, there

are only three nursing homes in the whole State that were designed for the purpose that they were to be used, everything else being conversions. We have eliminated conversions in our State. The regulations are so tough now with our 8-foot corridors, and so on, that you cannot convert a mansion or some type of building like that at the present time.

There are only 11,054 general hospital beds licensed in the State of Washington. We have roughly 3,000 more nursing home beds than we have general hospital beds. I think you will find, as you go about the country, that this situation is unique and I think an explanation of that would be interesting to the committee. In most States that you will study, you will find that they have general hospital beds, and they have chronic disease hospital beds, and they may have nursing home beds. In our State, there are no chronic disease hospital beds. When I say "there are no," that may be a misnomer. There is one institution that could be classified as a chronic disease hospital. The chronic disease hospital patients are in our nursing homes. We take them directly from the general hospital. So, we have eliminated the chronic disease hospital, and this is probably one of the explanations as to why we have so many nursing home beds.

Now, in 1951, there were 80 registered nurses employed in nursing homes in our State. There was no licensed practical nurse program at that time. In June of 1954, there were 449 registered nurses and 442 licensed practical nurses; in 1958, there were 607 registered nurses, and 544 licensed practical nurses; and in June of 1961, the latest figures we have, there are 768 registered nurses, and 608 licensed practical nurses employed in licensed nursing homes in this State. These figures are all taken from the health department, and Mrs. McCord is here and could verify it.

At the present time, the average age of patients in all nursing homes in this State is 79 years of age. There was some talk here by one of the witnesses about a halfway house. I would like to make a couple of comments on that.

Senator MORSE. May I interrupt just a moment? Counsel has asked me to ask you: What percentage of your patients are welfare patients?

Mr. JACOBS. It's about 71 percent, very close to 71 percent. The comment on the halfway house is that perhaps a halfway house would be necessary in many States, but in our State, when we have the four classifications of nursing homes, patients do shift from one classification to another. If they have a stroke, they go to the general hospital, then to the group I home. They get better, they get up and around and are rehabilitated to a group II home. Finally, they get ambulatory and go into a group III home, which I respectfully submit might be somewhat analogous to this halfway house that was discussed. Here is another problem: It's a halfway house to where?

It is an interesting fact that many of the people in our nursing homes don't have any relatives and have but few friends, and if it weren't for the staff, if it weren't for the ministers and people like that, there wouldn't be anybody. Oftentimes it's volunteers in the community. So, the halfway house patient has to have some place to go, and if there isn't a family or a family situation to return them

to, they oftentimes have to stay in nursing homes. It would certainly be better if they could be at home if they had homes to go to.

Now, the nursing home rules and regulations, as I said, are real tough. There is systematic and regular health department inspection of medical care, nursing care, medications, food, food handling, heat, light, ventilation, water supply, sewage and garbage disposal, sanitary facilities, equipment and furnishings, to name a few, and an important part of the health department work is workshops to train operators and staff. For this new project, which I am sure Mrs. McCord is going to tell you about, there was a $50,000 Federal grant involved in it, and it is a project for rehabilitation in nursing homes. We think it is real fine, and it has done an excellent job. They go in and they not only set up various activities, the weaving, and the handcrafts, and so on, for the patients who can participate in them, but they also have physical therapy for the patients.

If I could digress just 1 minute, you must remember, when you are working with people who are 79 years of age, their rehabilitation goals are necessarily limited. Sometimes the ultimate in rehabilitation is to teach somebody, who hasn't been able to feed himself. These people aren't going back into industry or anything like that, and so your goals are limited. Those limited goals, we certainly try to achieve wherever we possibly can.

As far as the welfare picture, there were 4,000 welfare recipients in licensed nursing homes in 1953; 5 years later, in July of 1958, there were almost 8,000; at the present time, give or take a few, as it fluctuates from day to day, there are 9,119 welfare recipients in nursing homes in our State.

Now, the increased utilization of the nursing homes is due to several factors, but I think three stand out. First, many people have been able to leave the old-age assistance rolls because of the liberalization of the Federal social security program, but these people are not able to afford nursing home care on their social security grants. They can get along until a major medical disaster hits. Therefore, the old age load decreases since many of these people have gone off the old age rolls because of their social security pension, but many of them have had to go back on the medical care roles when a physical disability struck. I would say this, that in our State at the present time I don't think there is any question that anybody needing nursing home care, who does not have the funds to pay for it would be entitled to nursing home care under our medical care law here in the State of Washington. I think this is real important for your committee.

We have taken full advantage of the Federal matching funds that have been made available to us, and we are very grateful for them, but at the present time, if somebody has a small pension and it is insufficient to take care of the nursing home care, they become what we call medical only and the State will pick up the tab for the difference. I am sure this is different than in many States.

Now, second, since the advent of the nursing home licensing law, there has been a marked improvement in the quality of nursing homes, not only in new physical plants, but also many new beds are being added to older plants through additions and alterations; also, the standard and quality of care is raised. Therefore, many doctors, who formerly would not recommend nursing home care, are now urging

people to go into nursing homes. The increased acceptability of nursing homes has encouraged welfare recipients to enter this program. Then there has been a conscious effort on the part of the medical care program to get people out of the hospitals quicker and into nursing homes in order to save funds for the taxpayers in the State of Washington. It is a conservative estimate that every time a welfare recipient is transferred out of a hospital into a nursing home, the savings to the division of medical care and thus to the taxpayers is approximately $20 per day. Then there is a new program of transferring mental patients and mentally retarded to nursing homes. There are 1,800 patients of this type who will come into our nursing homes in this biennium, and that is 1,600 from the mental institutions and 200 from the homes for retarded children.

One reason this program was instituted was again to take advantage of Federal matching funds because, as you know, the Federal Government will not match the care for recipients in a mental institution, but they will pay $47.50 of the cost of these nonpsychotic people in a nursing home.

Now, I am not going to review the cost of nursing home care, and we can skip two or three pages here. There were actually three cost studies. Dr. Hall has been on the last one right from the beginning. There were two prior to that.

On the overall nursing home contract that Dr. Hall spoke of, and which you have copies of, this represents a landmark in the history of payments by State governments to operators of licensed nursing homes. Not only is it the first such contract in the United States, but it is also a very comprehensive one, a contract setting forth in detail what the State is purchasing, and how much it is willing to pay for the services received. Although the department and the association might not always agree on some things, both agree that a contract of this sort is necessary for the protection of the division of medical care, the patient in the nursing home, and the taxpayer. I think it is to the credit of both the department of public assistance and the association that, when each side was invited by the other to submit a proposed contract, both submitted practically the same proposal. Minor differences were easily reconciled, and the contract became effective on January 1, 1961. Dr. Hall has already covered it.

While the contract is acceptable, the rates for payment contained therein are not satisfactory to the association at this time, and they will have to be the subject of continued negotiations in the immediate future.

Now, this cost study, the last one that was run, we think is deficient in two or three respects, as far as summarization. There is nothing wrong with the basic form of the cost study, but, in the summarization, they fail to take into consideration, I think, the increased labor cost that is involved in taking care of the "heavy care" patient. The department has recognized that maybe this is an oversight, and there are two or three other things that we are negotiating with them, and I am sure we are going to be able to reconcile our differences. I would also point out that this cost study is just that. It does not reflect any profit, and this is private industry, for the most part, and we do feel that we are entitled to some profit, even on welfare patients.

The wage and hour law, which was mentioned by Mrs. Kendall, is another thing that I would like to discuss with you because you have exempted nursing home and hospital employees on the national level, as well as the State. Exempting these people from the operation of the law does not require them to work for us, and we are in a real bind here. What happens in our State, they are paying $1.15 to wash dishes in a restaurant, but we only pay a dollar in the nursing homes. We say, "Well, the legislature exempted you; we don't have to pay $1.15." They say, "We don't have to work either; we can go down and wash dishes in a restaurant down the street." By January 1 of 1962, we will go up to $1.25, and we are going to be in a real tough situation then. So, when you study this cost study, recognize the fact that we are competing in the labor market, and to get the people to work for us, we are going to have to pay the minimum wage, even though the legislature says we're exempt.

Senator MORSE. I am glad you raised the point. I do not intend to make any comment on your State situation, but I think the argument you have just made is unanswerable so far as the practicable difficulties that the exemption presents to you, and, of course, you know that the legislative process involves some problems in getting that one vote over 50 percent necessary to pass the legislation. I think the exemption is unjustifiable, and I vote for no exemptions. I take the position that any worker in America, who is working in an industry that falls under the interstate commerce clause of the Constitution, is entitled as a matter of right to the benefits of the minimum wage, and I don't care where he works. We will get to that later and there will be a lot of controversy and fuss about it. It's the old story again of translating into legislation our moral obligations, and when you don't do it, you get into just this kind of an injustice and you incur this kind of a problem.

It will take a lot of public education, and a few of us have to be willing to be criticized, and, as I say, in this job of mine, criticism never bothers me if I am satisfied that I am carrying out what is clearly demanding social justice in our country. That is why you don't find the senior Senator from Oregon voting for any exemptions under interstate commerce, and as soon as the American people face up to the fact that, as a society, we owe this minimum standard to all Americans. Don't forget that every person we see is certainly one of us, because it is through his service, that this system of ours works. I am glad that you made the comment that you did for this record. You won't find everyone agreeing with you though.

Mr. JACOBS. Thank you. We would like to pay better wages because we realize it's unfair. We feel like we are exploiting at the present time; definitely, we are exploiting those people that stay with us because they are loyal, even though they can go down the street and get more money. If you have any social conscience at all, it is a very untenable position.

I have talked about medical indigents, and I now would like to say that we, as an association, are very reluctant to see any change in the administrative responsibility for the medical care of indigents in the State of Washington, as we have devoted many years to cooperatively building with our State government a comprehensive medical care program of which we are very proud and which we feel

provides excellent care to all who cannot provide such care for themselves. We very much appreciate the increased Federal matching funds which have been made available to the division of medical care from the Federal Government, and we sincerely hope that any further assistance on the Federal level will be in the form of matching funds or a subsidy to our State government in order that we can take advantage of the program now in existence and the administrative machinery which has been set up to make this program work, the cost of which administrative machinery the Federal Government is already sharing through matching funds. There has been talk of a national insurance program through our social security system or some other national administrative machinery. We here in the State of Washington are opposed to such a program for nursing home care. As a matter of fact, Senator, we are scared to death. In the District of Columbia, they pay $100. I don't know if there is a registered nurse there or not, but I am sure there are not very many of them. In our State, we pay $192. Now, if the Federal Government steps in here and sets up a national program, before we lend our support to it, we would like to know a little bit more about how it's going to be administered because we are realists enough to realize that the Social Security Administration isn't going to pay everybody in the country $192, and we are realists enough to know that, if they pay less, then some of our homes are going broke. We are afraid there might be a great leveling of payments and also of standards of care.

Now, this isn't true in hospitals. Hospitals are accredited. The hospital in Alabama is very much like the hospital in Oregon or Washington with some minor variations, but when you have such a tremendous variation from practically no care, practically no licensing and no supervision, to intensive care, strict licensing, strict supervision, we just wonder if the time is here yet when you can administer the nursing home program on a national level.

We would still have to have some administration in the State as everyone isn't on social security. That doesn't mean that the social security payments could not be funneled through the State, or some such thing, but, just as I say, we are scared to death, and this is the reason why we are trying to be practical on it.

The nursing home industry in our State is now pretty big business. Oftentimes the nursing home is the largest employer in our smaller communities. Fifty percent of their cost is labor and for a 50-bed nursing home in our State, in the group I homes, the payroll will run right around $5,000 per month. For the biennium starting July 1, 1961, the State of Washington has appropriated $34 million for nursing home care, and another approximately $30 million will be paid during that period by private patients, making the nursing home business in the State of Washington a $30-million business annually.

Now, the advances of medical science, the discovery of antibiotics and better rehabilitation, and so on, have added 10 to 20 years to the lives of all of us, and it we could slip it in between 40 and 60, it would be a great thing, but they are tacking it on the end. This means, as a practical matter, that these years are not always good years. You used to die from a heart attack, and now you live to be the President of the United States. You used to die from the first

stroke, and now you may have a series of strokes and live for a long time, and with timely applied rehabilitation you may be able to go back to work after a stroke.

Pneumonia was the old man's friend. You could figure in the fall of each year that certain of the nursing home patients just wouldn't make it through the winter because pneumonia was going to get them. Now, with the antibiotics, pneumonia is one of the least of the killers of people, and what this means is that each one of us, while we are going to live longer, is going to spend a greater percentage of his life span in some type of medical facility, and a greater percentage in a nursing home. We are trying here to provide good nursing homes, not institutions, and this is a most difficult thing, for operators to build new, modern, single-story nursing homes, and try not to make them look like institutions. They put wallpaper on the walls, they pipe music into the rooms. They do all the things they can to make it a home, and this is the kind of thing we need. We don't need institutions.

Now, our nursing home care is going to cost more. Remember, the cost study we made here took into no consideration whatsoever the rehabilitation services, and if you want to add them, you are going to have to pay for them. Physical therapists and occupational therapists come very high. It is really expensive.

I think that the only other thing that I would like to say is that we have had excellent cooperation here in our State, both with the department of health and with the department of public assistance. We harangue and we battle and argue, and so on, and so forth, but we are all going the same place, and we do get along. We will resolve our difficulties, and we would hate to see that upset.

I wish to thank Senator Morse and the committee for this opportunity—for coming here and giving us the opportunity to testify. If there are any questions, I will be pleased to answer them.

Senator MORSE. We are very glad to have your testimony, Mr. Jacobs. As I said, you are free to supplement it within 30 days. I am very glad you raised this matter in regard to Federal participation in the program and the administrative problems it would raise. I think, speaking for myself, we have to take into consideration the types of services needed by these various groups of patients, and it may be that we can take a chapter out of the Veterans' Administration service, who do have procedures there that take in converse groupings, and the cost of the service is considered accordingly. That is one possibility to look into, and particularly on that point, I would be glad to have any supplemental statement you may have.

Mr. JACOBS. There is one other comment I would like to make relative to that. It has taken at least 10 years to build the nursing homes into what they are today. Now, if you did pay more money, in many States it wouldn't solve your problem because the facilities aren't there. You have to have it all. It's a slow process, this thing is, and you might classify it and say you'll pay for intensive care in Wyoming, but there isn't any intensive care in Wyoming. Those people are in general hospitals. So, it's a far-reaching problem, and I thank you again.

Senator MORSE. Thank you very much. Our next witness is Dr. Peter T. Brooks, member, board of trustees, Washington State Medical Association. Dr. Brooks went to Harvard as an undergraduate, received his M.D. from Columbia, took a 4-year residency in the Massachusetts General Hospital in Boston, and was in the Navy for 3 years as a surgeon. He has been in practice in Walla Walla since 1949. As far as the medical association is concerned, he is one of the numerous past presidents of the local county society. He has been a diplomate to the State and local societies for 6 or 8 years, a member of the board of trustees of the State medical society, the alternate delegate from the State of Washington to the American Medical Association, a practicing surgeon, a member of the American College of Surgery, and a diplomate of the American Board of Surgery.

We are delighted to have you with us, Dr. Brooks. Will you take the witness stand and proceed in your own way?

STATEMENT OF DR. PETER T. BROOKS, MEMBER, BOARD OF TRUSTEES, WASHINGTON STATE MEDICAL ASSOCIATION, SEATTLE

Dr. BROOKS. Senator Morse, Congresswoman May, ladies and gentlemen, it is my privilege, as a practicing physician and as a member of the Board of Trustees of the Washington State Medical Association, to outline to you briefly the part played by the doctors in the State of Washington in the development and continuing improvement of health-care plans for the elderly citizens of our State, with particular attention to the nursing home situation.

Since its foundation in 1899, the Washington State Medical Association, through its official committees and through its individual doctor members, has played a leading role in the development and in day-by-day services of an integrated locally oriented system of medical care for the needy in this State. This program is described in detail in the Health Information Foundation pamphlet, No. A–3, entitled "Health Care for the Aged in the State of Washington." A copy of this pamphlet is submitted as an appendix to my statement.

Senator MORSE. It will be made a part of this record.

Dr. BROOKS. Thank you.

(The pamphlet appears in the appendix on p. 369.)

Dr. BROOKS. Our doctors have made significant contributions in the area of nursing home care by gladly furnishing, over a period of years, a substantial quantity of professional advice in the types and extent of illnesses as these relate to the licensing of nursing homes, and to the establishment of nursing home classifications. (These classifications are defined in the testimony submitted by the Washington State Nursing Home Association and have been alluded to already by Dr. Hall.)

In addition to this, our doctors, who are members of the State medical association's committee on rehabilitation and the committee on aging, are now working on several experimental projects in the rehabilitation of the infirm aged. Information concerning progress being made may be obtained from the State medical association office in Seattle, if the committee desires to learn more about what is being attempted.

Our doctors have been actively cooperating and participating in the nursing home rehabilitation project, which has been under the direction of Mrs. Vera McCord. This project is a cooperative effort on the part of the State health department, the department of public assistance, and the department of vocational rehabilitation in cooperation with a number of voluntary organizations.

In all of the above-mentioned activities, the Washington State Medical Association and its doctor members have been greatly assisted by the American Medical Association in its positive programs to help bring more and better medical and health care to more and more of the American people, the aged in particular.

Attached is a copy of the AMA's positive 10-point program for 1961. We believe it is significant that 3 of the 10 points bear directly on providing health care for the aged, and the other 7 points definitely and quite directly relate to better health care for the aged, as well as for the general population.

I think it is of the utmost importance to this committee to know the base upon which our State aged medical program rests be thoroughly understood. In every county in this State, there exists a program of voluntary, nonprofit, prepaid medical coverage, sponsored by the doctors in these communities. By utilizing this already functioning administrative and service program, the State of Washington, through its department of public assistance, has been able to give high quality medical care to its aging population. The success of this program has thus been the responsibility of the medical profession, and the high costs of administration and supervision have been minimized through the utilization of the county medical society service bureau. The Health Information Foundation pamphlet, which I have submitted, explains the program and its mechanics. But the heart of the program's success is found in the high degree of personalization of medical care and supervision, which we believe can successfully be rendered only in the context of a locally oriented program. We know from experience that this local arrangement provides the necessary personal touch, not only with the patients, but also with the local government officials involved.

No one claims that this is a perfect plan, as to the care of our elderly citizens, but we do feel that tremendous strides have been made in the right direction, and that with continued cooperation and revision, the program will constantly improve because it is the best way to provide the elderly with the kind of medical care they need and deserve.

I would close by saying I fervently hope that the citizens of the State of Washington will be able to continue to work out their particular problems in this field without the necessity of scrapping the years of sustained efforts which have been so fruitful to date. Thank you.

Senator MORSE. Doctor, we are delighted to have your statement. I am going to ask counsel to obtain for us the material, which you referred to, that we can get from the medical society's office in Seattle. I think that material too should be made as an appendix to this record.

(The following telegram was received from Mr. Neill:)

JANUARY 19, 1962.

WILLIAM G. REIDY,
Staff Director, Special Committee on Aging,
Old Senate Office Building, Washington, D.C.:

Reports of committees on rehabilitation and aging projects still in preparation by our doctors. Wonderful work being done on our pilot basis. Regret reports on them will not be ready for printer. Please advise Senator Morse copies of completed reports will be sent to him as soon as possible.

RALPH W. NEILL,
Executive Secretary, Washington State Medical Association.

Senator MORSE. Do you have anything, Mrs. May?

Congresswoman MAY. No questions.

Senator MORSE. Thank you, Doctor. The next witness will be Mr. Robert Avey, president, Proprietary Nursing Home Association of Spokane. Is Mr. Avey in the room?

(No response.)

Senator MORSE. The next witness will be Mrs. Vera McCord, coordinator of hospital and nursing home section, Washington State Department of Health. Mrs. McCord is employed by and has been employed by the Washington State Department of Health since 1951; first, in the administration of medical care and nursing home program; then on the workshop programs for nursing home personnel; coordinator of rehabilitation education service; project, involving research, demonstration, and a teaching program, which is being conducted in nursing homes for nursing personnel. She is responsible for the coordination of institution licensing programs, which include hospitals, nursing homes, boarding homes, and approval of health standards for national child care institutions. She is a certified social worker, a graduate of the University of Oregon, an active member of the American Association of Social Workers and International Conference of Social Workers.

She also has a very rich experience in public assistance outside the State of Washington as field representative, as consultant in the Federal Bureau of Public Assistance, San Francisco Regional Office; head of welfare section, War Relocation Authority, National Office. She served as welfare administration specialist to the Chinese National Government under the United Nations Relief and Rehabilitation; and later assigned by United Nations to the National Ministry of Social Affairs, National Government of China, as welfare consultant.

Needless to say, with this wonderful background, I am delighted to invite Mrs. McCord to take the witness chair.

STATEMENT OF MRS. VERA McCORD, STATE OF WASHINGTON DEPARTMENT OF HEALTH, OLYMPIA

Mrs. MCCORD. Thank you, Senator Morse. Congresswoman May, members of the committee, I wish to express our director's regret at not being able to be present, as he is in Detroit attending a meeting of the American Public Health Association, and I am representing him here today.

Senator MORSE. We are very glad to have you represent him.

Mrs. McCord. Before I start on my presentation, I would like to make two comments in relation to statements that were made by previous members at this hearing this morning. First, I would like to state that the figures I may give on the number of nursing homes available in the State of Washington and the number of nursing home beds will probably differ somewhat from both Dr. Hall and Mr. Jacobs, principally because my figures represent the count as of November 1, 1961. So, any discrepancy actually can be justified. Second, I would like to make a comment on the statement that was made by a speaker who stated that she felt that the community between State and local public agencies was most inadequate and that there was need for closer cooperation and better communication between the State agencies and the local agencies and between interstate agencies and interlocal agencies and I think that, as I present my paper to you today, you will see that there is a very definite effort in the direction of developing better communication and closer cooperation between all the agencies with one objective in mind—giving better service to communities.

I would like to take this opportunity to discuss the development of the nursing home program in the State of Washington as it relates to the Washington State Department of Health. The nursing home licensing law, which was passed by the Washington State Legislature in 1951, provided for two things: (1) the development, the establishment, and the enforcement of standards for the maintenance and operation of nursing homes, which in the light of advancing knowledge will promote safe and adequate care and treatment for the individuals therein; and (2) the improvement of nursing home practices by educational methods, so that practices eventually will exceed the minimum requirements of the basic law and the original standards.

The 1951 law designated the Washington State Department of Health as the licensing agent and provided that, after July 1, 1951, no person shall operate or maintain a nursing home in the State without a license as provided by the law of 1951.

The State of Washington in its law defines a nursing home as a home, a place, or an institution, which operates or maintains facilities, providing convalescent or chronic care, or both, for a period in excess of 24 consecutive hours for three or more patients, not related by blood or marriage to the operator, who, by reason of illness or infirmity, are unable properly to care for themselves. It is under this definition that we are doing our inspection of nursing homes to determine whether such institution should be licensed as a nursing home, or as some other facility. To insure a representative group and State interest in this program, the law provided for a nursing home advisory council, which is composed of the director of the State department of health, who serves as an ex-officio member, and 10 members who are representatives from the Washington State Nursing Home Association, State medical association, State hospital association, State nursing home association, State department of public assistance, and Washington State fire marshal's office, the Association of Washington Cities, and the Association of County Commissioners. This membership insures wide representation.

It is the duty of this advisory council to consult with the State department of health on matters of policy affecting the administration

of the law, and in the development of rules and regulations of standards, and to review and make recommendations regarding such rules and regulations prior to their adoption. The activities of this council has been the means by which close cooperation has been developed and maintained between the agencies involved in carrying out the nursing home program in Washington State. Supplementing these rules and regulations under which we function, the State department of public assistance has rules and regulations, as required by the State and are requirements imposed by the State department of public assistance, which are over and above those that are required by the State department of health. They apply only to those nursing homes which provide nursing care to dependent patients, for which that department is financially responsible. Some of the nursing homes in the State of Washington do not provide care for indigent patients, and, therefore, they come under the minimum standards of the State department of health.

There has been an interesting trend in the development of the nursing home industry in the State of Washington. In 1951, when the nursing home licensing law became effective, there were 301 homes that were operating as nursing homes with a total bed capacity of 7,553. As of November 1, 1961, there are 334 licensed homes with a bed capacity of 14,303. The bed capacity varies from 5 to 270, with an average of approximately 40 beds per home. Of the 334 licensed homes, 291 of them have a full license, and 43 have a provisional license; 5 of the 43 are due to change of ownership, and 38 have some remaining deficiencies, which are in the process of correction, as set forth by the rules and regulations.

During the 10-year period from 1951 to 1961, there were 49 homes which have retained their same name and the same administrators. We think this is significant because it shows the stability and the dedication of certain people to carry out this type of program for the elderly citizens. Of the 334 homes licensed, 23 of them are nonprofit homes, operated by church, fraternal, government or nonprofit corporation sponsorship, with a total bed capacity of 938 beds. The remaining homes in the State then are classified as proprietary facilities, that is, they are operated by individuals on a profit basis.

Since the beginning of the nursing home program, January 1, 1951, there have been 461 separate buildings that were licensed as nursing homes. Of this total number, 227 have been closed for various reasons. One was closed because they were unable to meet the standards. Some others decided to get out of business, and some decided to go into other occupations. There have been 80 new homes built in the period between February 1955 to November of 1961, which represents 4,918 beds. When I say new homes, I mean these are homes that were built from the ground up. They were planned for nursing homes and licensed for nursing homes, and they are carrying on now as nursing homes. This is the trend in the State of Washington.

In addition, there are 23 general hospitals that operate and maintain nursing homes units with a total capacity of 859 beds, thus increasing the total number of beds available for the chronically ill and disabled persons to 15,205. These beds that are included in the hospitals do not necessarily show up in the nursing home directory. In the hospital program, we license the total capacity of the hospital, and that includes acute hospital beds, as well as long-term-care beds.

The building trend in nursing homes is toward larger facilities and increased bed capacity, rather than an increase in the number of nursing homes, thereby making it possible to provide services to patients above that of just plain custodial care. With this increase in the long-term care facilities in the State of Washington, it has been suggested that a really more realistic method should be developed for determining the need for additional beds.

To date the bed need has been determined by the Federal ratio, as designated in the Hill-Burton plan for 5 beds per 1,000 persons, 65 years of age or over. This formula has been used with the approval of the nursing home advisory council. This formula provides a general basis for allocating beds to areas but it has many limitations. The population over 65 may differ markedly between regions in characteristics which are related to the use of the long-term beds.

In addition, future requirements for areas may vary considerably from the present because of the changes in the population characteristics and patterns of utilization. For instance, we have certain areas in the State where we have a particular program, like in the Richland district, where we had a younger group of population coming in to work in the plants at that time. This has now become a more stable community, and more people are settling there, many of whom are older people. With the change in the characteristics of the population in this area there naturally will be need for more nursing home beds as time goes on.

The State department of health made a recommendation to the advisory council to apply to the U.S. Public Health Service for funds to study and to develop a more meaningful and more reliable technique for predicting long-term needs for geographic regions of the State. It is planned to develop methods for forecasting long-term needs based both upon the trends in the different population groups that use long-term care beds and the size of the population groups in the basic community. The different populations included in the age groups are from 40 to 64, 65 to 69, 70 to 74, 75 to 79, 80 to 84, and 85 and over. We feel that this is a good grouping in order to determine the utilization in relation to the population, and this includes both males and females, different mental status, persons with different sources of financial support, and those living in rural and urban populations. These factors have all been found to be related to utilization of long-term beds in many different studies. The forecast of the rate of utilization will be combined with the population for the region, the forecast of long-term bed needs. Necessary information of nursing home utilization will be obtained from the individual patient record now maintained in the long-term bed facilities, as well as from several past surveys which have been carried out in this State by different agencies.

Original data has been obtained and published in a special census report. Research personnel from the University of Washington, as well as the State department of health personnel, will be involved in making this study. To date, we have not had a report on whether or not our request for funds has been approved, but we are hoping that it will be, so that we can conduct the studies in order to determine more meaningfully where the bed needs in the State are, how significant is the number of nursing home beds for long-term care patients in rela-

tion to the number of beds for the acute care patients in general hospitals.

As of November 1961, there is a total of 11,054 beds in hospital facilities, in contrast to 15,205 nursing home beds and beds in long-term care units in general hospitals. Nursing homes are being recognized now by medical resources of the community as is being evidenced by the direct referral of patients by the physicians and the early transfer of patients from the acute general hospitals to nursing homes which are staffed and equipped to provide heavy duty nursing care.

The promotion of the educational program, our second purpose as stated in our law, has had several approaches. These include consultation services to personnel of nursing homes, personnel of the State department of health, institutes for nursing home personnel sponsored by the University of Washington, workshops sponsored jointly by the State departments of health and public assistance, and the Washington State Nursing Home Association, on both State and local levels. Special educational projects have been conducted on nursing homes by the local health departments, which include demonstration of nursing techniques and procedures in patient care.

The activities involved actual discussion of licensing of nursing homes as a means of assisting the nursing home personnel to become familiar with the laws, rules, and regulations and the standards governing nursing homes, and at the same time they have assistance from the State department of health in applying them in the day-by-day job.

The interest of the nursing home operators and the desire of the nursing home personnel to develop new skills and their requests for assistance prompted the development of institutes and workshop programs. Institutes at the University of Washington include approximately a week of intensive study, demonstration, and classes of various aspects of patient care. And I would like to point out that these institutes are very well attended. People come from nursing homes all over the State to attend these nursing home institutes at their own expense.

Workshops are designed to fit the needs as indicated by the requests for help from individual operators. These were developed in local areas in cooperation with the State and local nursing home associations, with participation of local physicians, public and volunteer agencies, with the major responsibility being assumed by the local nursing home associations. These workshops are usually of 2 days' duration and are well attended. The subjects of these workshops include, but are not limited to, rehabilitation, with emphasis on self-help, services to the nursing home patient, nutrition, mental health, cardiac, and other specific areas of patient care. This program, set up on a statewide basis, reaches into most areas of the State and has made possible wide participation. In conjunction with this program, the State department of health employed an occupational therapist, who made her services available to nursing homes which wanted to establish an activity program for the patients. The occupational therapist provided service directly to the patients and at the same time taught nursing home personnel how to organize and carry out activity programs with and for those patients whom the doctor has recommended.

The reception of this service and the number of requests for a continuation of this program indicated that there was a definite need

and desire for this type of activity on the part of the nursing homes, as well as the families of patients. The change in attitude of the patients, as well as the nursing home personnel, appeared to point to the need for the extension of this type of service. To do so, it was necessary to enlist the help of volunteers in the community to assist the patients in this expanded activity which the nursing homes were unable to assume because of lack of staff and time. The use of volunteers has been the means of interpreting to the community the need for this type of service in the care of the aged population.

Since the passage of the law, there has been a concerted effort on the part of the State department of health, the State department of public assistance and the Washington State Nursing Home Association to improve nursing home practices and to develop standards of operation which will provide safe and adequate care and treatment for nursing home patients. Because of the increasing demands of the nursing homes, the manifested interest by the public, the legal responsibility of the State departments of health, public assistance, and vocational rehabilitation, it was mutually agreed that an effort would be made to provide an expanded teaching service to nursing home staffs, to improve and extend patient care, with the firm belief in the philosophy that a chronically ill person should have the opportunity to obtain their maximum potential, to participate in activities of daily living, the right to be respected, and an opportunity to retain their dignity as citizens.

It was decided to demonstrate that this can be done by a jointly sponsored project designed to provide in-service education to nursing homes staffs on a statewide basis, and thereby extend the services to a larger number of elderly persons in such facilities. The three State agencies applied to and received Federal funds from the Office of Vocational Rehabilitation Federal funds to carry out a 3-year rehabilitation and education service project for patients in nursing homes in the State of Washington beginning January 1, 1959, and terminating December 31, 1961.

The purpose of this project is threefold.

The first is to develop within the nursing homes an organized program of rehabilitation education service through teaching and demonstration to determine the potential of the older patients of such institutions for maximum care and for vocational rehabilitation, to reduce dependency, and to make it possible for many such persons to be discharged to their own homes, or to engage in remunerative work in a sheltered workshop, or in a community situation.

I would like to point out that the rehabilitation, as used in this sense, does not mean that efforts are being made to push chronically ill people into highly competitive industry, but it does mean, however, that it is assisting patients to become able to make more use of their physical and mental capacities in some form of productive activity. In other words, it is a restorative program.

Our second objective is to teach and to develop teaching techniques, which facilitates expansion of this type of rehabilitation and educational service to other nursing homes in the State. This has been done through the development of materials for instruction of nursing home personnel which are being distributed to nursing homes for their use.

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The third is to test and evaluate the effectiveness of this type of service as observed in the application of the new techniques and skills by nursing personnel in caring of patients. In other words, we have to measure and we have to find out to what extent patients are helped toward self-care by the application of rehabilitation services.

Serving in an advisory capacity to this program is a technical advisory committee which provides technical consultation in the development of the conduct of the program. This committee consists of representatives from the schools of physical medicine, nursing, and social work of the University of Washington, and representatives from these sponsoring agencies and the local health departments.

In carrying out the program, the project team, as designated, spends approximately 2 months in each nursing home during which time it conducts an educational teaching program for the nursing staff. This program includes general orientation of the broad aspects of rehabilitation, lectures, discussions, and demonstrations of nursing techniques and procedures. There are approximately 24 hours of class instruction during the 2 months' period, and the remainder of the time is spent with the nursing staff at the patient's bedside, assisting the nursing personnel to put into practice what they have learned during class. All shifts of the nursing home are included in the training program.

Members of the project team do not render direct service to patients, but, instead, they teach the nursing personnel how to carry out self-help services and techniques with their patients. At the termination of the 2 months, arrangements are made with the nursing home for regular followup consultation visits by program members of the team to advise on problems involving the patients and to observe the nursing practices that were taught during the project period.

The project staff consists of qualified and experienced personnel representing the various rehabilitation disciplines. Included on the staff is a coordinator, three rehabilitation nurses, an occupational therapist, a physical therapist, social worker, a vocational rehabilitation counselor, and a secretary employed full-time. Serving on a part-time basis is a physiatrist, a psychiatrist, a statistician, and a project designer who is responsible for the research aspects of the program.

I might add here, although I have not indicated it in my paper, that we do have specialists who come in as the need is indicated; such as a speech therapist, a hearing-aid consultant, or any other specialist that is needed to render service and consultation to the nursing home staff in the care of patients in addition to providing direct service to patients. The project nurses are responsible for teaching skills and techniques in rehabilitation nursing to the nursing staff of the home by means of lectures and practical application and serve in an advisory capacity to the nursing personnel, regarding nursing procedures.

The occupational therapist provides a general activity program in addition to therapeutic occupational therapy under the direction of the physiatrist. Under the direction of the private physician and the physiatrist, she teaches certain supporting procedures, such as remedial activities and the use of adaptive equipment, which the nursing staff can safely use in caring for the patients. She doesn't attempt to teach nurses in the home to be professional occupational

therapists. She only helps them to do the things that they can do with safety and which we consider only as good patient care, which should be included for all types of patient care. Likewise, the physical therapist does not attempt to make professional therapists out of the nursing staff, but she teaches them how to apply the supporting services approved by the physiatrist that can be used safely with the patients, in such procedures as ambulation, transfer activities, or muscle reeducation.

The social worker plays a most important role in this project. She has an understanding of the patient's social, economic, and emotional problems. She helps the patient to accept his disability and at the same time encourages him to accept the services which will reduce his dependency. She encourages the family and friends to maintain an active interest in the patient less they feel rejected and no longer wanted or needed. She assists and encourages the nursing home staff to utilize the service of volunteers. The social worker not only helps the patients maintain their identity with the community, but through volunteer groups she arranges extra services for them over and above that which the nursing home can give. If a particular patient becomes interested and participates in the activities of the program, certain vocational rehabilitation potentials may appear which result in referral to the vocational rehabilitation counselor for evaluation and perhaps planning for a specific program with the patient. Often his latent skills may be revived or new ones developed, such as engaging in a small business enterprise, selling greeting cards, manufacturing small articles for sale, create some new and interesting work for their patients. To be able to earn money, regardless of how much gives that feeling of independence that the patient needs and has since lost.

The nursing homes which request the services of this project must be licensed by the State department of health, must be approved by the State department of public assistance, and must provide care for both private and public assistance patients. Thus, both the private, as well as those on public assistance, are included in the program. The nursing home administrator must arrange for all nursing staff to participate in the training program and be willing to provide essential basic equipment for teaching and demonstration.

Private physicians, in cooperation with and in participation in the program as it relates to their patients, are necessary if the service is to be effective and meaningful. Experience has shown that any educational program for nursing homes must have full support of the local agencies, the private physicians, and the State and local nursing home associations, if it is to be effective and continue after the demonstration has terminated. Therefore, in considering requests of nursing homes for services of this project, careful preplanning is done by the local health and public assistance departments, the nursing home administrators and staff and private physicians, who are concerned with the patients in the home, as well as those who are interested in good patient care generally. This provides an opportunity for them to become familiar with the objectives of the program, the method by which it would be conducted, and enable them to understand the importance of their participation.

The project team, in developing a realistic and sound self-help program and participation, must never forget the nursing home plays a most significant part in the community as a medical resource. More and more chronically ill persons are being referred by their physicians from hospitals to nursing homes, so as to make hospital beds available to acutely ill persons. The increase in nursing home beds is based upon the need for extended care of the chronically ill patient, whose nursing needs can be adequately met in a nursing home. In responding to this need, many of the nursing home administrators are building facilities which will facilitate the development of expanded nursing services to include specialized rehabilitation programs. A marked change in emphasis from one of strictly custodial care to assisting patients to become more independent and self-sufficient, is evidenced by the many requests for the project team to help them to develop and carry out a more comprehensive program.

During this 3-year project period, we had 62 formal applications from nursing homes who have asked us to come to the nursing home to help them develop this type of program in their home in addition to many informal requests. This, we think, is an indication of the interest on a statewide basis of the nursing homes in trying to develop better care and services for the patients. There has been a definite increase in referrals by private physicians to the demonstration homes where nursing home personnel have learned to carry out such rehabilitation and restorative services medically prescribed. This project has demonstrated that much can be done to help patients to obtain the maximum potential in activities of daily living, to be less dependent upon the nursing home staff, to motivate patients to help themselves and once again become a member of a social group, even in the limited environment of the nursing home. Many return to their homes or community situations because they have learned to be less dependent upon others. True, many never leave the nursing homes because they have no place to go and may be in need of continuous nursing care.

The success of this project, we believe, can be attributed to the close cooperation and the participation of the three State agencies and the State nursing home association with common objectives and the interest and development of local community groups, that continue to serve the patients in the nursing homes. This demonstration has set the pattern for other nursing homes that may wish to incorporate such services in their regular nursing services. However, we are convinced that this is a reflection of the operative efforts that have been manifested since the inception of the nursing home program in 1951.

Senator MORSE. Mrs. McCord, this has been an excellent statement. If you have time in the 30-day period that I referred to before, you would help me and, I think, the committee if you would give consideration to this problem of overstaffing, and also the problem of understaffing, that was raised by Mrs. Kendall in her testimony this morning. I would like to have you give us the State's position in respect to this staffing problem.

I think I would like to have you include in that, to make my point clear, your view on the difference between minimum staffing, adequate staffing, and overstaffing, keeping in mind what Mr. Jacobs pointed

out, that it involves the type of home that you are dealing with, whether in group I, II, III, or IV.

(The request for a report on staffing was referred by Mrs. McCord to the department of public assistance; the report appears on p. 391.)

I think I also would like to have a memorandum from you, and you may include it in this memorandum, on this problem of the halfway home because, as Mr. Jacobs pointed out, you have a policy in this State of moving patients from home to home, depending upon the change in the condition of the patient. It may very well be that certain homes in this system have many of the characteristics of the halfway home. Due to the fact that there was sufficient evidence presented to us at the Federal level, it convinced us that in many States the halfway home would be needed. So, we appropriated money for demonstration homes. So, as I view the comparison of that with the Washington situation, I would appreciate your valued judgment as to whether it would be of any help or not. Mr. Jacobs made the point, and I think there is no question, when you start dealing with halfway homes, you have to keep in mind, halfway to what. That raises the problems of the type of welfare and public assistance patient who apparently has no place to go because there are no relatives left, or, if there are any left, he has a relative problem and you wouldn't help the patient by sending him into the relatives' home. I was interested also in your comments in regard to the changing attitudes that have developed over the years in various parts of the country. I am not a competent witness on it, but I think it would be rather interesting to have the benefit of any valued judgment you might shed on the differences in attitude among different groups within our population.

It is sad, as you go into some parts of the country, take New England, for example, where there is apparently a long established and traditional family sense of deep responsibility in regard to the aged. Once we were inclined to approve and then say it was fine, and yet when you get an individual that hates it sometimes, you will find that there may be a very fine family attitude, but the family is not in a position to give the care, and, in some instances, this very fine sentimental, moral sense of obligation may not work out best for the patient. After all, we can't ever lose sight of the patient. So, you see what is going through my mind in regard to some of these problems. This committee seeks what is going to be best for the patient.

I want to thank you very much for this testimony and any further help you can be to me.

Mrs. McCord. I would like to make a comment, which is really sort of off the record, but when you mentioned that Mr. Jacobs stated that the halfway house was halfway to what, I was reminded of a situation that happened in one demonstration nursing home. When this team of specialists was in a nursing home, they were trying to get one of the elderly gentlemen to get up and walk. He could, the doctor said he could, there was no reason why he shouldn't. He had no motivation to do it. He didn't want to walk. He didn't want to do anything.

One day the nurse casually said to him, "Come with me to see the flowers that I have just planted near the patio." Without any hesitation he accompanied her to the patio where he offered advice regard-

ing the care of plants. This was the beginning of his interest in leaving his chair—he had a reason for walking—a motive.

Senator MORSE. Yes. Thank you very much, Mrs. McCord.

Now, our afternoon session, which we will take up at 2 o'clock, will not be on nursing homes alone, but on any and all problems of the aged and aging as well. So, the witnesses will be welcome to speak as soon as we finish with certain scheduled witnesses. Our first witness has been very cooperative with the committee, and he has agreed to hold over until 2 o'clock, and that will be Mr. Howard Whitbeck.

So, we will recess until 2 o'clock.

(Whereupon, at 12:45 p.m., the subcommittee recessed until 2 p.m., of the same day.)

AFTERNOON SESSION

Senator MORSE. The hearing will come to order. Our first witness this afternoon will be Mr. Howard Whitbeck, a native of Schenectady, N.Y., educated in the schools of that city, employed by Pacific Power & Light Co. at Portland in September 1911, and continued in that employment for nearly 47 years until retirement March 1 of 1958. Mr. Whitbeck was recalled by Pacific Power & Light Co. for 2 months, September and October 1960, and again in January 1961, and this to continue through the year 1961. He resided in Walla Walla continuously since 1948 and has been a member of St. Paul's Episcopal Church, vestryman and lay leader of the church, trustee of St. Paul's School for Girls, and a member of the Walla Walla County Deputy Sheriff's Civil Service Commission, the county planning commission, the regional planning commission, the executive board of the community service council, and a member of the Governor's council on aging.

We are delighted to have Mr. Whitbeck with us. You may proceed, Mr. Whitbeck, to the witness stand and testify in your own way.

STATEMENT OF HOWARD WHITBECK, WALLA WALLA COMMITTEE ON AGING

Mr. WHITBECK. Senator Morse and members of the committee staff, I would like to present the fact that the area in which we are dealing is with people on fixed income, and that the continued trend of costs has been upward. This applies, of course, to medical expenses, which includes the cost of nursing homes and care in one's own home. I am of the opinion that for one to go into a nursing home requires considerable income per month, and realizing that the operators of nursing homes are entitled to a reasonable return on their investment, it is my opinion that many of their accounts are uncollectible, and, consequently, this is absorbed in overhead and in the accounts that are collected. This is fundamental business.

Now, what I propose is that the social security be increased to the point that a separate fund for each recipient be established through social security to be drawn upon to provide for nursing home care and medical treatment, these funds to be placed with private insurance companies, who today have medical programs available. Many private industries provide such a program for retired employees, which is a very commendable program, as well as an adequate one.

Being on a fixed income, one has absolutely no control over increased costs, and, therefore, the plan which I have suggested seems most reasonable and, by the same token, would relieve the States of a great deal of responsibility in their medical and welfare programs. Having mentioned the State welfare programs and the lack of control of costs by individuals on fixed incomes, we realize that the States welfare programs are operated through taxation. I am probably going far afield here to express myself, but I sincerely hope that it will be understandable in its conclusion.

Now, I am of the opinion that individual responsibility is something we read and think very little of and assume none of. I am thinking of parents who have been responsible through the years to their children and, in later life, when it comes turnabout, the children are unwilling to assume any responsibility for their happiness and the provision for care of their parents. I hear people say, and I imagine they are thinking that, "It is not my responsibility to care for my parents, for I am unable to do so and provide adequately for my family." However, in extreme cases, it undoubtedly would mean depriving oneself of some luxuries and necessities, but should we not be willing to do this for the ones who through the years have been willing to do this for us?

Now, if this could be brought about, the requests and the appropriations required by the State legislatures could be decreased, and, consequently, taxes could be lowered, for we all know the people of 65 and over enjoy their own homes and surroundings as long as they are physically able, and a vast majority of us own our own property, and in each year we are being confronted with increased taxes, higher maintenance costs, and, consequently, many of our homes are depreciated through our inability to provide the maintenance costs, and they are ever increasing in depressed areas in our cities.

I do not know how such a program could be placed in operation without full knowledge of the mechanics, which I feel I am not qualified to provide. I feel that a great deal of study could be made in this field. I am deeply concerned with the responsibility. From my observations, we are all too willing to pass our responsibilities along to someone else, and I am wondering if this could be considered as a fact, that we are becoming selfish individuals. We are all deeply interested in one another. However, I feel that our responsibility should not be passed along to our Government in the areas of providing medical care, housing, and recreational activities. Thank you, Senator.

Senator MORSE. Thank you very much, Mr. Whitbeck. We already have had a whole series of various proposals by way of insurance assistance through private insurance plans, and I shall see to it that this proposal of yours is given full consideration by the committee. We will also make available to every Member of the Senate this full record, so that they will have that available to them too, and in the meantime, if you wish to supplement further your suggestion with any more detailed information on it, I will see to it that gets in the record too. Thank you.

Our next witness will be Mrs. Lucille Kelly, on the Committee of Legislation of the State Nurses Association. Mrs. Kelly was director

of nursing services at St. Mary's Hospital; has a B.S. and a degree in nursing education and a minor in social science.

We are delighted to have you with us, Mrs. Kelly.

STATEMENT OF MRS. LUCILLE KELLY, COMMITTEE ON LEGISLATION, STATE NURSES ASSOCIATION

Mrs. KELLY. Thank you. Senator Morse and members of the committee, as a representative of the Committee on Legislation of the Washington State Nurses Association, a professional organization of registered nurses, I wish to remind this committee that the American Nurses Association has gone on record in two biennial conventions supporting the extension and improvement of the contributory social insurance to include health insurance for the beneficiaries of old-age survivor and disability insurance.

Testimony in support of this principle was presented to the House Committee on Ways and Means in July by our Washington, D.C., representative and is a matter of record.

A point in the testimony regarding nursing homes is one I would like to reiterate here. The American Nurses Association in its statement of standards for nursing care in the nursing home is what we believe are minimum requirements for providing nursing care. Briefly, these are that the nursing home should provide direct supervision of nursing care by a registered professional nurse under the direction of a physician, and that there should be a registered nurse or a licensed practical nurse on duty at all times.

We recognize that in many instances undesirable practices are being carried on, and in some so-called nursing homes there is little medical supervision and no skilled nursing care. We recommend that any payments from the social security fund be limited to only those facilities which provide at least a minimum of professional services. We feel that all these people should have adequate nursing care. Thank you.

Senator MORSE. Thank you very much, Mrs. Kelly. We are glad to have your statement.

Our next witness will be Mr. William H. Ebding, Sr. Mr. Ebding was born and raised here in Walla Walla and has called this his residence for 67 years. He is a member of the Walla Walla Aerie No. 26, Fraternal Order of Eagles, and is a veteran of World War I, serving 4 years in the Navy. He had worked at the local Veterans' Administration hospital for 34 years, before he retired on account of his health in 1952.

Mr. Ebding, we are delighted to have you with us. Will you take the witness stand and proceed in your own way?

STATEMENT OF WILLIAM H. EBDING, SR., WALLA WALLA AERIE NO. 26, FRATERNAL ORDER OF EAGLES

Mr. EBDING. As an Eagle and a senior citizen, I am interested in what is called nursing homes. I believe that the word "nursing" is misused. Many of us are not at the point where we need nursing, and possibly a better name could be used. I also believe that the present nursing homes are profiting and that facilities should be provided for

those aged who do not have sufficient income to enter these so-called nursing homes.

But what are we providing for these aged? Are there any laws protecting them? Do they get the consideration they so rightly deserve, after having dedicated their lives in making this world a better place for you and me?

The Fraternal Order of Eagles have, in a measure, solved some of these problems by providing what we call Eagle Village. On March 28, 1961, Eagle Village in Florida was dedicated by the grand aerie officers. Fifty cottages were built with the help of all the Eagles. These cottages consist of two- and three-room units, which are available to eligible people. It is planned to have this operated as a group, duly organized with its own government. As soon as possible, this type of program will be instituted. Since this village has been built, Eagles in the State of Washington are asking the grand aerie to consider plans for an Eagle village here in the State of Washington.

The Walla Walla Aerie, back in the early forties, realizing the aged's problem, started an Eagle home at Third and Sumach Streets here in Walla Walla. This home was not necessarily limited to Eagle members. In fact, there were more non-Eagle members who lived in this home during its 5 years of existence. The home was administered by a board of Eagle members, who saw to it that the funds were properly handled for the residents, and it was self-supporting. This home was condemned by the city as not fire safe. Efforts were made to find another place for these people, but no suitable place was found and the whole idea was abandoned.

The Eagles have long been working together in sponsoring legislation that will provide a living for our own senior citizens, such as social security, and now the jobs-after-40 legislation. The National Committee on Jobs After 40 report that a total of 15 States have now enacted laws on this discrimination of older persons. The grassroots support given by the Eagles has given impetus to the White House Conference on Aging and has entered into State and Federal action. This action has awakened to our Nation our obligation to our senior citizens. I would heartily endorse any measure that this committee will take to help solve this problem. Thank you.

Senator MORSE. Thank you very much, Mr. Ebding. Your testimony raises several points that I would just call attention to in the record. I judge that the Eagle home and the type of home that you are referring to is really a retirement home, and not a home for the care of sick and incapacitated Eagles. Am I right about that?

Mr. EBDING. The one back in Florida; yes; I believe that is what it is.

Senator MORSE. It is quite proper in this session to raise all these problems of the aged because, as I say, at this point we are not limited to nursing home problems here this afternoon, although we are glad to take more testimony on that subject. While we haven't gone into this as yet in this hearing, you are certainly welcome to do so, as to the matter of what kind of a program should be developed by way of retirement homes for people with lack of economic means in order to maintain themselves fully in a retirement home. A good many of our fraternal organizations, such the Eagles, have retirement homes.

This raises a question of public policy. I cannot pass judgment on it now. It raises a question of public policy as to what extent, if any, should States and the Federal Government go into the matter of retirement homes.

Then you raise in your statement this question concerning employment discrimination due to age, which, of course, is one of the most difficult of our labor economic problems with the rapid rise of automation. We have a Federal law that Congress has passed on this matter in respect to Federal employees. There can be no discrimination based upon age, except in those classifications in which mobility, a great amount of physical exertion and activity is required because of the nature of the work and the very best of physical condition is essential: for example, the Federal Bureau of Investigation is an exception to our congressional policy in regard to eliminating age as a factor. In our hearings in Oregon, we were informed of a State law in Oregon that prohibits discrimination on age. We are also informed of a law in our State that prohibits newspaper advertisements that include this condition of advertising for labor with an age limit.

This age factor is one that bothers us very much in the legislative field because we get a lot of conflict of rights and interest. We have developed the so-called fringe benefits, and the contribution that the employer, under many of those agreements, has to make for the fringe benefits undoubtedly has had as a side effect, is a tendency on the part of many companies through their personnel management to put in an age limitation. It is understandable, but it creates very serious economic problems in a community and a resulting serious social problem.

So, this is another one of the problems for our edification which has been raised by your statement here to which some thought has to be given. I want to thank you very much for it and anything further you want to submit by a later written statement, I will be glad to receive it.

Our next witness will be Mr. Robert D. Lester, president of the Golden Age Club of Walla Walla. Mr. Lester has been a resident of Walla Walla for 31 of his 58 years. Will Mr. Lester come to the stand, please? We are glad to have you, and you may proceed in your own way.

STATEMENT OF ROBERT D. LESTER, PRESIDENT, GOLDEN AGE CLUB OF WALLA WALLA

Mr. LESTER. I feel entirely out of place in the capacity here to testify. I am here more to gain information that I can pass on to our club. So far, we are recreational solely, and I would like to release this time to someone who is better qualified to speak, and thereby gain any knowledge that I can take back to our club.

Senator MORSE. Well, we will see that the record is made available to you, but I have some knowledge of the wonderful work that the Golden Age Clubs across the Nation are doing in the field of recreation for the elderly. Of course, when you start dealing with the matter of recreation, it branches out into many other channels too. It so happens that I have a married daughter, whose husband is taking graduate work at Yale, who spends a part of each week in the Golden

Age Club at New Haven, where she conducts classes in painting and in dressmaking, and she gives me wonderful reports as to what this type of a program has done for the elderly. This goes to the testimony of witnesses this morning concerning the matter of motivation. As you know, I served as a delegate at the United Nations last fall and I made arrangements to have them take this Golden Age group down to New York in a bus and spend most of a day at the United Nations, where they were taken through the United Nations and given some lectures in regard to the work of the United Nations. My daughter told me what a wonderful outlet that was for a good many members of the club, who were quite unaware of many of the things that were going on in the United Nations.

They have a great contribution to make. A good many of your recreational programs lead into the development of hobby work in helping the aged, needlework, toy building. In fact, you would be surprised what wonderful jobs some people in the Golden Age Clubs do in connection with the culinary arts.

So, there is no reason why you shouldn't feel right at home here today to testify about the wonderful work your organization does. I close these comments by saying that you do supplement in many instances what was suggested here this morning by several of the witnesses, that there is a need for community interest in the elderly people who are in a situation where they cannot go to a Golden Age Club because they can't get away as they are incapacitated in a nursing home or in a hospital. It is also my understanding that your Golden Age Clubs are being of assistance to the nursing homes across the country. You are helping to bring to the elderly people in the nursing homes various programs that have been developed in connection with your Golden Age work.

I want to join in making this record with you on the Golden Age Club as I see no other witness on here that might testify in regard to what the Golden Age Clubs are doing, and I thought it very important that we have in Walla Walla some reference to what your club is doing. If you have anything further you want to add to any comments I have made, you go ahead and make them.

Mr. LESTER. Well, in regard to our activities, if you wish, I could make a statement as to that. We entertain patients at the Veteran's Hospital with different types of recreation. We have a cigarette fund that we distribute to all veterans. Then in our own club, we have our one business meeting per month, a recreation night every Saturday night. We have dancing. Bingo is a fun night, which is solely to maintain our own law that all funds are to pay the rent, and so forth. We have hospital visitations and some forms of recreation that the women work up themselves.

Our hall is occupied by others than the Golden Age, as we sublease it to supplement the cost of operation, but we are definitely going to look into this care of the aged because they are all interested in it, and I will take back the information from this meeting to the club.

Senator MORSE. Thank you very much, Mr. Lester. We are glad to have you as a witness.

Our next witness will be Mrs. Lillian Stegmiller of Walla Walla. The chairman has not been supplied with any information regarding

the activities of Mrs. Stegmiller, and, therefore, I hope, when you come to the witness stand, you will tell us of your interests and of your background. We are delighted to have you, Mrs. Stegmiller.

STATEMENT OF MRS. LILLIAN STEGMILLER, WALLA WALLA

Mrs. STEGMILLER. I didn't bring any material as I couldn't think of just what I wanted to say.

Senator MORSE. You just tell us what is on your mind.

Mrs. STEGMILLER. Well, maybe, if you wanted to ask me some questions.

Senator MORSE. You tell me what your background of interest is, what organizations, or what interest in the problems of the aged you are associated with.

Mrs. STEGMILLER. Well, if it's concerning the nursing homes, I think they are real nice. They're the thing we should have.

Senator MORSE. Do you assist in any of the nursing home programs?

Mrs. STEGMILLER. No, but I've been in one.

Senator MORSE. You were in one?

Mrs. STEGMILLER. Yes.

Senator MORSE. At the present time?

Mrs. STEGMILLER. This spring.

Senator MORSE. Which one were you in?

Mrs. STEGMILLER. I was in one this spring.

Senator MORSE. I see. Well, could you tell us what suggestions you have in mind in order to be of assistance to the nursing homes?

Mrs. STEGMILLER. Well, if we could have a lot of them, or if they could be run as smoothly and everybody have as good care as I had, well, I would say that that would be wonderful.

Senator MORSE. Which one were you in?

Mrs. STEGMILLER. The infirmary.

Senator MORSE. That was testified about this morning by Mrs. Kendall?

Mrs. STEGMILLER. Yes.

Senator MORSE. You have heard the testimony in regard to the matter of nursing service as provided and required under Washington laws. Did you find the nursing service adequate?

Mrs. STEGMILLER. Yes; very much so.

Senator MORSE. At some of our hearings elsewhere in the country, there has been some mild criticism to the effect that sometimes it was difficult to get as much medical service in the nursing home that some of the patients seemed to think they ought to have. Did you have any feeling or think in any way that every member of the profession provided you with all the assistance that you needed?

Mrs. STEGMILLER. Well, I think they had everything. I think they had everything in the infirmary. I couldn't praise them enough. There were lovely nurses, and it was just like being at home. A nursing home for someone elderly or with a chronic condition that can get up and go in and out of the room, and there was a nice cheerful view. It was just like home, and they are comfortable. They have their books, their bible, and sewing, and such and such like that, and we were just happy. I think it's wonderful. If they could all be like that

one out there, I think the world should be full of them. I hope that we can always have them.

Senator MORSE. I think you are a wonderful witness in support of the nursing homes. We are very glad to have you before us, Mrs. Stegmiller.

Mrs. STEGMILLER. A hospital is nice where there are new babies coming and fractures, and things like that, but a nursing home is just a little different. When they are not sick or not really down, they can go across the hall and into their neighbor, or down the hall to television, and talk and visit, and work on quilt patterns, and such, and they are contented. It's just like being at home.

Senator MORSE. Fine. I think that is wonderful.

Mrs. STEGMILLER. I got along fine and had lovely care and a lot of friends. We went to church on Sunday, and I had everything.

Senator MORSE. Well, thank you very much. We are very glad to have you come before us. Thank you.

The next witness will be Mr. Warren Ray, president of the Golden Age Club of Milton-Freewater. He is scheduled to testify at this time, but Mrs. Amy Bock, secretary treasurer, has informed us that Mr. Ray is ill. Is there anyone in the room that represents the Golden Age Club of Milton-Freewater that could pinch-hit, shall I say, for Mr. Ray?

STATEMENT OF MRS. JEAN PENNELL, MILTON-FREEWATER, OREG.

Mrs. PENNELL. Senator Morse, I am Mrs. Jean Pennell, 703 Evans Street, Milton-Freewater. Our club like Mr. Lester's of Walla Walla, Wash., is mostly recreational, but I have brought a little outline of what we do there, and the pleasures that we have at the club. If you would like me to, I could read that.

Senator MORSE. I would be glad to hear it.

Mrs. PENNELL. A small group over 50 years of age got together in the year of 1957 under the name of the golden age club, also under the supervision of a recreation agent, an employee of the city. We were never incorporated. Our members are not assessed for dues. We are sponsored by the city of Milton-Freewater. They furnish us with a place to meet and transportation. Our membership has grown to 48 members. We have lost some by death, and others have moved from our midst, but from time to time we are getting new members.

Our officers are president, vice president, secretary, treasurer, musician, and reporter, all elected by ballot in the month of December. We meet each Thursday from 7 to 10 p.m. Our funds are for coffee and other incidentals, which consist of good will offerings from our members. Each meeting night, we hold a business meeting, after which we play cards and other games, have music furnished by some of our members on a violin and piano, an entertainment committee that arranges special programs at intervals. We always have refreshments at the meetings, and hostess committees are appointed.

Along in the summer, during the hot weather, we have a picnic. We think it is a wonderful way to spend a few of our lonely hours and are very grateful that Milton-Freewater has given us this opportunity.

Senator MORSE. Mrs. Pennell, we appreciate very much this statement, and let the record so show that Mrs. Pennell is from Milton-

Freewater and has been very active in the golden age club in that community. Needless to say, I am glad to have you from my own State. I am going to supplement your testimony with the statement that we received from Mrs. Amy Bock, and a brief statement on some of the other work of your club at Milton-Freewater. You have honored me by coming. Thank you very much.

Mr. Warren Ray, president, Golden Age Club, Milton-Freewater, Oreg., was scheduled to testify at this time. Mrs. Amy Bock, secretary-treasurer, has informed us that Mr. Ray is very ill. Is there someone here representing the club? If not, we have a brief statement describing the club's activities which we will place in the record.

(The prepared statement of Mrs. Amy Bock follows:)

PREPARED STATEMENT OF MRS. AMY BOCK, SECRETARY-TREASURER, GOLDEN AGE CLUB, MILTON-FREEWATER, OREG.

The Golden Age Club, Milton-Freewater, Oreg., was organized in the year 1957, sponsored by the city of Milton-Freewater; they furnished a place for us to meet, and transportation.

We started from a small group all over 50 years of age, and now show a membership of 48 members; have lost some by death, and others have moved away, but we are getting new members from time to time.

Our officers are president, secretary-treasurer, musician, and reporter, all elected by ballot in the month of December.

We meet each Thursday from 7 to 10 p.m. For a time we were under the supervision of a recreation agent, hired by the city, until the time came when they no longer wished his services; but they still retain the sponsorship of our club.

Our members are not assessed for dues; our funds consist of a free-will offering from the members called the kitty, but we have no expense, only a little money on hand to buy coffee, cream, sugar, and other incidentals. We are not incorporated.

Each meeting night we hold a business meeting, after which we play cards, and other games, have music furnished by some of our members, on violin and piano. Have our entertainment committee that arrange special programs at intervals. Refreshments served at each meeting; hostess committee appointed.

Along in the summer we have picnics.

Our club does not consist of many who dance, so we do not dance, unless we invite our neighboring clubs, such as Walla Walla, Pendleton or Hermiston. These clubs like to dance.

We think it a wonderful way for us oldsters to while away a few lonely hours each week, and do thank our city for furnishing us this opportunity.

Senator MORSE. Our next witness will be Mr. Al Lair, representative of the Retired Railroad Workers. He worked with the Union Pacific as an engineer for 40 years and was legislative representative for one of the brotherhoods, the Brotherhood of Locomotive Firemen & Enginemen. Is Mr. Lair in the room? I want to say, Mr. Lair, that I am pleased to call you to the witness stand, because I have had some past associations with the railroad brotherhoods, as you know. I happen to be the one that handed down the first arbitration in the war in the history of the railroads of this country that provided for paid vacations, at that time and in that case, for railroad clerks. I guess you know it has spread now throughout the industry, and that was in 1941. There have been a lot of changes in the relationship between the carriers and the brotherhoods since, but I think now you would have a very difficult time finding a president of any railroad in this country who would advocate taking the same position as their counsels in 1941 in regard to vacation with pay.

I am glad to welcome you to the stand. You may be seated and testify in your own way.

STATEMENT OF AL LAIR, REPRESENTATIVE OF RETIRED RAILROAD WORKERS

Mr. LAIR. Thank you, Mr. Senator. My words are brief. As you know, Mr. Senator, our retirement is set up actually, as you said, through negotiation, and the vacations and our hospital plans. Our hospital plan is negotiated with the different railroad companies and the employees that work with them.

I just want to speak a word for our poor retired employees when they become elderly and their relatives have passed away. We are interested in adequate nursing homes, properly staffed, with care, where these people can go and be taken care of for the remainder of their years when they are unable to be taken care of at their homes or at their place of residence. That is one of the questions in the State of Washington.

I have nothing to bring up about our retirement or hospital plan because that is under Federal law, under the retirement. It's just a matter of some places within the State of Washington that I am representing our brotherhood. Some very good points have been brought out here today, and I have enjoyed listening to the discussions and the testimony, but I just wanted to let you know that we are concerned with the elderly railroad retired people in the nursing homes.

Senator MORSE. There is nothing, Mr. Lair, in connection with your railroad retirement plans or your own hospital program that would make any of your railroad retirees ineligible to take advantage of some of the Washington law in respect to the nursing homes?

Mr. LAIR. None that I know of.

Senator MORSE. Thank you very much. We are glad to have you.

Our next witness will be Mrs. Neil Meadowcroft of Walla Walla, chairman of Christian Social Action of National Board of Christain Women. Mrs. Meadowcroft attended the White House Conference on Aging as a representative of the above ward; was an advisory member of the Council on Christian Social Action, United Church of Christ; a member of the League of Women Voters, Walla Walla; and a member of the First Congregational Church. Her husband is a civil engineer in the Corps of Engineers. They have been residents of Walla Walla for 8 years and have three children, all married.

We are delighted to have you, Mrs. Meadowcroft, and may I say, as a fellow Congregationalist, I am very glad to have you come and testify in regard to the social conscience philosophy of the Christian social action of our church.

STATEMENT OF MRS. NEIL MEADOWCROFT, WALLA WALLA

Mrs. MEADOWCROFT. Thank you, Senator Morse. My interest in the problems of the aging has increased because of my attendance at the White House Conference. I went as a nonprofessional person, a delegate from the board of the National Fellowship of Congregational-Christian Women. This statement is submitted as a citizen of Walla Walla, as a homemaker who is concerned for the preservation and development of human resources. We need to find ways to utilize the abilities and experiences of older persons and to develop their latent potentialities.

I am particularly struck by our attitude toward the subject of aging. We are insensitive to the fact that what we do and become on retirement depends on our preparation during all the years leading up to it. We need to realize that education is not complete when we receive a formal diploma, that all of our life must be a learning and growing process. Our present concept of education primarily for the young dates back to the days when the life span was 30 years, and now it is 70 and on the increase. Instead of adult education being an extra added to our school system, if there is financing available, we are beginning to realize that education for adults is a must.

I am concerned that we do not have more training for responsible citizenship. In some instances, the increasing numbers of retired voters colors the complexion of a community. By resisting change, community development may be retarded. When we vote, it is no longer good enough to use the formula, "When in doubt, vote no." We need to be informed. If attitudes and interests are kept up to date, senior citizens could and would continue to be productive, contributing to the community welfare. We need to recognize that gainful employment can no longer be the sole symbol of human worth, that other activities of community value should give equal status. As Dr. E. L. Bortz, former president of the American Medical Association, has put it, "Ideally, the first career having been personal and acquisitive should give way to a second career which is devoted to the larger interest of serving the people around one."

I have read with interest the report (January 27, 1961) of your Subcommittee on Problems of the Aged and Aging, submitted to the Committee on Labor and Public Welfare by Senator McNamara, chairman. The recommendations, I think, are quite complete. I agree with the conclusion that the first priority in the field of legislation should be the provision of financing health services for older persons, whose needs have increased beyond their capacity to pay for them. It is to be hoped that the coming session of Congress can come to grips with this need. Developments in this field will be watched with interest. The recommendation to make Government bonds available for use after retirement, providing protection against cost-of-living increases, is also a very desirable proposal.

The recent changes in the FHA law, providing financing for elderly people, is a very helpful step. We also need more low-cost housing for senior citizens with small incomes. This need exists in smaller communities, such as Walla Walla, as well as in the metropolitan areas.

I agree that a U.S. Office of Aging is needed to aid in the coordination of studies by Federal, State, and private agencies, to coordinate research in the needs of the aging, legislation, housing, health, education, and so forth. The major function of the Office should be to encourage the States and local groups (both public and private agencies) to take the initiative wherever possible. As one citizen, I am glad to give encouragement to these and other proposals in your report. Thank you.

Senator MORSE. Thank you very much, Mrs. Meadowcroft. I am very glad to have your testimony. You can supplement it if you care to within the next 30-day period.

Now, we come, ladies and gentlemen, to that part of our hearing which we call the town meeting of senior citizens. This provides an opportunity for Congress to learn from the older people themselves, those with personal knowledge of the problems which aging brings, which of those problems they believe most important. From them, too, we hope to get suggestions and proposals on how we can best attempt to solve these problems.

Our committee is going to be hearing from senior citizens in every part of the United States. This is the State of Washington's opportunity here in Walla Walla. This is the time, I hope, that every one of the older people here today, who believes he or she has a suggestion to make, will make it. Then when the Congress reconvenes and studies these hearings, the views of the people of the Northwest will be given equal weight with those of other senior citizens elsewhere in the country.

Our procedure in conducting these town meetings is as follows: We will ask those who want to address the subcommittee to come up to the microphones you see down on the floor, or this other microphone if you care to sit down at the witness table itself. We will, of course, ask each individual to begin by giving his or her name and address to the reporter so that he can get it down for our official printed record of the hearings, and so that we will have the address available to us to send out to you such mailings in connection with the hearings that we think you might be interested in.

In fairness to all those who want to speak, we will ask each individual not to talk for more than 4 or 5 minutes. In case there should be more people wanting to be heard than time permits, or in case—and there always are such people—there are people who would rather file their views in writing, rather than testifying orally, you will find tables in the front of the room with some papers that you can write on, letterheads addressed to me. These letterheads say, 'If I had had an opportunity to speak, this is what I would have said." You are not limited to one sheet of paper. Write as much as you want and send it to the address on the letterhead. You will also find franked envelopes on the table that do not require any stamps. Put your comments in an envelope and send the comments to me.

Now, I want to say that these town meetings have been very, very helpful to this committee. I want you to understand that this chairman will not limit any witness to any point of view. One of the great freedoms of this country is the freedom of free speech. You don't help legislative representatives by holding unto yourselves your criticisms of what the Congress, for example, may be doing or not doing, and since you are maintaining a free government in this country, it is the criticism of our citizens of the operation that helps. It is so easy for us to overlook the truisms on the basis of which this Republic really stands, and one of those truisms is that the Government is the servant and not the master of the people. Now, here is the opportunity for you to express your views. You can tell off your Government, and that is a pretty precious right.

As you may remember, several years ago, I became involved in a controversy in the Senate because I didn't think the Senate ought to adjourn and run home just because a Russian Communist by the name of Khrushchev was coming to Washington. I took the position we

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ought to stay in session and demonstrate to him that in the United States, we can stand up on the floor of the Senate and, if necessary, criticize the Government and not be shot for it. That couldn't happen in Russia. So, you will recall that I held the Senate in session until he did arrive in town, and we did get him before the Foreign Relations Committee, and we subjected him to our own cross examination for two hours and a half, and you know, some of my critics, prior to the meeting, came up to me afterwards and thanked me because I had prolonged debate long enough to force out of the Senate a recognition of the practice of the Senate. We have done that for years. Every time a foreign visitor would come to Washington, it has been a practice of the Foreign Relations Committee to invite him before the Foreign Relations Committee for questioning, if he wants to come.

So, I mention this incident because I want you to know you have a chairman here that has no thin skin and isn't afraid of any criticism, either on himself, on the Senate, or the Government as a whole. We are dealing, ladies and gentlemen—and let's be frank about it—with one of the most controversial domestic issues that confront the Congress. Sincere, honest men and women have different points of view over what responsibility and in what degree the Federal Government has the responsibility of being of assistance to the States in connection with medical care for the aged, and I want your views. I want your views on taxation, I want your views on nursing. In many of these town meetings, the elderly people are very critical of some of our tax policies in regard to the elderly. I want your views on any facet of this general subject matter that you would like to give to me. It is up to you. I will stay as long as I can, between now and plane time, to take your views if we have that much discussion.

On the other hand, I will close the hearing just as soon as it becomes clear to me that we have exhausted the testimony that is available to us in the room.

I am pleased now to recognize the first witness. Who would like to be the first to express himself or herself on any phase of the problem of the aged?

STATEMENT OF MRS. EDA R. BURKES, TREASURER, LEAGUE OF WOMEN VOTERS, AND PRESIDENT OF AAUW, WALLA WALLA, WASH.

Mrs. BURKES. I don't know that I want to be the first one.

Senator MORSE. I am delighted to have you.

Mrs. BURKES. There were two matters on which I wanted to express myself. My name is Mrs. Eda R. Burkes, I am the treasurer of the League of Women Voters of Walla Walla, and president of the AAUW, and that is why I am here today. We have a chairman of—that is, we are supposed to have a chairman of social and economic issues, who would be here today, but she is newly appointed and I couldn't get in touch with her. So, I came in her stead to make a report.

Senator MORSE. Would you permit me to interrupt you long enough just to make this statement? Based on 17 years of experience in the Senate, if I were to be asked to name organizations that are of greatest help to us in the legislative process, in presenting to us intelligent and

carefully worked out prepared statements on various legislative issues, I would have to put the League of Women Voters exceedingly high on that list, and also the Association of University Women.

I want to take about a half a minute more. This is so important to make this democracy of ours work. I recognize that all citizens have a responsibility to make their views known to the elected officials. What kind of views? The kind of views that the league makes known. I get a lot of mail, you know, the kind of stuff, political pressure stuff that says, "If you don't vote such-and-such a bill, we'll take care of you in the next election." I throw that in the wastepaper basket. That's where it belongs, because that mail is subversive to good government. That kind of mail is blackmail. If someone doesn't have some reasoned discourse that they can present, I don't know what makes them think that any self-respecting man in the Senate is going to jump at that kind of a political threat, but I can have my vote changed by just one letter from anywhere in the United States that sets forth facts and evidence and data that I can't answer and hold with my preconceived notion on some subject matter, and that frequently happens. I change my mind in the last 5 minutes of debate if I find facts that I can't answer.

But I want to say to you, as a witness for both of these great organizations, I don't think the members of your organizations know what a constructive influence you exercise in the Congress in educating the politicians because you make a great mistake if you think we know very much about anything. We sit there as your legislative counsel. That's what we are, and we can be of help to you as your legislative counsel only if you supply us with the facts and evidence that help us reach that point where the decision we have to make is a good one. I would put it this way, on the basis of the facts presented to me: Where is the public interest on this issue? Once I am satisfied I can answer that question, I don't care what direction the politics happen to be going at the time. I do not owe it to the people of my State and my Nation to play politics with issues.

No one has ever improved on that great statement of Burke in 1774 as to the responsibility of an elected official. Paraphrased, it goes somewhat as follows, "No elected official has any right to vote certainly because a pressure group asks him to vote that way. He has a duty to vote that way if the pressure group has proved its case." It is awful hard to get across to some people, particularly who think it is important that you are reelected—and, of course, it isn't important that anyone be reelected. We could all die today, and we wouldn't be missed by the time our funeral is over, as far as political importance is concerned. What is important is that, while we are there, we follow where the facts lead. I have gotten off on this and I am going to keep still now, but I want the League of Women Voters and the Association of University Women to know my sense of gratitude toward the great help they have been to me in helping me find the facts over the years.

The floor is yours.

Mrs. BURKES. I should like to thank you for that statement. However, I want to correct any impression the group may have that I represent either one when I stand here. I am just an older citizen of the city of Walla Walla, and I am interested in two questions.

One of them is—it isn't really a question. Perhaps I should make it as a statement. I think that, when we're carrying on a program for elder citizens, that we should be very careful that we do not hurt their pride and consider them perhaps a lesser group of citizens. They have as much pride as they had the day before they retired, and often the retirement is forced upon them by company rules and regulations, or by ill health, one or the other. Neither one will make the elder citizen very proud of himself when he is in need. He has to keep what personal pride he still has. We should be careful of that in all matters dealing with the senior citizens.

There is another matter which I have hassled about for some time. There is in our country a tendency to double up upon pensions. Maybe this isn't the place to speak of it, but I haven't found the right place. I have spoken of it in a number of places and been rebuffed. People seem to think that I have peculiar ideas. I live very much as all of the teachers of the State of Washington live. I know them. I am in the same groups that they are in. I taught with them. They are the ones I belong with. When they retire now in the State of Washington, they will have two or three times the retirement amount that I am getting now, and which probably will never be very largely increased. They say, "We have paid for that." That is true. However, as a citizen, I am paying part of that. In fact, I am paying two parts of it. I am paying both their pensions, and I am getting one. Now, I see no reason why any group, and there are many of them, should be favored to the point where they get two pensions, and the others only get one. It's a class division which I don't like. They don't need any more than I need, if it's a question of the basis of need. They don't need any more than I need because I live very much as they do, and many of them are my closest friends, and I wouldn't for the world hurt them.

But couldn't this problem in some way be approached and solved? It is a problem. I know people in this town, very lovely women, who are trying to live on $80 a month, and you and I know they can't possibly do it and maintain their self-respect. When I brought that up in a subcommittee of the chamber of commerce 1 day, 2 or 3 years ago, where a man was speaking who knew about these matters, I was told that what we should do, if our social security was not sufficient, was to make application for welfare. Now, that is what I mean when I say we should help these people keep their self-respect.

I know there are many people who need to ask for welfare, but are they considered the cream of the crop? Are they considered to be the people who have managed to keep this Government operating in our economy? Are they the retired people who are on welfare? Is that the way it should be? If we need to give people money out of welfare to augment their social security, why don't we give the social security through State welfare? Now, that is just a question which probably comes out of my utter ignorance, but it's a matter of great importance and means a great deal to me, and, believe me, I am not the only one. I may be the most vocal, but I am not the only one that wonders about it. I believe that that is about all that I have to say just now. Thank you.

Senator MORSE. That is a very helpful contribution. You raise one point here in regard to welfare. To give you one type of problem that we have to deal with when we consider any legislative changes, we have learned through these hearings that in some States—it happens to include my own, I'm sorry to say—that, when this seemingly modest and inadequate social security benefit was passed this last year by the Congress, some States reduced their welfare payments accordingly to a similar amount, and this means that someway, somehow, there is a need for effective Federal-State discussion in this matter to see if we can work out some understanding with the States as to what the policy is going to be if the Federal Government recognizes there is a need for some change in social security payments. They find out that the Federal Government has increased it by "X" dollars, and the State government decreases it "X" dollars.

We have another type of problem in connection with Federal employees that we will go into in the hearings that we are going to have in January. I happen to be chairman of the subcommittee in the District of Columbia that has jurisdiction over this program. In fact, I receive more mail on social security problems than any other issue and have for years, but recently—oh, it was over a year ago now—there was an increase in the Federal pay scale, and very, very shortly after the increase, which makes it a remarkable application of coincidence, which always interests me, Blue Cross raised its rates in the District of Columbia, and I was amazed by these complainants of the remarkable coincidence that the increase in the pay of the Federal employees should bring about so suddenly an increase in the Blue Cross rates. I am a good enough lawyer to know that you have to get your facts, and so I am giving the Blue Cross an opportunity to present its facts in January in regard to this matter.

Who will be our next witness?

STATEMENT OF JAMES E. MORRIS, WALLA WALLA

Mr. MORRIS. Senator Morse, my name is James E. Morris, and I live at 105 Spokane Avenue. I am a member of U.S. Veterans of World War I, and I am a disabled veteran, drawing disability and social security, and I am nonservice connected.

First of all, I want to thank you for your undivided support to us World War I veterans and our social security, and I, for one, believe that the aid to the aged should go under social security.

One other thing I would like to mention is that—I guess it's water under the bridge now—when I first received my social security, for some 16 months, as you know, under disability, my pension was taken from that social security. Now, since this administration started, they seem to want to get money into circulation, and I still feel that the social security owes me for some 12 to 14 months and $60 was taken off right to start, and I wrote to Senators Jackson and Magnuson on the question, and I merely made mention about it, and I believe that's all I have to say. Thank you.

Senator MORSE. I am glad to have this testimony. To make sure I understand the question that you raise, I asked my counsel and he shares my view that what you really raised was a requirement for a

legislative change of an existing law. I am glad you mentioned it, and it undoubtedly is going to be one of the issues that this committee is going to have to consider in making its final recommendations to the full committee, and I can just gather the evidence here and present it to the committee.

I have just been told by Miss McCamman here that Mr. Arthur Farber, who is the able director of the Jewish Family and Child Service of Seattle, Wash., was scheduled to attend today, but was unable to attend because of some emergency which confronts him in Seattle, but he sent a very penetrating statement with reprints of articles he has written in the field of care of the aged, and I will now rule that this material is made a part of the official record at this point.

(The prepared statement of Mr. Farber and the articles referred to above follow:)

PREPARED STATEMENT OF ARTHUR FARBER, EXECUTIVE DIRECTOR, JEWISH FAMILY AND CHILD SERVICE, SEATTLE, WASH.

I am genuinely sorry that agency business will not permit me the opportunity to accept your invitation to appear before the hearings of the Subcommittee on Nursing Homes of the Senate Special Committee on Aging on November 10 in Walla Walla.

In regard to your request for a brief biographical sketch, just prior to my current position as executive director of the Jewish Family and Child Service, I had been director for the past 5½ years of the Caroline Kline Galland Home for the Aged, a nonprofit Jewish nursing home. Prior to this position I had specialized in work with older people, having been supervisor for 4 years in the services for the aged division of the Jewish Community Service of Long Island. I am a graduate of the New York School of Social Work of Columbia University (M.A. 1941) and hold an advanced degree from the University of Pennsylvania.

I am enclosing a reprint of an article which I wrote on noninstitutional services for the aged which touches on some of my past experience in this field, as well as being an indicator of some of the work that the Jewish Family and Child Service of Seattle may be undertaking in the near future. Incidentally, our family agency has just applied to the Family Service Association of America Project on Aging to be one of the selected agencies for demonstrating the development of counseling services to the aged as well as initiating a foster home program.

I am enclosing six copies of a reprint from the Journal of the American Geriatrics Society entitled "Medical, Nursing, Recreational and Personal Adjustment Programs for a Small Institution for the Aged and Chronically Ill," which will give some background and information about the program with which I was so closely associated in the nursing home area.

Presuming that your interest is primarily in relation to my observations regarding nursing homes, may I offer some of the following ideas:

It seems to me that facilities for the care of the chronically ill and emotionally disabled need altogether much more adequate programing and financing.

The publications put out by the Senate Special Committee on Aging regarding the condition of American nursing homes is, I believe, a thoughtful and adequate survey of the problem.

An observation about financing is that a much more effective pattern might be that which I understand was adopted in the State of New York for nursing homes, or that which we have here in the State of Washington in relation to public payments toward hospital care. As I understand this, homes which meet certain criteria, such as having specialized personnel, like occupational therapists, trained social workers, etc., may be eligible for the top payments for care from the State, i.e., say $250 or $275 per month. Should such a home offer such a program and in addition, supply audit reports of expenditures indicating that

they were actually spending at the maximum rate or beyond, then such a home would be eligible for the maximum payments.

I think we now find the anomalous situation of commercial nursing homes getting the class I rate in the State of Washington of over $190 per month wherein the actual amount of care given may be less than that given to a patient in a lower paid category and wherein a particular home's costs may actually be less than they are being paid by the State department of public assistance.

In other words, there needs to be some incentive, some premium given rather than penalizing better programing and improved services.

The provision of food, shelter, fire precautions is simply not enough. It is essential that positive and preventive programs of medical care, nursing care, and the provision of auxiliary health services, such as occupational therapy, physical therapy, social service, including casework and group work, be incorporated into programs of care.

Of course, one cannot look at nursing homes by themselves because otherwise, they can all too readily become dumping grounds in lieu of the absence of a broad spectrum of community facilities and services. Just this morning, a visiting architect from Sweden, Mr. Bo Boustedt, conducted a public meeting and lecture about homes for the aged in Sweden and there is much we could learn from that country's experience that may be applicable to our situation. Communities need to develop home helps or home care in order to help old people to stay on in their own homes in the community as long as possible. Additional low rent housing for the elderly needs to be developed so that again people can stay on in their own homes. Adequate maintenance must be provided from the public assistance agency and better still, social security coverage should be extended. I believe that medical care including coverage in nonprofit homes for the aged and in nursing homes under social security is must legislation when the Congress meets next year. Substitute housing arrangements, such as foster homes for the aged, boarding homes and homes for the aged with adequate programs need development. Facilities for the care of the chronically ill and then hospitals for acute conditions or the surgical procedures needs to be available. If you do not have this broad availability of services in a community, then any one of these facilities, such as the nursing home, can become a catchall.

Another area of concern is the way in which patients may get caught up in the bureaucracy of large separate departments. For example, the department of institutions runs the mental hospitals in this State, and the State department of public assistance pays for care, for those who are eligible in nursing homes. It costs the taxpayers $165 a month to care for a mental patient in the State hospital today, while placement in a nursing home as a class III patient might cost around $130 a month. If many patients were to be discharged, this would increase the budget of the department of public assistance. While the latter department might be very ready to give the necessary help, often this service is under attack or pressure from certain groups in the community who take only the narrowest kind of interest in what happens to older people in need of care. An approach may be used which looks to the immediate goal of reducing expenditures in a very compartmentalized fashion. We must relate to the question of what is best for the patient, rather than what is most convenient for each department or institution or agency.

The reality of and the public image about nursing home care needs to be changed. Because most nursing homes are so inadequate, because they offer so little in rehabilitation and become merely custodial institutions, people develop negative attitudes toward them. The unpleasantness associated with these institutions gets carried forward unconsciously into a pushing away attitude in which the community develops guilt feelings that get reflected in a desire not to support these unpleasant places. Communities need to be educated, not only through the negative impact of disastrous fires and neglectful conditions, but to a positive awareness of community responsibility, for a condition which all may need to face someday in their lives. At a point in time when our Nation's productive capacity and economic wealth is greater than it has ever been, humane and positive care of our aging is a priority which demands and deserves community and public support.

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BY ARTHUR FARBER

Noninstitutional Services for the Aged

THE FACTS ABOUT the growing rate and numbers of our aged population, and the ways in which our American industrialization have created changes in the three-generation pattern of family living are by now familiar to all social workers. They have drawn attention to the need for new approaches, new programs, new services for the aged. Noninstitutional programs have been born not because of some ideals dreamed up by social work "eggheads"; rather, solutions outside the institution have been sought because the cost of hospital care has mounted to astronomical proportions, because of overcrowding in homes for the aged.

Before examining the specific types of services that are possible in community agencies, we should remind ourselves that no one resource will provide all the answers. At times we tend to become overexcited about the effectiveness of a particular service, and replace the previous pessimism about work with older people with a "bandwagon" approach which engenders false optimism. Those who have witnessed the thrilling things a day center or Golden Age Club can do in transforming a group of people and literally returning them to living have endowed this group work and recreational service with the magic of being "the answer." There are enthusiasts for foster homes for the aged as a means of allegedly replacing the institution and providing the "ideal" living arrangements for all older people. There are enthusiasts for home care programs under hospital auspices.

However, what appears most important is the need for over-all community planning and co-operation among public and private agencies. More than one community has had all the component parts of a good plan —but did not put them together.

Historically, practically the only service offered to older people by the community was its institutional program with the community salving its conscience by depositing its more dependent, feeble aged in a home for the aged. With the new developing clinical and rehabilitative approach, some now see the home as the center of all activity for the aged.

The home for the aged is no longer the exclusive and removed place on the outskirts of town that it used to be. It is becoming one of a network of resources in the community designed to meet the spectrum of needs of older persons. The institution is gaining definition as a social agency which provides a protective environment for those aging individuals who for physical and/or emotional reasons are no longer able to live by themselves or with their families. The home (as a basic part of its program) attempts to provide individualized services, and an opportunity for each resident to live as independent a life as may be possible within the limits of his capacities and the congregate living situation. Persons now being admitted into homes are generally

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ARTHUR FARBER, M.S.W., *is director of the Caroline Kline Galland Home for the Aged, Seattle, Washington.* *This paper was presented at the Western States Regional Assembly, Council of Jewish Federations and Welfare Funds in January 1957 in San Francisco, and is based on the author's previous experience as associate supervisor in the Services for the Aged Division of the Jewish Community Services of Long Island.*

a sicker and older group than before. The function of the home and its services necessarily needs to keep pace with this change in the characteristics of its population by providing not only for the ambulatory healthy group but for the chronically ill and mildly emotionally disturbed as well. It follows that increased attention needs to be devoted to the development of medical, nursing, and social services in the institution.

In many communities new institutional facilities have been built. The most frequent pattern, where an adequate number of beds exist, is for almost total reliance on the institution for aged and/or chronically ill care. There are instances where there are not enough beds or where there are not provisions for the specialized care required by those in need of medical and nursing services. Oddly, there are even examples where a community may have too many beds.

Social agencies share the basic responsibility to find the ways and means to help more older people stay on in the community. It is a fallacy to believe that all the problems can be effectively resolved through the institution. In fact, some problems are created by persons who go into the institution and who do not require this specialized type of resource. Most people have not been accustomed to living in group situations and when they grow older, if they knew of ways of being able to manage, would prefer living in circumstances more like those they have known.

One of the traditional roles of the family agency has been that of demonstrating a service by means of a so-called pilot project. The voluntary agency can hardly justify itself in duplication of services available elsewhere in the community, nor can it realistically meet mass need. Dr. Hinenberg, medical care consultant of the Federation of Jewish Philanthropies of New York says that, "Services under governmental auspices are the foundation for all voluntary philanthropic services in this field. The needs of many people will be met only by governmental financing of services. The conditions of public agency service also affect voluntary agencies. Boards and staffs of agencies should give continuous attention to standards of public agencies and to legislation affecting health and welfare services." [1]

States such as New York and California have pioneered in giving community leadership to planning for the aged. Recently Pennsylvania has been taking action on an over-all program that sounds quite interesting. We are informed that they are stimulating local community planning to "Provide a constellation of programs for aging people designed to prevent or postpone the deterioration which requires institutional care," and "to establish devices for further discrimination in the use of institutions." "The chief impact of the Department program, it is hoped, will be to stimulate local communities to develop homemaker and other noninstitutional programs to assist aging persons to continue in their own homes, those of their relatives, or in boarding homes. Such a program will not only help prevent personal deterioration of the individual, it will also lighten the growing burden of expense resulting from the greater and greater load that is being placed on the facilities of mental hospitals, nursing homes, and domiciliary and convalescent institutions." [2]

WIDE RANGE OF SERVICES POSSIBLE

Let us now look at some of the services that other communities have found to be helpful in dealing with problems of older people.

[1] Morris Hinenberg, "Community Responsibility for the Chronically Ill." Address delivered at the General Assembly of the Council of Jewish Federations and Welfare Funds, Inc., Chicago, November 1955 (unpublished).

[2] *Aging: A Community Responsibility and Opportunity*, Department of Health, Education, and Welfare Publication No. 26 (Washington, D. C.: U. S. Government Printing Office, 1956).

No agency needs to take, intact, the demonstrated services of other agencies, but there is value in examining critically what the special needs are for one's own community, and what an agency is ready to invest in terms of work and money. Should these services be given under the auspices of the home for the aged, the hospital, the private, or the public agency? The answer is, of course, that they have been given in a variety of settings. Each community has to decide which agency can best sponsor a particular service.

We can with logic point to the traditional function of the family agency as dealing with the preservation of life in the community and, also, practically speaking up until now, casework skill has for the most part been located in this setting. Casework know-how can be, and is beginning to be, purchased by institutions. There may be some genuine advantages in the built-in integration of services when one agency—the home—has responsibility for both intra- and extramural services permitting an easier flow of clients back and forth between institution and noninstitutional service in accordance with the client's real need. But whether the family agency or the home for the aged sponsors such programs is really less important than that such a service be developed and made available in many more communities than is now the case.

Noninstitutional services have been developed and provided for by differing professional and nonprofessional personnel. Sponsors of programs have included public agencies, private voluntary agencies, communal organizations, and commercially run ventures. A random enumeration of some of what has been done would include hospital home care, group work and recreation programs, residence clubs and boarding homes, geriatric diagnostic centers, and other programs which virtually cover every aspect of aging, employment, health, housing, recreation, and education. In this paper we shall consider the battery of services possible in the family agency.

Family agencies are seeing more and more aged clients, and are offering such services as counseling, homemaker service, foster care, employment counseling, skilled referral services about other community resources, group counseling, psychiatric diagnosis and treatment, friendly visiting, family life education, and direct financial assistance for specialized needs.

The Jewish Community Services of Long Island, a multiple-service family agency on whose experience this paper is based, found that specialization has demonstrated not only more quantitative help to the aged, but has provided a qualitatively more effective service. Because of the prevalent negative attitudes toward the aged, some form of departmentalization appears to be necessary if the aged client is to obtain the service he deserves. We all know instances in the undifferentiated agency where older persons have been served and well. However, the trend in most generalized family agencies is to shunt aside the older client by giving him to the student as the "easy" case; or taking too literally the presenting request for service; or not following through as one might with a client whose situation appears more interesting or urgent. Because of shortage of staff, clients may be in competition for the worker's time and marital or parent-child problems may have more appeal to the worker—the social worker, unfortunately, is not immune to the elder-neglecting virus which is widespread.

HOMEMAKER SERVICE

In the search to find ways to help the aged stay on in the community, homemaker service is an important one in the battery of approaches. It is a combination of practical nursing and housekeeping service sensitively administered by the caseworker of the agency to enable a family or a single person "to keep the home fires burning." A couple comes to mind, recent applicants to a home for the aged, who really would have been much happier if they could have had such a service as this and could have

kept up their own apartment. The woman, in her middle 70's, was finding the job of shopping, cooking three meals a day, and cleaning her apartment physically more than she could stand. She had one married son but her daughter-in-law, try as she could, was overwhelmed herself with the task of raising four small children on a very moderate income. The older couple's income from social security and a small old-age assistance supplement from the public agency enabled them just to get by. This hardly allowed for any kind of domestic help, let alone the kind of understanding assistance that could help the older woman gracefully and partially relinquish some of the arduous aspects of her housework that had come to symbolize her reason for living.

It was felt that a complete separation from all that was familiar to her—and entry into a home for the aged—would be killing to her, and that homemaker service would be a better answer. Homemaker service, even over a long period of time, need not be continuous or full-time care; the homemaker may be needed for only half-days, perhaps only two days a week. It certainly is a less costly and more effective way for some individuals to stay on in the community.

COUNSELING SERVICES

Counseling services for children and parents, for husbands and wives, and for older persons are not new—family agencies have been giving these services for years. There was a time when the voluntary agency seemed literally to control the lives of a large group of families for a long period of years. Then the pendulum swung to giving short-time focused services in connection with such problems as emergency family assistance, help to new Americans, and so on. Somehow, work with the aged was not considered much of a challenge, perhaps because there is something about these later years that seems to make us retreat both personally and professionally. This was a phase of life we had not gone through ourselves, as contrasted with childhood, and we could not quite understand how it felt. Or if we tasted its bittersweet flavor, we were equally repelled, since there seemed no satisfactory approach or answer.

We know now that counseling can directly help older people and also help the younger people with the burdens and responsibilities of caring for aging family members when that becomes necessary. There are many in the community who are faced with the problem of where the aged widow or widower should live. Regardless of place, there are poignant difficulties of interpersonal relationship between adult children and aging parents. Many an older person or adult daughter or son may be locked in an unhealthy conflict for an unnecessary number of years. If they could use the services of the family agency's counselor, they might be helped in arriving at more satisfactory relationships.

PRIVATE RESIDENCE PROGRAM

Foster home placement for the aged, as its popular name indicates, is borrowed from the child placement field and has proved to be an effective way of helping older people stay on in the community. Because the aged are not children, the preferred term is "private residence program" and describes the provision of a substitute family living arrangement. The aged person has the privacy of his own room, takes his meals with the family, and shares in the privileges and responsibilities of family living. This is no cold rooming or boarding arrangement. The resident, as the client in placement is called, becomes a part of the household, is included in the social life of the household, uses the living room, TV set, and telephone, and contributes of himself to the life of the family. He may have relatives and friends visit. He may come and go as he pleases, participating also in the life of the community as he has until now. In addition to the direct services provided

by the residence owner, the agency's core service is the help given by the trained caseworker who helps make this plan really work—through administering the financial aspects of the plan as well as helping with the relationships with adult children and the residence owner. Important, too, is the provision of a medical preventive and treatment service under the agency's sponsorship.

The private residence program can serve a number of purposes. It can be used as an interim resource for those who may be on a waiting list of a home for the aged; it can be used as a temporary plan if a family is incapacitated by illness or wishes to take an extended vacation; short-time placements during holidays have also been successful. Primarily, however, foster care is an effective plan in itself for a way of life that is most satisfying, psychologically, to some individuals.

The private residence program for the aged has not yet been tried out extensively on a national scale—the contention is that in intermediate-sized cities it is not a workable plan. However, instances could be cited of unsuccessful ventures in large cities as well! Those who have seen the program work are convinced it can be done elsewhere. In addition to conviction and skill, one can profit from the experience of pioneers in this area, and thereby avoid some of the mistakes that they made. There is an available, though small, body of literature for study and reference.

It is not easy to establish and make a private residence program work; something more than generic casework skill and knowledge is required. Direct experience in foster home care of children may be of help. However, too facile analogies have been made to show how "orphan asylums" gave way to foster home placement, with the intriguing possibilities of its being a cheaper way of handling the problem. But it looks glamorous only on the drawing board—implementation is another thing! The casework process of finding homes and helping the aged with their ambivalence about a new service is a slow and painstaking thing.

Home finding. The motivations for becoming a private residence owner may be many but the agency recognizes two primary factors: financial remuneration and a genuine interest in and feeling for older persons. At the beginning, newspaper advertising was the source of finding homes, with very few selected from many inquiries. Subsequently, referrals came from the community. Out of the experience of what proved most helpful the following requirements were established for private residences. (1) The family must be Jewish (this was a Jewish agency). (2) The family must have an independent income for its own maintenance—verification of this is requested. In other words, they cannot be wholly dependent on this payment. (3) The applicant must be ready to be interviewed in the agency office and file an application. (4) The family must show readiness to allow the caseworker to visit the home and to interview other members of the family regarding their feeling about taking in an aged person. (5) Medical verification by applicant's own physician of physical capacity to care for another person, including freedom from communicable or contagious conditions. (6) A private room must be offered. (7) Both dietary needs and special diets must be offered. (8) Readiness to care for the older person during acute illness—the way one would attend to a member of the immediate family—is needed. (9) Extension of socially accepted hospitality toward client's family and friends is another expectation. (10) Readiness to supply basic necessities such as soap, linen, and use of telephone is required. (11) Readiness to work with the agency and to accept supervision and help is also a basic requirement.

DEVELOPING THE PROGRAM

Most new social service programs require two or three years to develop and demonstrate what can be done; this is particularly

true of foster care for the aged. Potentially good foster homes are hard to discover. A great deal of casework time goes into the sifting out process and then it takes time to develop and train—so to speak—residence owners to an agency's expectations and way of working. Since a matching of resident-residence owners is done, there may be a fine home that is accepted, for whom there may not be a prospective resident because of its special characteristics.

Another time factor is that while it takes a minimum of six to eight weeks to effect a placement because of the ambivalence of the applicant, it may take as long as six or nine months to complete. Some persons have dropped out only to return a year or two after initial exploration and consideration of the service. To the social worker and the agency who are new to the program, this lag may be quite anxiety-producing and frustrating and may result in a premature withdrawal and rationalization that the program does not and cannot work. It may be helpful to know that Adult Home-Finders and Counselors, a commercial, professionally staffed agency found that it took more than two years to get going before their work load became heavy. (Incidentally, here is an interesting area for the private practice of casework where the preparatory training of social work seems altogether appropriate.)

It seems elementary that people are not going to request a service they do not know about. Obviously, too, new services need publicity in order to become known. Once the service is available, then people can make use of it. Proposals for studies to demonstrate the need are apt to be misleading and academic for, in such a new venture as foster care of the aged, it is the supply which creates the demand and not vice versa. Also, the demand for this service will not come as an automatic response to the fanfare of launching and setting up the program, but the tested and successful experience itself has a way of bringing as many referrals of both prospective residents and residence owners as all the other sources of referrals combined.

We have sketched in a number of non-institutional services for the aged that have been successfully demonstrated. The reality is that few of these types of services are as yet available in most communities. Helping the aged to meet its pressing needs deserves the highest priority on the social planning calendar.

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MEDICAL, NURSING, RECREATIONAL AND PERSONAL ADJUSTMENT PROGRAMS FOR A SMALL INSTITUTION FOR THE AGED AND CHRONICALLY ILL*

ARTHUR FARBER, M.S.†

Caroline Kline Galland Home, Seattle, Washington

The Board members and the administrator are the people who carry the responsibility for the nature and character of an institution for the aged. The level of service, the quality of the programs and the standards of the home which they direct are dependent upon their basic understanding of the function of their agency in a changing society (1, 2). This appreciation of the needs of the aged people whom their agency is designed to serve is reflected in the provision of the means and leadership necessary to sustain and nourish an effective institutional program.

THE INTRODUCTION AND COST OF NEW PROGRAMS

This paper deals with the medical, nursing, leisure-time and personal adjustment programs in an institution for the aged and chronically ill. Such programs were either minimal or unheard of a generation or two ago, yet today they are practically the justification for the existence of homes for the aged. Not so long ago, the medical and nursing programs were appendages, and they gradually became attached to the home by necessity rather than by design. Even today, recreational and personal adjustment programs are often regarded as frills, and have to be especially underwritten by specific gifts or bequests, or else conceived as "running themselves" through unsupervised volunteers, or by a resident who has had some recreational experience.

The transition of the institution for the aged from a domiciliary and custodial form to a social agency for the care, treatment and rehabilitation of the chronically ill and those in need of protective care, has become more and more of a necessity in every community. This does not make painless, however, the changes that have, and should take place. There are a number of instruments for this change, and the pattern in each community will vary according to its own local and particular situation.

Whenever any institution has been in existence for a long period of time and has developed a history and tradition of its own, it has built-in machinery for its own perpetuation. Persons in power have developed a stake in what they have helped to create to the best of their knowledge and capacities, and the product of their work may have served its function well, until changing circumstances posed new necessities. There may also be a tendency to glamorize and idealize

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† Executive Director, Caroline Kline Galland Home.
Address: 7500 Seward Park Avenue, Seattle 8, Washington.

past accomplishments. This does not mean that we should discard what was valuable in the past and may still be useful. In any event, there is bound to be resistance to the new, not alone because it may supplant the old, but because the new is apt to be more costly. In some ways, it may be much easier to start a completely new institution than to go through the metamorphosis of an old one.

Usually, the change receives its impetus from the developed awareness on the part of Board members for the need to provide the newer types of service. The Board's understanding is helped along by either the central planning body in the community, or the national standard-setting agency. The first step may be for the local institution to request that a professional consultant make a survey of existing programs and offer recommendations. If the pattern in the institution for the aged has been that of a lay Board's direct management of the home, with the use of a matron, superintendent or housekeeping couple, the next most fundamental step in advancing the standards of the institution is the employment of a professional as executive director. The employment of this person, who should qualify as a trained social worker or hospital administrator and who should accept and like older people, is perhaps one of the most essential and crucial responsibilities of the Board.

It is in the employment of the administrator that conviction about the institutional purpose becomes so essential. Not only will his salary have to be higher than that of a matron, but it will be necessary to professionalize and raise the standards of all personnel employed by the institution. Salaries are likely to rise from less than 50 per cent of operating costs to between 60 and 75 per cent, and total costs will also increase.

There may be compensating factors in the increased cost of salaries (aside from humane values and the nature of the care provided). For instance, income may be increased proportionately. Most Jewish homes for the aged receive 70 per cent of their income from payments for services, equally divided between public and private sources. Some homes may not have been availing themselves of public payments. Generally speaking, with the rendering of more specialized service, homes may charge more and thus receive more income. It is noteworthy that in the State of Washington, monthly payments are made as follows:

Group I (heavy nursing care)	$192.00
Group II (moderately heavy nursing care)	$157.00
Group III (moderately light nursing care)	$127.00
Group IV (light nursing care)	$102.00
Board and Room (domiciliary)	$ 68.00

Thus it may be possible, because of these incentive payments, to hire a better qualified and more adequate nursing staff at perhaps no greater net cost.

The administrator plays a decisive role in implementing and putting into practice the evolving policies which the Board formulates. Clarity of purpose and a desire for a fine program of care are most important, but translation from the blueprint stage to the working stage requires skills and knowledge in the field of gerontology and the capacity for attracting, coordinating, supervising and

training a large staff of persons with diverse disciplines and job classifications. It is not enough to employ a good physician, nurse and social worker; they must learn to work together as a team. A good chamber-music ensemble is much more than a group of virtuosi who may not be able to subordinate themselves appropriately. The administrator is responsible for helping to create an atmosphere of understanding, and the development of constructive staff attitudes. In the care of the aged, let us not forget that the client has more hours of contact with the nurse, the waitress, the maid and the janitor than with the supervisory personnel. Unless these employees are selected and trained to understand both their jobs and their attitudes toward the client, good care cannot be rendered.

Among the factors involved in the everyday management of a home for the aged are the following: admission policies; relationships with other agencies serving the aged, particularly the family agency; nursing and medical programming; the use of casework and psychiatry within the institution; problems concerning emotionally disturbed persons and so-called borderline cases; leisure-time activities; and the relationship of the voluntary institution to the level of public services.

ADMISSION POLICIES

Every social agency, in order to operate effectively, should have a defined policy, know its function, and act upon it. There are so many unmet needs of the aged that an institution cannot make up for all the lacks in the general community. If the institution continues to attempt to meet all of the needs for care of older people, it will not only be failing in this endeavor on its own grounds, expanding beyond what it should do, but will be retarding the development of other services by other community agencies. Balance in this respect is necessary. Asking for a definition of agency function is not a request for a rigid set of authoritative rules. A home for the aged should be an adaptable, flexible agency related to the needs of clients with various degrees of emotional and physical impairment.

An institution for the aged must work out its own definition of what it can and cannot accomplish, and who belongs in it and who does not. Such a definition might be: To serve those older persons whose physical condition or social and emotional circumstances necessitate a protected environment, and for whom a non-institutional plan would not be appropriate.

A home for the aged should consider the admission of applicants in the following groups: 1) the healthy ambulatory aged needing protective care; 2) the chronically ill needing long-term, but not hospital care; and 3) the bedfast and infirm needing intensive nursing care. With regard to any of these categories, the home needs to assess its equipment, staff and finances to see if it can provide the appropriate service. It may, for example, assume some responsibility for those who are bedfast and infirm to the extent that it will look after persons who enter under categories 1 and 2 and subsequently need infirmary care, though it may not be ready to offer infirmary service to new applicants. With sufficient under-

standing and planning and as the necessary physical facilities become available, expansion of service to such a bedfast group may eventually be possible.

In general, a home for the aged should not accept following groups: 1) those who do not have the capacity to make their own decisions about coming into the home; 2) those whose limitations require custodial care in a total way, and who are unrelated to their environment; 3) those who do not have the emotional capacity to accept the necessary minimum of medical and nursing supervision; 4) those who may be detrimental to themselves and others; and 5) those with communicable diseases. One can readily see that to administer such policies, it is necessary to acquire a thorough knowledge of the applicants in advance. To obtain a perceptive and confidential social history that can at the same time be constructive and helpful to the applicant, requires the service of professional case work. Institutions which are large enough, and in which there is sufficient understanding of the value of such a program, usually employ their own social case workers to make their admission studies. The smaller and intermediate-sized Jewish institutions, for example, are usually able to work out arrangements with the Jewish Family Agency for this necessary service. When no professional person is employed by the Jewish Family Agency, a working agreement may be sought with the non-sectarian family agency.

Professional studies regarding admission policies are usually presented to an Admissions Committee of the Board. Every Board should ascertain whether an effective professional admission policy is part of its operating procedure, both for the benefit of the client in arriving at a decision regarding entry, and for the protection of the institution.

RELATION TO THE FAMILY AGENCY

There are many non-institutional services which the existing community agencies should offer to the aged, both on a preventive and on a treatment basis. The institution should not be the sole resource or the "catch-all" for every aged person requiring special service. Group living is alien to most people, and good service in an institution is far too costly to be given in undifferentiated fashion. The family agency, the public agency and the hospital extension program help aged people to remain in their own homes through such means as homemaker service, foster home programs, home care and meals-on-wheels, all of which have an important place in the group of services for fulfilling the unmet needs of the aged (3). The liaison and working relationships between the institution and these other agencies, therefore, become vital factors in enabling a community to plan on the basis of the clients' needs.

Although each agency should contribute vigorously towards its goal in meeting present needs and should participate with the central community organization in planning, the initiative and the overall perspective can best be supplied by the latter agency (4).

NURSING AND MEDICAL SERVICE

Nursing service

Even after exclusion of the persons who are too sick to be served in the institution and the persons who are well enough to remain in the community, there is still a broad spectrum of clients ranging from the ambulatory to the bedridden. An important document in giving the picture of trends regarding the medical care of residents in Jewish Homes for the Aged can be found in "Organization of Personal Health Services in Homes for the Aged" by Goldmann and Deardorff (5). The trends are unmistakable in terms of the increasing quantitative and qualitative employment of nursing personnel. The nurse, perhaps more than any other single employee in the institution, has most contact with the client. In the smaller institution, the charge nurse is not only responsible for her own staff of licensed practical nurses and nurses aides, but frequently acts as the assistant administrator, and she is one of the key persons in maintaining a program of high standard. It is invaluable to have as the supervising nurse a woman of maturity who is interested in and dedicated to the care of older people. She must be able to accept aged persons and to be challenged by the problems they constantly present. She is like a barometer or Geiger counter in spotting and referring problems to the physician. She must appreciate what the doctor has to offer and he, in turn, must be sensitive to her point of view when she calls his attention to the symptoms and health status of the patients.

Nursing service is needed not only by patients who are assigned to infirmary beds, but by practically all residents in one form or another. In our Home, for example, 39 of our 40 residents are classified according to the state standards as being in need of some form of nursing home care. Currently, up to 50 per cent and more of residents in Jewish Homes for the Aged require intensive medical and nursing care. There is no doubt that as the proportions of such residents rise in homes—and this is decidedly the trend—costs of medical care will increase (6). Whereas some patients require intensive care because of incontinence or almost constant supervision because of mental confusion, most others require nursing help by way of administration of medications, washing and personal care, and some assistance with feeding.

The Council of Jewish Federations and Welfare Fund made a study of 70 Jewish homes and found that the average number of nursing personnel compared to residents was about 1 to 5, although the variation was large. There were as many as 25 to 30 nurses assigned per hundred beds. It was suggested that the highest ratio be taken as a potential guide.

Medical service

Good medical programming is essential in the care of aged persons in institutions. Medical care must be preventive and continuous, rather than symptomatic and occasional. In cities where homes for the aged exist along with a hospital or other hospital facilities, there should be a close liaison and relationship with these institutions, as there is obviously much advantage to be secured by such an arrangement.

Our own Home in Seattle has had to improvise and work out a program for itself which appears to have many advantages. A medical policy committee was established, consisting of 5 physicians representing the following specialties: internal medicine, general practice, urology, surgery and psychiatry. This representation of specialties is not inflexible. These men were asked to serve because they are respected, experienced practitioners in their own fields. Their basic job is to help shape and evolve medical policy. There is also a paid rotating panel of 4 physicians who are specialists in internal medicine, each of whom acts as the staff physician for a period of four months; thus, each turn comes again after sixteen months. The staff physician conducts a medical clinic for about an hour and a half to two hours, two mornings a week. He is also on call for questions and consultations from the staff, and in case of emergency. He conducts all physical examinations on applicants, and makes semi-annual and annual medical check-ups for the residents of the Home. Every two months, a chart-rounds breakfast meeting is held, at which the 4 staff physicians are present together with 1 member of the medical policy committee. The staff doctor on duty presents the cases of one-quarter to one-third of the residents in the Home. The discussion about the patient's condition is lively and informative. It enables each doctor to keep in touch with the medical status of all of the patients, even when he is not on service, and it provides each of the physicians with the professional opportunity to share his colleagues' opinions about diagnosis and treatment. It has made the care of our patients more interesting to the physician and has enabled the patients, in turn, to receive a higher quality of service.

In our Home, the great majority of our residents are receiving Old Age Assistance. The state has worked out certain drug formularies, so that the team composed of the physician, the charge nurse, the administrator and the medical policy committee has a simplified job to perform in this area—that is, to use these formularies in the most constructive fashion. Recently, through diligent work with our physicians as well as with some of the state authorities, we were able to effect an arrangement whereby the state will pay for some items that are not listed in the formulary. Additional necessary drugs are also given in order to furnish the very best of medications and treatment for a patient's condition.

The physician's attitude toward the aged and chronically ill is of great importance, not only because of the direct impact on treatment and care of the patient, but because the physician's feelings are so apt to influence the outlook of the rest of the staff. Dr. Charles Cameron of the American Cancer Society indicates that physicians, like the rest of the population, can readily convey common attitudes of despair and hopelessness when they encounter recurrent emotional and physical illness in the patient. These attitudes may lead to 1) inertia and the rationalizations "why take money when nothing can come of it?" or "such minor gains are not worth the risks involved in further treatment"; 2) an over-optimism that lets the patient down because of its very unreality; or 3) rigid and brutal telling the truth, regardless of the patient's readiness or capacity to take it (7).

Dr. Cameron points up the problems in such approaches: "There is one grave danger in adopting the attitude of compromise in caring for any patient—even the patient with advanced and seemingly hopeless cancer. Such compromise

may become expedient at some point in the course of cancer. But where shall that point be designated? If it seems best to give up in one case, why not in the next? If prolonging life appears normally unsound in one case, will the same not hold in the next one? When shall the doctor and his team slacken their efforts? Who shall say when the battle is over? The danger is obvious: To reduce therapeutic effort at any time, under any circumstances, is to endorse partial 'therapeutic nihilism.' It is not an unattractive expedient. It saves work, and, better yet, it saves worry. Of course, full commitment to that practice would save the doctors all worry—and, incidentally, all work."

The effort to develop optimistic and hopeful attitudes requires constant and vigorous attention. How can each aged patient be regarded and treated as if he were a celebrity?

In our concern for improving the care of the patient, and in our dealings with the medical and nursing personnel and our medical policy committee, the question of mortality rate has been raised. This is a touchy and complicated subject, and needs to be dealt with in a realistic and responsible manner. The extreme point of view dismisses all accountability with the easy diagnosis which is no diagnosis, namely, "old age." Many patients have multiple and almost continuous complaints which must be recurrently investigated. These can get to be like the little boy's cry of "Wolf, Wolf!" The medical team (doctor and nurse), after investigating the complaint a number of times, may label the person as a "chronic complainer" and underestimate the seriousness of the "alleged" difficulty. It should always be remembered that, especially with the aged chronically ill, no matter what the neurotic overlay or emotional disturbance, the patient eventually dies of a specific (or multiple) illness. Symptoms may be difficult to differentiate, and careful attention by trained and interested professional personnel can literally make the difference between life and death.

The relationship of the administrator to the medical and nursing staff requires a tremendous amount of understanding and diplomacy for the development of the best elements in a working team and high staff morale. The administrator is responsible for the proper functioning of the medical and nursing program, and he should be familiar with and actively interested in each patient's health and care. He is in continuing communication with the doctors and nurses about the ever-changing medical and emotional status of the patients. This vital give-and-take, the encouragement of questions and fresh approaches, the interest in the patient as an individual, and the serious considerations of public health problems, all result in a high standard of health care.

Costs of medical services in Jewish Homes for the Aged

As a backdrop for estimating costs of medical services, it may be helpful to have some general information. Daily operating costs in 6 small institutions for the aged (18 to 46 beds) in 1954 averaged $6.70 per resident, ranging from $5.10 to $7.90. In 12 larger homes (150 to 250 beds) in 1955, daily operating costs averaged $5.12 per resident, ranging from $4.10 to $7.10. However, costs have gone up since 1954–1955 in almost all institutions for the aged. Moreover, the small home

is less economical to run than the larger one. In the smaller homes the total salaries usually take from two-thirds to three-quarters of the total operating budget, whereas in the larger homes the proportion is from one-half to two thirds (6, 8).

Although I do not have medical service costs for the smaller homes, a 1954 study of 6 large institutions showed that there was a fairly narrow range in 4 of the 6; in these 4, the medical salaries constituted about 50 per cent of all salary costs. At the Galland Home in 1959, medical and nursing salaries constituted about 53 per cent of our salary budget. Medical expenditure for salaries, supplies and expenses tends to amount to about one-third of the total operating budget, and therefore is *the* most expensive item in the costs of management of the modern institution for the aged. In any discussion of per capita, per diem figures, comparisons with a particular home should be made with caution, since there are at least four important variables: 1) variations in resident population as to sickness and need for intensive care, as well as services being offered; 2) the extent to which other community services, including medical case work and group work, are available without cost to the institution; 3) the size of the institution; and 4) the regional and local factors regarding labor, materials, food and other costs (6).

USE OF CASE WORK AND PSYCHIATRY WITHIN THE INSTITUTION

Case work

Professional case work is extremely important in the admission procedures of a Home. Placement in an institution, in itself, involves a difficult separation process for even the healthiest of persons with a positive motivation for giving up his previous way of life. Case-work help for three to six months for each new resident and his family is thus a necessary service; even a longer time may be needed for some clients. With the onset of new illnesses and medical conditions that inevitably take place, the traditional skills of medical social work are required. A basic conviction and knowledge about the applicability of case-work aid for aged persons is needed, as well as administrative sanction, if such a program is to prove helpful to the client.

Up until last fall, the Jewish Family and Child Service staff was providing case-work services to residents of the Galland Home. The agency was giving the Home from two and a half to three days a week of professional time in active supervision of about 20 cases (half the resident population), in addition to taking care of admission work. This was a valuable contribution. In order to maintain the proper kind of liaison between both agencies, we conducted monthly meetings at which were present the family agency staff, the Home staff physician, the charge nurse and the administrator. Usually, one of the social workers presented a case and gave a summary of contacts; this was followed by discussion. In addition to these monthly staff meetings, workers from the family agency were in almost weekly communication with the cook, charge nurse, doctor, administrator and other personnel of the Home concerning their cases. The workers also received supervision from the administrator in regard to cases under care. Carbon

copies of the current interviews were sent in advance of regularly established conferences, and the Home was able to have its own record of case-work contacts.

More recently, the Galland Home and the family agency were able to work out an arrangement for the Home to have its own case worker on a part-time basis. The Home has benefited by having a worker, all of whose professional time is spent in helping the residents and their relatives, and in work with the staff. In addition to individual interviews with clients, there has been group work in developing some features of self-government by means of a Good and Welfare Committee, and several other projects. Also, the Home has a second-year graduate student from the school of social work. In a small institution, it is particularly helpful to have an administrator who is professionally equipped to offer case-work supervision, and is prepared on occasion to do case work himself. Although the administrator has to maintain contact continually with each of the residents, this is not a substitute for a planned case-work service.

The following is an illustration of how case work may help: *Mrs. F.* was an 88-year-old woman with a history of having had a tumor removed some three years before coming into the Home. She had been widowed for many years and had no living relatives. She needed to cover up her dependency needs with a pose of superiority, so she isolated herself from the other residents by getting into pitched verbal battles. When her gastric symptoms became more intense, she threatened to leave the Home. Her complaints about the food were quite unrealistic, but nevertheless loud and vituperative; suspiciousness and great distrust were evident. Her case worker, having established a warm and accepting relationship with her, was able to help her undergo a medical check-up and referral for an intensive gastro-intestinal work-up in the county hospital. Despite the client's disclaimers that she didn't care if she died, the social worker was able to get her to express her fear that she was going to die of stomach cancer, as had her husband. Her brave front crumbled as she cried it out with her case worker. No longer alone, she could face the reality of her medical condition. In this instance, there was good news from the doctors; thus her anxiety tended to be less displaced regarding food and her relationships with the other residents. Because of Mrs. F's experience with her case worker, she felt more comfortable in the Home, and had a sense of belonging that had been absent previously.

Psychiatric consultation

For almost a year we have employed the skills of a consulting psychiatrist for about four hours a month. His time is used in a variety of ways, *e. g.*, to deepen the understanding of disturbed personalities, and to find more effective ways of dealing with cases of upset behavior. The psychiatrist attends the training sessions with the nursing staff, which are held on a monthly basis. His time is also used for diagnostic evaluation and suggestions regarding therapy for individual patients; he sees the patient on some occasions and has discussions with the case worker at other times.

THE DISTURBED AND DISTURBING PATIENT

Whatever the diagnosis, whether it be senility, mild psychosis or disturbed and disturbing behavior, what is the responsibility of the voluntary institution

in caring for such persons? One of the facts that has impelled the voluntary institution to take responsibility for patients in this area has been the inadequacy of solutions under public auspices. The standards of care for the disturbed aged and the senile patient in state hospitals have been woefully inadequate. In reaction to this state of affairs, and because of the resistance on the part of families to commitment to state institutions, tremendous pressure has been exerted to care for this group of persons otherwise. With proper administrative sanction, the development of staff understanding, the employment of auxiliary health specialists, and recognition of the bounds within which effective help can be given, much constructive programming can be done in working with these so-called borderline cases. Ultimately the responsibility should again come under public auspices, in order to underwrite the care of this group of patients (often done through qualifying them under nursing classification payments), and/or to improve the public facilities. There are some states, such as New York, that are actively considering the establishment of "homesteads." These will be separate facilities for the disturbed aged person, so that commitment to state hospitals will not be necessary.

The value of psychiatric consultation is illustrated by the following case: *Mr. S.*, a 75-year-old man, was admitted to our Home about two years ago. He was scheduled to go to a state hospital. His 4 adult children and their families had found it impossible to keep him in their own homes, and he had "failed" in 4 proprietary nursing homes because of his severe behavior problems. This man, who spoke primarily Yiddish (it was later ascertained that he was able to communicate in English in a minimal way with our non-Jewish staff), got into loud altercations and displayed obstreperous behavior with the other residents and particularly with the nursing and dietary staffs. We had asked for a psychiatric diagnostic examination before his admission, and it was found that Mr. S. was not psychotic in spite of his obvious emotional disturbance. An incident during his first week at the Home may illustrate his lack of socialization; the charge nurse saw him on all fours eating a spilled soft-boiled egg from the floor. However, real progress was made through intensive case-work help and cooperation of the staff, especially the nurses who had constantly to administer to his multiple medications and attend to his insatiable demands for care on the most infantile level. Today he is accepted as one of the regular residents despite his difficult behavior pattern and occasional flare-ups. He now considers this to be his home and has been able to modify his behavior and get along better than his family or we might have expected.

RECREATIONAL AND LEISURE-TIME ACTIVITIES

Programs of this nature are vital in preventing unnecessary and costly human decline. The value of participative, rather than passive, use of leisure time is an important principle. To be successful in activating eyes and hands that have been fallow, or spirits that are pessimistic, insecure and despairing, requires a program with professional supervision. In most communities, the availability of staff members from a community center is a ready resource. This service to the aging on the part of a Jewish Center, however, involves no monetary return in terms

of fee payments by the client group. Therefore, it is most essential that the Center have a conviction about the importance of programming for these clients.

Extension service by Jewish Centers to homes for the aged, as well as other settings, has become an established practice. When this can be worked through on a mutually satisfactory basis, it can be most productive to both agencies. It is essential that the group worker from the Center be given administrative support to operate within the Home setting, and that this worker have a liking for, and interest in working with the aged. When such a worker cannot be obtained from the Center, the institution should employ its own worker, but the costs of doing so on a professional level are high for the smaller home. Where there is conviction, however, it can be done. For example, special gifts can be obtained by women's auxiliaries or individual gifts can be earmarked for this purpose. Once the funds are available, there may be problems in recruiting trained personnel. Here the professional leadership of the administrator can be important in selecting and finding personnel, provided the Board has established policies which are enlightened and will underwrite the type of service desired. Improvization may be necessary in the smaller home. If there is a worker on the staff who has skill in the group process but is deficient in arts and crafts abilities, it is possible to provide for the latter type of program by means of session workers and volunteers operating under the supervision of the group workers.

THE VOLUNTARY INSTITUTION IN RELATION TO THE LEVEL OF PUBLIC SERVICES

Voluntary institutions are directly affected by the level of public welfare programs, and by the direct monetary payments they make to qualified residents. Experience in the family agency field has demonstrated that the private agency simply is unable to foot the bill for basic relief needs, though before the great depression of the 1930's this had been its primary function. Public payments for service are a major source of revenue for institutions for the aged. Not only do these direct payments make possible a more adequate nursing and medical program, but frequently the public agencies, because of their control of the purse strings, have contributed towards raising the levels of care by their requirement that certain minimal standards be met.

We can take a page out of the book of the Washington State Nursing Home Association in regard to the stake held by the well-run nursing home in raising standards. The nursing-home group, including commercial and nonprofit institutions was alive to the implications of creating a more favorable public image; therefore it helped to secure more equitable rates for care from the legislature, and showed genuine interest in working towards improved conditions and practices. It is interesting that the licensing agency (the Hospital and Nursing Home Section of the State Department of Health), which is concerned with the administration of the Nursing Home Act, finds that it can work effectively in concert with a responsible self-regulating group such as the Nursing Home Association. These agencies have jointly conducted educational workshops for staff training.

There has been recent discussion in the Jewish institutional field concerning the development of a national association for non-profit homes for the aged. Apparently there is interest in this development on the part of the Department of Health, Education and Welfare in Washington, D. C. Undoubtedly there is need for effective channels of communication between federal, state and local public agencies and voluntary agencies, with the aim of raising the level of services and care for the ever-increasing numbers of aged and chronically ill patients in institutions.

Active community leaders and members of Boards of homes for the aged have an important role to play, not only in such associations, but on local Health and Welfare Councils and on Governor's Legislative Committees on the Aging, as well as in geriatric and gerontological societies. All of these forms of membership can serve useful functions in both learning from and contributing to others, and in advancing the services to this Number One priority group—the aging.

SUMMARY

Responsibility for leadership in the development of modern facilities and programming for small homes for the aged and chronically ill rests with enlightened understanding by the Boards and administrators of these institutions. Medical, nursing, leisure-time and personal adjustment programs for such a home are outlined. Important considerations are the criteria, policies and processes of admission, and the relationship with the family agency. Various aspects of nursing, medical casework, psychiatric and creative activity programs are discussed, as well as the relationship between voluntary institutions and public services.

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Senator MORSE. Next witness? We are delighted to have you. Will you give your name to the reporter, and proceed in your own way?

STATEMENT OF A. W. LADE, RICHLAND, WASH.

Mr. LADE. Senator Morse, ladies and gentlemen, I want to take this chance to make a public declaration of my support to the Congress of the United States when they passed the Social Security Act in 1935. I don't know whether you voted on that. I think you did, didn't you?

Senator MORSE. No, I didn't. I wasn't in the Senate. I was elected in 1944.

Mr. LADE. Well, anyhow, I am sure you would have. You would have supported it if you had been there, wouldn't you?

Senator MORSE. I have offered so many amendments to improve the social security system that I think my record of offering amendments couldn't have been a more ardent support of the social security system.

Mr. LADE. I believe that, Senator Morse. I probably shouldn't mention that, but I thought I would throw it in.

Senator MORSE. I should ask you a question. Do you vote in Washington or Oregon?

Mr. LADE. I vote in Washington, Senator.

Senator MORSE. I am just teasing you, but I can see, from what you have already said, I would like to have you in Oregon.

Mr. LADE. Did I state my name?

Senator MORSE. No; you didn't.

Mr. LADE. My name is A. W. Lade of Richland, Wash. I am past president of the senior citizens group in Richland for 1960. I will just say a few words about that. Ours is more or less of a social group. It's just for entertainment for the members themselves. We meet every Tuesday night, and, personally, I think it's too often. There are several people there that are older people and they like to come once a week. I tried to get that changed, but I couldn't.

Now, as far as activities are concerned, it's mostly social. We do have a few women who go to the nursing homes around the tricities area, of which there are three of them and probably should be more.

I also want to mention the fact that in the city of Richland there is a peculiar situation there. As you all know, this was a city that was started and grew up during the war. It just recently became incorporated, and up to 3 years ago, anybody who retired from GE had to leave the city, but that's been changed now, and people can stay after they retire. I retired 3 years ago, and I'm still living in Richland, but it's surprising to see how many senior citizens have come up since the city became incorporated. As I say, at our meetings, we have all the way from 25 to 40 people at our meetings, which shows that there are a few older people there. In other cities throughout the country, of course, they must have more percentage of aged people.

Now, my interest is to have the medical aid to senior citizens hooked up with the social security. I think it's the only fair and just way of helping the aged people, and I am sure that any young person working now would be glad to lay quite a small percentage of his earnings away, if he could be assured of security and medical atten-

tion when he got older and had to retire. Now, I think I will conclude now and give somebody else a chance.

Senator MORSE. It has been very helpful testimony and I am glad to give you this opportunity. Who will be our next witness? Is there anyone who would like to come up to the microphone and make a statement?

FURTHER STATEMENT BY MRS. LUCILLE KELLY, COMMITTEE ON LEGISLATION, STATE NURSES ASSOCIATION

Mrs. KELLY. I would like to speak again.

Senator MORSE. We are glad to have you back, Mrs. Kelly.

Mrs. KELLY. Thank you. I'd like to speak just as a citizen because this does affect me in three ways. This affects me as a homemaker, as a nurse, and as a member of my association. We are concconcerned because we feel that these people need to be cared for. I'm concerned because I have an elderly mother living with me. She gets social security of $49.50. She is a diabetic. She cannot afford adequate medical care. So, my brother and I help contribute to this. Another reason that we feel that there should be help to elderly citizens is because she does not like to take this help from us. As a lady stated here earlier, this is a matter of pride with her.

Again, I have a boy just going into college. We have four children. They tell us it's going to cost $2,000 a year to educate these youngsters. I am anticipating an indebtedness of $40,000 if each one of them goes 5 years. We are happy to do this. We try to educate our children. We feel that this is a big hole in our budget, too. We are able to provide for it through my working and my husband being a farmer. However, there are other families that have this same problem. They cannot provide the adequate care that these mothers need, and yet they do not need to be in a nursing home.

So, I feel, as a citizen, this would be helpful for social security insurance to do that, to help our elderly citizens. Thank you very much.

Senator MORSE. Thank you very much. It is very, very helpful. The next witness? There surely must be others who want to help us with our problems.

STATEMENT OF NEIL MEADOWCROFT, WALLA WALLA, WASH.

Mr. MEADOWCROFT. Senator Morse, members of the committee, my name is Neil Meadowcroft, husband of Mrs. Sally Meadowcroft. I am a Federal employee here in town. I am a Federal employee in Walla Walla with the Corps of Engineers. I am speaking and interested in the subject of the day.

As a Federal employee and as a professional employee with a sufficient salary, I find myself with the prospect, after service of nearly 30 years, that the retirement income won't be adequate. Since over an extended period we have contributed between—I think originally it was 2½ percent, and now it's 6½ percent of our salary to this fund, the Government supplementing that, it seems to me that one of the means that is available for our older citizens is that the social security contribution that they make those individuals might well be

increased as time proceeds so that they could have benefits which are comparable.

Just a few days ago, I visited my brother in California who is approaching retirement, about the age of 64, and next year he will retire, and he told me that the company that he works for, the Pacific Gas & Electric Co., will contribute about $170 a year—excuse me—that the social security program will contribute that a month, the Pacific Gas & Electric Co. about half, and then another former employer about the same amount, adding up to considerable.

Now, however, there are many, many people, as you are well aware, who are not in this category and certainly do not have this opportunity. We have been much interested, as members of the Congregational Church in Walla Walla, in the social action aspect of our faith, and in moving around the town and observing how people live, one of the things we have noticed particularly is that there are many older people living in substandard houses. This is true not just of this town, but I don't want to cite it as an exception.

About a year ago I attended a convention of the American Society of Civil Engineers, of which I am a member, in Spokane. One of the most significant things that I learned at that meeting was that under the urban redevelopment program a considerable portion of what used to be one of the finest residential and business sections of Spokane, though now you might call it a blighted area, will be replaced with good apartments and otherwise housing suitable for people perhaps in the low-cost housing range. It seems to me this type of thing is certainly worthwhile and it should be expanded.

Senator MORSE. Thank you very much, Mr. Meadowcroft. Any other witnesses?

STATEMENT OF FRED E. DAVIS, WALLA WALLA, WASH.

Mr. DAVIS. Is there an age limit?

Senator MORSE. No age limit at all.

Mr. DAVIS. I am Fred E. Davis. As I hear this, I think that since some of us younger citizens can speak up and be heard, I would like to know what has become of the old-fashioned "I can do it" individuals, the days of explorers, the fur traders, the first families to come here and homestead this territory. They sure weren't looking for somebody to take care of them the rest of their lives. They made it through themselves.

In my own family, my family came here at the turn of the century, school teachers, army personnel. My grandfather taught high school in Portland, and, in the course of his meager earnings as a high school teacher, he managed to earn enough to buy some property, and spent the last 8 years of his life down there—well, 6 out of the last 8 were down there and the last 2 were in a nursing home because he required constant care and the last few months he was in St. Vincent's Hospital. Although he had only a very small income as a high school teacher, he, through my grandmother, was able to liquidate his property so that by the time he died, he had one house left over, and my mother and myself didn't need his income, and he took care of himself.

My other grandfather had served in the Army in the Spanish-American War and World War I, and he was taken care of in his old age, and my father had a small business and, as he got older, when he got paralyzed and it was difficult to get in a car, he had to be helped into a horse and buggy, and one point I would like to bring up here is that he is now completely cured of his arthritis because they were able to give him a drug, which is not a drug that's normally found, and this is one that was produced, you might say, by one of the pharmaceutical companies, and it completely cured him and he is fully recovered.

Another point is the matter of pride for the old people. I don't think they ought to have to be told that they had to go to welfare. One witness brought up that she had to work hard to put her children through school. Well, Senator Morse, you know how some of these kids got through school. Give them a chance and they would see the necessity and they would do it again.

Now, as far as care for the aged, why should a fellow have to be told this? If he's a veteran, naturally he would be taken care of, service connected or not. I have no quarrel with that, and I think that is perfectly okay, but if he goes through life and has a job, he would have money taken out on his social security for that and someone else, and he is paying for something he isn't going to get because he has already paid for it by the service with his company. Those are the things I wanted to bring up.

I would like to see a person's ability to take care of himself started early in life and then come back to the old program and try to make people want to work after 65. If they didn't have social security and they didn't want to quit, you could let them ramble a bit. Look at the poor American Indian until he was taken care of by the Government.

Senator MORSE. Thank you, Mr. Davis. The witness in the back of the room now.

STATEMENT OF H. S. CROUTER, WALLA WALLA

Mr. CROUTER. Senator Morse, may I say my name is H. S. Crouter, and I live at 350 South First, Walla Walla. I think mine is more in the line of a little preventive maintenance that might be of particular interest to the younger people here.

I believe that this would take legislative correction on the part of the Senate or the Government, but I believe that, prior to retirement, that the employee should be advised just what his retirement benefit would be. This might apply to industry or government, or the railroads, but I believe that, if such information could be put out, in quite a number of instances, the employees would automatically augment their retirement, and, in this manner, they would stay away from possibly the old-age aid benefit. I don't know just how to go about it, probably, as to the submission of this any more than to state the fact that I know as long as 4 years after the retirement has been cut. Should the employee have been aware that this 4 years would have been critical, I'm sure he would have continued his employment, and his benefits would have been substantially raised, and he would have gotten his retirement and he wouldn't fall back on

dependency at a later time, and I think these younger fellows coming up should have the advantage of making such a determination and knowing just what their benefit would be.

Senator MORSE. I understand now, I think, and so that we can get this record perfectly clear, you are suggesting a hypothetical. Mr. A is working for X company. X company has a retirement plan, but your point is that in too many instances X company does not make known to Mr. A what his retirement is going to be when he does retire, and what those retirement payments will be at different ages in case, for some reason, he finds it necessary to leave the employment due to illness or accident prior to the retirement age maintained under the retirement plan. Is that what you are after?

Mr. CROUTER. Yes, sir; or even voluntary.

Senator MORSE. That is, your feeling is that there ought to be a legal requirement that, when you have as part of the wage structure of the company one of the fringe benefits known as retirement plan, that the employee have made available to him an accurate statement as to what his retirement payments are going to be under a series of circumstances that would be set out in such an arrangement? Is that it?

Mr. CROUTER. Yes, that's it.

Senator MORSE. I am very glad to have it in the record. I won't find it possible to comment on it until we find out what all the practices are and what State policies are in regard to this, as well as Federal policies, and I should think it also would apply to any government retired man.

Miss McCamman tells me that one of the recommendations of the White House Conference on Aging pertains to the very point that you are making. That was one of the recommendations of that conference.

Mr. CROUTER. If you wish, I have a draft prepared. I don't have it with me, but I can mail it to you.

Senator MORSE. Send it to the committee, and we will make it a part of the record.

Mr. CROUTER. I will be glad to do that.

Senator MORSE. Be sure and get one of these envelopes that I referred to earlier and send it to the committee. Any other witnesses?

SUPPLEMENTAL MATERIAL SUBMITTED BY H. S. CRONTER

The attached draft was mentioned during the town meeting November 10, 1961, Walla Walla.

The following is a schedule pertaining to one actual claim determination:

April 13, 1961: Filed request for retirement.

May 5, 1961: (1) Received certificate of appreciation 28 years service.

May 8, 1961: (2) Received letter of commendation 28 years service.

July 5, 1961: Received tentative claim determination covering full 28 years; $290 a month.

September 19, 1961: Received redetermination of claim deducting more than 4 years of service; replaced to $251 a month.

Since the facts have been brought to light there is no exception to either the length of service or completed value.

Exception is taken to the fact that actual service was not made available prior to actual day of separation.

The draft is considered to be self explanatory.

PROPOSED REQUEST FOR RETIREMENT (GOVERNMENT EMPLOYEES)

It is proposed that retiring employees be required to furnish the employing agency not less than 120 days' written notice of intent to retire, and that upon receipt of such notice the employing agency will forward the employee's record to the Civil Service Commission for checking and computing in order that both the employing agency and employee may be advised of, the number of years of service, and dollar value of the retirement, prior to the actual separation from service.

Under the present procedure, the employee:

(*a*) Files written notice 30 days to 6 weeks prior to date separation is desired.

(*b*) This notice is held in the local office until date of actual separation.

(*c*) Civil Service Commission furnishes the employee a tentative schedule within a 6 weeks to 2 months period stating:

(1) Gross and net monthly allowance.

(2) Total dollar value contributed to the fund by the employee. (This notice contains a statement to the effect that the records will be checked and adjustment made to the claim if a discrepancy is discovered.)

(3) In some instances 3 months after the tentative schedule has been received such adjustments are made, increases and/or deductions including the withholding of overpayments made during payments of the tentative determination.

Under the proposed plan:

The employee furnishes the employing agency written notice of intent to retire 120 days prior to the date actual separation from the service is desired.

(*a*) Upon receipt of such notice the employing agency will:

(1) Forward to the Civil Service Commission the employee's records and service dates proposed for consideration in the retirement.

(*b*) The Civil Service Commission will—

(1) Process and verify such dates and services.

(2) Prepare a statement of gross and net monthly annuity.

(3) Furnish a statement covering an increase or decrease of services rendered, if required.

(4) Return to the employing agency for delivery to the employee within the 120-day period.

(5) Request additional time for determination if the case is a difficult case.

Comments—Proposed request for retirement:

1. There is no desire or wish to deviate from the practice of central control. The procedure is considered thorough and should be continued.

2. It is considered that each retiring employee has a right to know, the amount of time or service considered in the computation and the dollar evaluation of the claim prior to the actual date of separation from service.

3. The 120-day lead time is considered adequate for final determinations purposes, in most instances, Deviations could be arranged for in difficult cases.

4. Verification of claim as submitted, or the statement covering the increase or decrease of services rendered will in the majority of cases aid the employing agency in confirming the determination with the employee, and will eliminate much of the correspondence now required to clarify disputed claims.

5. Return of the determinations through the forwarding agency will furnish a guide as to the proper procedures to be followed, give such agencies an opportunity to correct any similar cases on hand, and finally result in near perfect submission of retirement applications, within an estimated 3-year period.

6. A conservative estimate of the time required by the agencies involved in reevaluation, review, and correspondence pertaining to a disputed claim is considered to approach $100 in value; therefore, adoption of the proposal could result in a very substantial saving to the Government.

FURTHER STATEMENT OF A. W. LADE, RICHLAND

Mr. LADE. I don't want to contradict the former speaker, but I am sure all of the companies have a policy whereby they advise their employees shortly before they retire just what their retirement benefit is going to be. General Electric calls in their employees once a year for the last 5 years of their employment.

Now, I forgot something, and I have a right to forget. When I was up here before, I forgot that I had another point to bring up that hasn't been brought up, regarding things that affect old-age people on a fixed income, and that is inflation. I think that is the biggest bugaboo to the person, especially the retired citizens on fixed income. I don't know what you folks in Congress can do about it, but I would appreciate it if you could do something. Thank you.

Senator MORSE. If you give me a solution to that problem—I don't mean to be facetious, but you certainly put your finger on one of the great problems that confront us in connection with this whole retirement matter, retirement at a certain amount and then finding 10 years later that you are still being paid the same as at the time of retirement although costs have not stayed the same.

Next witness?

STATEMENT OF PHILIP GIBBONS, SR.

Mr. GIBBONS. My name is Philip Gibbons, Sr., and I come from Oregon.

Senator MORSE. Delighted to have you.

Mr. GIBBONS. As to several things that have been filed here today, I will take this attitude of approach. My understanding of democracy has always been that it should be a classless society, and it also should be a free society, and certainly no discrimination in any respect or in any way with any particular class by placing them in a more favorable position through governmental aid than some other class that does not support you. The consequence of all of our attempts to remedy a good many of our social evils is that we are creating or seem to be creating as many new evils as we are removing the old ones, and I don't know just how long this theory is going to last, or how long it is going to be, but I was very interested in a comment from a friend in our neighborhood where, starting in earliest youth, each one should go out for himself and without any government aid or from anyone, and that the taxation should be kept in proportion to a man's ability to pay what he needed or had to pay.

All during civilization, the many things that we are suggesting here have failed and long since passed into pages of history as failures, and that doesn't just include the Roman Empire, which fell because of the fact, in the first place, that the law of ancient Rome was the thing that started it. Whenever we start these kinds of movements, we sometimes help to stir imaginary ills up among those who feel that they should have a better chance than what they are obtaining, and it would seem that the only source is through Government aid.

I don't know. I'm just a young chap. I haven't had much experience. I don't know as my views would be really what you are looking for here today, but if you want to know, my candid opinion of it is that the more bureaus that are established, the more trouble you have getting taxes enough to get the bureaus and keep them going without being any help to the recipients that they are supposed to bring. So, I leave that statement just as it stands. Thank you.

Senator MORSE. I want to thank you very much because you certainly have testified in the spirit of one of our great institutions in this country, the town hall, and as we know, the town hall really was

in a very real sense the cradle of democracy, and here is the place for an exchange of all points of view, and I thank you very much for the contribution you made to this record, and the response of the audience shows that they appreciate it as well.

The next witness?

STATEMENT OF HERMAN J. BOLST, WALLA WALLA

Mr. BOLST. My name is Herman J. Bolst. I live at 1803 East Isaac. I want to bring out about this Federal lottery business, which I am in favor of, on which you shouldn't be able to spend but about $1,000 or less per year. When you came to buying it, you could buy no more than a dollar's worth, and, therefore, it could be broken down, 2 for 50 cents each, or 4 for a quarter. If we keep on running the taxes the way they are, in which there was quite a writeup in one of the magazines, which I'm going to send to you later on, a reprint of it, where it shows that, if a national lottery was put into effect, which, as you know, a Republican leader reintroduced that bill, and if it was regulated on a stated income, the religious organizations I don't think would oppose it too strongly because they know they would protect the family check of income from anybody taking and spending a whole pay check on buying lottery tickets. This way, there would be no hardship on the families. The only reason I can see why that bill was never acted upon in Congress is because there was no protection from a family income check being spent all on gambling.

Then on social security, people are having a hard time living today. I think it should be regulated a step up so that, if the prices go up, the income of social security pay should be regulated on the same percentage as the wage scale across-the-board system, only on the wage scale board I notice there is a little bit of discrimination. A laborer just cleaning would make a WA–2 or a WA–1, but when it came through on this last increase, which was 6 cents an hour more, they did not get the 6 cents an hour. Those in the higher brackets do, but those in the lower bracket do not get it. They might get maybe 2 cents or 3 cents. There is where the discriminating part is. I'm in favor, whatever the rate is, regardless of who the grade is, they all should get the same 6 cents, 8 cents an hour more. They should all get it. After all, those people have to live too, as well as those in the upper income, and that is one big discrimination on the wage scale system. As you know, with the VA employees, the kitchen employees, they have been trying to get that straightened out, and in the laundry, and the whole trouble is in that discrimination, but the law permits it that way. When a certain percentage comes through for an increase, they do not all get it. It's based upon the grade, what they are making, WA–2, or WA–3 or 4. They do not get the full rate of what the percentage pay increase is supposed to be.

Then on Federal highway construction, which between here and Milton-Freewater, you can't see it. That was approved, but some places where you come under a bridge, there isn't even a road shoulder there. In fact, I went by there the other night, and a car was completely over in the ditch. As you know, the highway accident rate is very high. One of the reasons is because, for the simple reason, if

you're stuck behind something, such as a big truck, and you want to get by, well, you just can't get by. That's why I'm in favor of it, but a Federal law should be passed for all highways to be made four laners with a big road shoulder on each side, so that, if you have a flat tire, you don't have to stop in the center of the highway to change a flat tire. That one particular place, between here and Milton-Freewater, as soon as you come out of Milton-Freewater under the bridge, you see the road is—there isn't a road shoulder. It's just rounded right off.

Also, I have written to this Attorney General Kennedy and also the President on this matter of union funds and the labor bosses, which I want to bring up about, too. As you know, there are many hearings on it, but no proper laws have been passed. I've written to them, urging that a law be passed to put all union funds under the same regulations as the banks. Therefore, when the auditors come around, if what is in that bank shouldn't check out with the books, if they don't calculate, somebody is going to have to sing to the music and learn the music because they are going to have a long trip to jail.

Senator MORSE. Thank you very, very much. I am glad to have your testimony. Any other witness?

STATEMENT OF ELMER R. HARDY, WALLA WALLA

Mr. HARDY. Senator Morse, I've read much of you and I appreciate your being here. I am Elmer R. Hardy, formerly of Borger, Tex. My final employment had been 33 years with the Phillips Petroleum Co. I worked 38 years all told for major corporations, and 8 years as a farmer. I have never been any kind of a leader.

I suppose you realize that in the society that we have been living in, there is always radicals among us, and since my premature retirement in 1955, I have spent full time in philosophical writing. I find it hard to write to those publications, and the last thing I do is to see it published, which is what I want, but one predominant concept I would like to offer today is that I believe we should have two streams of society, a separate stream of society for the defectives and another for the elders. This, of course, will come as a serious statement. In years to come, I think we will find that we, the American people, must all go to work, that we must do a lot of work, and we must do it because we conceivably think that work ought to be done, if for no other reason than that perhaps the peculiar elders, under which we list them, is not, after all, the answer.

I have written a philosophical fiction, expressing all this, but I would rather not read that. There is much rough land in this country. One of us elders cannot operate a bulldozer or anything like that as a full-time worker, but three of us elders could probably run it in turnabout form and together in full swing. In time to come, due to the population explosion, we are going to have need of more and more arable land, and there is also some sign that we need more raw food. I suggest nuts and sunflower seed, and such as that, which seems to not have commercial value in quantities sufficient for society.

What I would recommend for the aged and the defectives that find it difficult to hold their place in the regular stream of society is to be assigned in communities themselves or close by, and in units of per-

haps a thousand, where they can, through their own service, work an overall average acre in agriculture and perhaps that of leveling the land, and, as I suggest, food crops that is not much damage to the commercial market.

The time is coming surely when it's very important that there be a standardization of a place in the scheme of things for all of us that are able to do a reasonable amount of common work.

Senator MORSE. Thank you very much for your contribution to this hearing.

Are there any other witnesses before we close?

Mrs. KELLY. Could I speak again? I didn't know I would be occupying the floor so much.

Senator MORSE. It's quite all right.

FURTHER STATEMENT OF MRS. LUCILLE KELLY, COMMITTEE ON LEGISLATION, STATE NURSES ASSOCIATION

Mrs. KELLY. You know me by now, but, as you know, this is a pretty hot potato among we nurses, and since we are standing on this as a principle, but also as a citizen, it affects me in many ways. I have been called a Socialist. I have been called a Democrat. I've been told that, if I were a man, they would slap me or knock me out, since I've gotten into this program, but I don't care. I want to speak for what I want to believe in, and that is the reason I'm on this committee. I believe in it.

I'm getting a little tired of people telling us that we have lost the old pioneer spirit. I'm getting a little tired of them telling us to go back to the do-it-yourself age. We are doing it ourselves, and I think that most of us are trying to instill this in our children also. I speak about my family because I know them. I deal with it every day. I deal with the other problems every day, and I know those, too. So, I just talk about what I know.

However, dedication and the pioneering spirit is going to take a little more. I think all of the senior citizens would love to put aside enough to take care of them in their old age, but what took care of them 20 years ago does not take care of them now. For example, the gentleman ahead of me says his father could provide for the wife, and so on, and so forth. That's fortunate. My mother was left a widow, and she educated two children—and again this is personal—by cooking on the boat that goes up and down the Columbia River. At that time, education wasn't as high as it is now, and I didn't mean to imply that I was going to have to educate my children by myself because that's not true, but I may have to help. I don't know what it's going to cost, really. We're just anticipating the debt.

However, when you start to try to help your elderly citizens, too, it does make a difference, but we are happy that we are able to do it. My point is that many families cannot afford it.

May I give you another example? Supposing you yourself had only say meager funds, you had some, and you had to go to your physician, and he is going to do all for you that he possibly can. We know that most of them do. But he has to decide. If you are the one that's paying for your own care, and supposing that he thinks you need an electrocardiogram, which costs all the way from $15 to $25,

he's got to make a decision whether he wants to go ahead and give it to you on his own, which he couldn't possibly afford to do for everyone, or whether you could afford to pay for it yourself. If you tell him you can't, you probably won't get it. Again, if you're on old-age assistance, you probably won't get it unless you have special permission from the screener.

All right, is this adequate care? Don't you think that this should concern all of us? Maybe it might help the doctor to make a diagnosis that will prevent that patient from being in a nursing home, if he can afford it. This is my concern and my point and my principle. I would like to see all of these people have, if they can afford it, and that's fine if they don't want to accept the other. They speak about insurance, they'll take out insurance. This is something which is fine too. I think we're insurance poor in my own family again, but, in 20 years, is it going to be adequate? I don't know. I'm hoping it will be. I hope I will never have to be a recipient of old-age assistance, but if I am, I would like to feel that I'm paying into something that is going to help me, that is going to provide me with adequate medical care and that I will still have enough pride that I can function on my own, and not train people to take care of these people to take care of me. Perhaps I'll have a stroke and, if I want somebody to help me rehabilitate, it's going to cost. I probably can't afford it.

So, I'm still standing on the principle that, if these people need medical care, even as a nurse, when I see this every day, it breaks one's heart to see them lay there and vegetate, and you are all approaching that age, believe me. It's coming. You don't know whether it's today, tomorrow, or the next day, but you're going to have to have specialized professional care. There are lots of things that aging can do. All right, we still have to train people to take care of this kind of person. That takes money. Who is going to pay for it? Their meager funds will not allow it. If they have a stroke, this is a long return program, and it takes time, and you may be in that boat. Thank you very much.

Senator MORSE. Thank you very much. Any other witness?

FURTHER STATEMENT OF NEIL MEADOWCROFT, WALLA WALLA, WASH.

Mr. MEADOWCROFT. Thank you for another moment, Senator. I would just like to ask a question, which is really based on the lengthening age of our average citizen, shall I say. In your hearings throughout the country, has the matter come up or been pointed out what apparently seems to be the situation where we have now as many as four generations in certain areas, so that the responsibility from generation to each successive generation now becomes much more complex and is becoming a problem, especially in areas where there is a considerable decrease in the proportion of say the third and fourth generations. I just wondered if you have any remarks for our benefit on that point.

Senator MORSE. Well, these hearings are just replete with last minute survey studies in regard to what is happening in longevity in this country. The old biblical three score and ten no longer applies to thousands and thousands and thousands of Americans. We have read into the record a good many statistical tables from various

parts of the country as to the terrific increase since 1950, during the last 10-year period, in the number of people reaching the age of 80 and 85 and 90, which is dramatic evidence of the great advance in medical knowledge that the medical profession has made. As our counsel just said, one of the most disturbing bits of evidence is the man who has to take forced retirement at 60 while supporting an 85-year-old parent and in many instances he in turn becomes dependent to a large measure on his 40-year-old son, who also has to take care of the young members of the same family.

I know there are no simple answers to this problem, but I think all of these facts will help to furnish it. You are quite right, though, longevity has greatly increased in this country. We have just heard from the evidence we have gathered as to what early retirement is doing economically in this country. Along with your increase in longevity is, of course, the medical benefits to the people in the ages from 50 to 65, which they are enjoying, over what people of the ages of 50 to 65 had available to them 40 years ago. If you take a look at this phase of it, you would be surprised at how many companies and how many local governmental agencies have compulsory retirement when men and women are in their best years of contribution. It's not only limited to the professionals—I'll say something about that in a moment—but I'm talking about skilled workers. A lot of men are finding it almost impossible to get a job, when they're out of a job after they're 45. I said earlier today one of the reasons is that, because of this competition in American industry, it's understandable since employers have to take on additional costs in regard to certain fringe benefits, and I will tell you quite frankly it costs them more if they have a man of 50 than if they covered him when he was 28.

These are all very interesting things that are happening. In many of our industries, the number of workers from the age of 25 to 40 has greatly decreased in industry, and they don't have the labor market to draw on and they hadn't as recently as 10 years ago. So, many of them are confronted with the necessity of having to depend upon the 45 and 50 and 55 age groups. So, there is no doubt this committee has a terrific responsibility in the report that we are going to have to prepare and the recommendations that will probably grow out of the report. What are we going to do in this country in regard to just the kind of problem that you are raising in connection with these various facets that I just suggested?

Let me say, as an old law school dean, if you were to ask me the greatest law faculty in America today, I would not name Harvard or Columbia or Yale or Michigan, nor the School of Minnesota, Wisconsin, Chicago, or any of the other law schools that have the reputation of being the great law schools of the United States. You know what I would name? The nonaccredited law school, the late afternoon and night law school, Hastings, down in San Francisco. You know why? Because the Hastings law faculty is composed almost entirely of the great retired law school professors and deans, like Fraser, who undoubtedly is the greatest living authority, in my judgment, on real property. He had to take compulsory retirement. And Morgan of Harvard on evidence, and there is a great collection of legal scholars that had to take their retirement when they were at the very

height of their ability to contribute to the law student. They are teaching at Hastings.

A lot of thinking has to be done about this matter of retiring people. A lot of rethinking has to be done in regard to compulsory retirement. If I were president of a university, I would not take the easy way out. A lot of these compulsory retirements, may I say to you, makes it easy on the administrators. Since it is compulsory he does not have to cast a value judgment, or frankly say to a man of 60 that ought to have been retired probably when he was 50, because he became incompetent at 50, "We're going to retire you because you no longer have the ability to really carry on the research work." A lot of our college presidents and administrators like compulsory retirement because it is automatic, and they do not have to get into those very difficult human relations of saying, "We're going to retire you at the age of 65, but we are not going to retire Mr. Wyatt at the age of 65 because he can still produce for the university, which you no longer can."

I am a strong supporter, as far as I am concerned, of the voluntary retirement system, but not compulsory, and that bears upon the problem that you raise too, and I want to thank you for this last contribution you made at this hearing.

Mr. MEADOWCROFT. I have a young nephew who is a graduate from Hastings and is now practicing quite well, sir.

Senator MORSE. Thank you very much. Any further comments?

STATEMENT OF DR. H. H. HENDRICKS, MAYOR OF THE CITY OF MILTON-FREEWATER, OREG.

Dr. HENDRICKS. I am Dr. H. H. Hendricks, newly appointed mayor of Milton-Freewater. While I live in Milton-Freewater, I practice medicine here in Walla Walla, and I am well acquainted with the problems of the nursing homes and the hospitals, and I say that I agree with Mrs. Kelly. We are in need of programs, such as rehabilitation of the stroke patients, which takes a great deal of time and it takes expense. I agree with all she said.

The thing that I get confused on is, when I read testimony to the effect that, if we have a local charity that takes $1.10 for every dollar that we get back, if we go up to the county level where it takes $1.23 to get a dollar back, if we go to the State level where it takes $1.49 to get a dollar back, then when it comes to the Federal Government, we have to pay $2.10 for every dollar that we get in return. Now, I can't vouch for the validity of these figures, but these are the ones that are generally quoted in publications. I agree with Mrs. Kelly that this problem exists. Nobody feels any more compassionate for these people than I do, and I really don't have the solution to it, but I don't feel in my own mind that, with these figures in front of me, having the Federal Government take part in it is the solution. As I said, I don't know the solution, but I don't think we should jump at conclusions that the Federal Government should enter into it.

I argue this back and forth with my patients and advocate the so-called Forand legislation, and I have a little bit of a game I play with them. I say, "Well, I feel the answer to this thing is that, if we have four doctors in the community of Milton-Freewater who have a certain number of patients on their books, what we should do

is that we don't charge anybody directly, but we list the number of office calls that each one of us makes during a month's time, then we put this in a master list and total up the number of charges we make, and then we send each one on our rolls a proportionate bill; if you have 7,000 on the rolls, you send bills to 7,000."

I'm not advocating this, but this is an easy thing for the patient to see, and they say, "Well, I'm not going to pay for so-and-so; he stays in your office all the time, and I'm not going to pay for somebody else because he owns a cattle ranch out here and he can well afford to pay for it," and then I point out to them that, if we had this dole under the social security, that's exactly what we would be doing, and it seems to change their viewpoint.

Again, I'm just as confused and I would like to see a solution to the problem, but it just doesn't seem to me that this is it.

Senator MORSE. We are very glad to have your testimony, Dr. Hendricks. I would like to have you submit a prepared documentation for the record, with supporting statistics, because the hearings that we have are subjected to the toughest cross-examination and the testimony just doesn't bear out your statistics. Take, for example, the matter of the cost of collecting taxes. The facts, that have not been successfully challenged, are that it costs 5 cents per dollar to collect local taxes, a cent and a half out of the dollar to collect the State tax—we're talking about national averages—and one-half cent per dollar for Federal tax, and one of the oft-repeated charges is that the Federal Government is a wasteful Government in regard to its administrative costs and expenditures, but the people making that allegation have never been able to substantiate it to my knowledge in any hearing in Washington on the basis of documentation that will stand up.

We took testimony for weeks in connection with the educational issue this year. I happened to be chairman of the education subcommittee, and I'll tell you one thing that stood out in those hearings was that those who contended that the Federal Government was wasteful in connection with the collection of money for educational purposes completely failed to make their case. I know that such figures, as we have heard this afternoon, are commonly used, but I have an obligation as chairman of this subcommittee, to call for the documentation so that the committee staff can go into it when we present our contentions in the committee.

Further testimony?

FURTHER STATEMENT OF MRS. EDA R. BURKES, TREASURER, LEAGUE OF WOMEN VOTERS, WALLA WALLA

Mrs. BURKES. I want to mention one more thing. I am not an employer, but I believe that, if we could assess the social security payments more or less upon the employer and more upon the employee, we would do away with a great deal of our opposition to the medical addition, the addition of the medical costs to the social security.

Frankly, the small businessman—and I know because I have been a bookkeeper for many years—he is very fearful of losing his business. He has the employment insurance in the State of Washington, and the employment insurance is a heavy burden. Three percent of

every man's wage that you pay him has to be paid by the employer into the State of Washington, and maybe once in 3 years we get a little bit of it back. It goes in, but it never comes back to the employer. Well, I'm not making any accusations, but it just doesn't come back, and the employer who is a small businessman has all that he can stand, especially where he is in keen competition and cannot raise the price of his goods to the public, to the consumer. I know and I say that consumers' prices have gone up, but if you investigate those consumers' costs, they do not go to the retailer. That additional cost has gone into packaging to make it easier for the housewife so that she can go out and hold another job and provide two incomes in the family, which in many cases goes for luxuries and for education. I'm not criticizing. I'm stating just what I know to be the fact.

I want to say one word for the employer, both the large and the small.

Senator MORSE. I am very glad you did.

STATEMENT OF GENE TAYLOR, WALLA WALLA

Mr. TAYLOR. Senator Morse and members of the board, my name is Gene Taylor, and I live here in Walla Walla. I'll have to improve on my first sergeant's voice. I don't believe it's fair to raise question after question in this community without offering a few alternative solutions. I am interested in the construction of convalescent homes and retirement homes and similar facilities.

Mrs. McCord, when she stated that the right hand sometimes doesn't know what the left hand is doing, as far as the State is concerned, is guilty of a gross understatement. The right hand isn't even speaking to the left hand in some places. To give you a for instance, in order to build a convalescent home here in the State of Washington, I must, first of all, if I am going to utilize State funds, have a certificate of necessity from the State department of health, then I travel over to the fire marshal and get his approval of my plans, then to the bureau of labor and industries for their perusal, and after about seven of these various bureaus have churned through and added a comment of good or otherwise to our papers, then we go back and look at the pile that we've got, and sometimes we think, "Well, to hell with it. Let's forget about it," but one thing that would greatly facilitate our work, and we are not asking for tax money, but this is coming out of our own pockets. We're putting up the money. The FHA doesn't put up any money, as you know; all they do is insure a loan.

If you want us to continue in this field, then, in heaven's name, get your house in order, and this applies not only to the State agencies, but this applies to the FHA. At present, we are building retirement homes here in Washington State, in Oregon, California, in Texas, and in Idaho, and all of them have FHA agencies, and, Senator Morse, you wouldn't even recognize the comments coming from the agencies on one project. We're lazy, as we use more or less a format on our projects. This agency says, "We like this feature," and that agency says, "Oh, no, we can't have that."

My suggestion is that some place, somehow, you get these people together and say, "Look, boys, this is the direction we're going," and then when you get your agencies, State and Federal, organized, you're

certainly going to encourage our money to build these institutions, and you won't have to worry about that portion of taxation. Thank you.

Senator MORSE. Thank you very much. Any further comments?

STATEMENT OF RAY BEVENS, MILTON-FREEWATER, OREG.

Mr. BEVENS. Senator Morse, I was invited over here by State Senator Loyd Key of Oregon. Ray Bevens is my name. I heard Mrs. Kelly talk and her husband is a farmer, and I heard Mr. Gibbons talk and he's a farmer, and I would like to state some facts about what can happen to the farmer.

In 1938, we had a farm and we had a fire, in which my wife was terribly burned. I bought my place for $15,000, and in 1½ years I owed $15,000 on that place that I spent on doctor bills. That will show you how quick a farmer can just plain go broke. If my creditors had come in on me, I'd have been broke overnight.

Then just a year ago, I had a stroke. Everybody here can see this thing I squeeze. It's to get my hand back. I had a stroke, and if I would have been in the hospital for 2 years, I wouldn't have had my farm again.

So, I don't know what the solution is, but there's got to be something for people that work all their lives to get something, and then when they have trouble, that they don't have to be bums or beggars, or whatever you call it. We work all our lives to get something, and then some calamity happens and within a couple of years we're broke.

I have another farmer friend and his wife, who sort of retired and they went to Hawaii. While they were over there, his wife had a stroke. He brought her back here and she was down in the hospital for approximately a little over 2 years. I think there is a lady here that will know about that. If they would have been small farmers, they would have been broke.

So, I would just like to state a little of the farmer's side of this business. I don't know what the solution is. I think that 95 percent of the people here believe in independence, working like heck all their lives to get something so they can live to an old age, and that's what I've done, and I think 95 percent of these people here have done that, and they believe in it.

Senator MORSE. Thank you very much, Mr. Bevens.

In closing these hearings, I want to say, on behalf of the committee, that we are greatly indebted to the residents of Walla Walla for joining us in putting democracy to work because, when it is all said and done, that is what these hearings are. It is only by getting all points of view presented to your legislators that you have any hope of any final action in the congressional body being an intelligent one.

I think you have made a good record here today, and I want it to be clear that, when these hearings have been finished and the record has been printed, I shall be very glad to make it available to those interested.

On behalf of Mr. Miller, Mr. Reidy, Miss McCamman, and the full committee, I thank you very much, and I declare these hearings adjourned. Our next hearing will be under another chairman, and I will be glad to participate in the hearings to be held in Honolulu.

We stand adjourned.

(Whereupon, at 4:15 p.m., the subcommittee was adjourned.)

APPENDIX

Prepared Statement of Dr. Robert Hall

We of the department of public assistance would like to present to the committee—

1. A method of certifying nursing homes.
2. A definition of adequate nursing home care.
3. Classification of patients.
4. Classification of the nursing home.
5. An analysis of the nursing home caseload.
6. A cost study by which we determine the per diem rate of pay.

The people of the State of Washington have been providing nursing home care for their senior citizens for more than 15 years as a part of a very comprehensive medical care program.

The Washington State Department of Public Assistance has a very keen interest in the nursing home problems of this State since, at the present time, approximately 75 percent of the nursing home beds are occupied by recipients of public assistance.

Recently we have, in cooperation with the nursing home industry, worked out a contract with each individual nursing home in which we attempt, with some success, to define what we expect to be included in nursing home care which the State is purchasing. We also include criteria for the classification of the homes and the patients. These two items are the basis for payment of care provided. We feel that since this contract is unique and based on many years of experience, it may be to the committee's interest to review this contract in some detail.

In so doing, we will explain points 1, 2, 3, and 4 as mentioned above.

EXHIBIT A

It is hereby agreed by and between the parties hereto as follows:

1. The home agrees to provide nursing home care in accordance with the present rules, regulations, and policies of the department and schedule I to those recipients of public assistance accepted by the home for such care, the home reserving at all times the right to refuse to admit or continue to care for recipients whose care is found undesirable by the home.

Nothing in this contract will be construed to prevent a recipient from exercising his right to request and be moved, when authorized by the department, from one nursing home to another.

2. The home further agrees to provide, upon reasonable request from the department, such information as necessary to justify the rate of payment and to file with the local medical care field office, State department of public assistance, all fees and rates charged patients for personal care services including, but not limited to, charges for haircuts, shave, and personal laundry.

3. The home further agrees to provide, at no additional charge to the department or patient, clinitest tablets, aspirin, mineral oil, body lotions including alcohol, milk of magnesia, and antidiarrhetics.

4. The home further agrees to provide reasonable care and attention for the safety of recipient patients as their mental and physical condition may require which shall be in proportion to the physical or mental ailments of recipient patients unable to look after their own safety.

5. The department agrees to pay the home on a monthly basis for such care as follows:

(*a*) Group I: $6.38 per patient day.
(*b*) Group II: $5.27 per patient day.
(*c*) Group III: $4.66 per patient day.
(*d*) Group IV: $4.14 per patient day.

6. The department agrees to classify recipients in need of nursing home care on four levels, i.e., group I, group II, group III, and group IV. Patient classification will be accomplished by departmental screening physicians and classification nurses in accordance with their professional judgment, taking into consideration information supplied by attending physicians, supervising and/or attending nurses, nursing home records, personal observation by screeners, and utilizing schedule II as a guide.

7. The home agrees that, in consideration of such payments by the department, the home shall not seek or accept any additional compensation for such services, the extent of these services being limited to those services set forth in schedule I attached hereto and not to include any of the following:

(*a*) The furnishing of toilet articles, comb and brush, cosmetics, smoking materials, stamps, writing paper, post cards, pen or pencil, shaving materials, notions and incidentals, newspapers or periodicals, transportation, personal clothing, wheelchairs, walkers, crutches, and other aids or appliances for the individual personal use of patients.

(*b*) Haircuts, shave, hair care (other than shampooing), drycleaning, personal laundry and long-distance telephone, for which service charges are made by the nursing home when provided by the home, or these services may be purchased directly by the patient from sources outside the home.

Paragraph 8 merely says in a very complicated way that the department in cooperation with the home does the bookkeeping and makes payment by use of machines.

Paragraph 9 designates the type of home as established by the department's rules which we will cover under schedule III.

In Paragraph 10 the home agrees to have a currently valid license which is issued by the department of health and to comply with all rules and regulations of the department of health.

If you will now turn to schedule I, where we define adequate nursing home care.

Adequate care of the nursing home patient means responsible, knowledgeable, kind and understanding care which includes: (1) medical supervision; (2) medications and treatments competently administered; (3) personal hygiene; (4) promotion of self-help; (5) meeting emotional needs and/or behavior problems; and (6) safeguarding personal possessions.

We then define in some detail just what is meant by (1) medical supervision, (*a*) an admitting diagnosis; (*b*) reporting to attending physician; (*c*) doctor's orders, etc. Under (2) medications and treatments, we again define the home's responsibility and what they are expected to provide, and we continue on through (3) personal hygiene; (4) promotion of self-help; (5) meeting emotional needs and/or behavior problems; (6) safeguarding personal possessions.

As you can see, this is quite a comprehensive listing but the remarkable thing is that these points have been agreed on by the nursing home industry of the State of Washington. It has been our experience that they are just as anxious to raise the standards of care as we are. This contract has given both the home and the State a base from which we can work out our mutual problems.

Schedule II gives the basis for classifying patients.

SCHEDULE II. NURSING HOME CRITERIA FOR THE PLACEMENT OF WELFARE PATIENTS IN NURSING HOMES

1. Hard and fast rules cannot be laid down for the classification of all nursing problems into four categories of care.

2. Good judgment and interpretation will be observed by the department's screening personnel when using the guide outlined below in the classification of nursing home patients.

Classification decisions will be rendered in accordance with best professional judgment. Such judgment will be based upon information supplied by the supervising and/or attending nurse(s), the attending physician where indicated, the nursing home record, and personal observations made by the screener.

Group I
- Status A:
  1. Confined to bed.
  2. Helpless.
- Status B:
  1. Confined to bed.
  2. Semimobile.
  3. Additional problems must be (one or combination of):
     - (a) Complete incontinence (urinary and/or fecal)
     - (b) Tube feedings.
     - (c) Medications and treatments of maximum complexity (includes dressings).
     - (d) Severe behavior problem due to (one or combination of):
       - (1) Mental confusion.
       - (2) Communication problem(s).
     - (e) Feeding problem—maximum or complete.
- Status C:
  1. Semiambulatory.
  2. Additional problems must be (one or combination of):
     - (a) Complete incontinence (urinary and/or fecal).
     - (b) Tube feedings.
     - (c) Medications and treatments of maximum complexity (includes dressings).
     - (d) Severe behavior problem due to (one or combination of):
       - (1) Mental confusion.
       - (2) Communication problem(s).
     - (e) Feeding problem, maximum or complete.

Any patient meeting these criteria would be classified as group I, for which the State would pay $6.38 per day.

Group II:
- Status A:
  1. Confined to bed.
  2. Semimobile.
- Status B:
  1. Semiambulatory or ambulatory.
  2. Additional problems must be (one or combination of):
     - (a) Frequent incontinence (urinary and/or fecal).
     - (b) Major modification of regular diet.
     - (c) Medications and treatments of moderate complexity (includes dressings).
     - (d) Moderately severe behavior problem due to:
       - (1) Mental confusion.
       - (2) Communication problem(s).
     - (e) Feeding problem, moderate or partial.

Any patient meeting these criteria would be classified as group II, for which the State would pay $5.27 per day.

Group III:
- Status A: 1. Bedrest (intermittent, daily).
- Status B:
  1. Semiambulatory or ambulatory.
  2. Additional problems must be (one or combination of):
     - (a) Infrequent incontinence (urinary and/or fecal).
     - (b) Minor modification of regular diet.
     - (c) Medications and treatments of moderate to minimal complexity (includes dressings).
     - (d) Moderate to minimal behavior problem due to (one or combination of):
       - (1) Mental confusion.
       - (2) Communication problem(s).
     - (e) Feeding problem, minimal.

Any patient meeting these criteria would be classified as group III, for which the State would pay $4.66 per day.

Group IV: Status:
1. Ambulatory or semiambulatory.
2. Additional problems must be (one or combination of):
   (*a*) Oral medications.
   (*b*) Treatment of minimal complexity (includes dressings).
   (*c*) Mild behavior problem due to (one or combination of):
      (1) Senility.
      (2) Communication problem(s).
   (*d*) Requires supervised care.

Any patient meeting these criteria would be classified as group IV, for which the State would pay $4.14 per day.

SCHEDULE III. PERSONNEL REQUIREMENTS FOR CLASSIFICATION OF NURSING HOMES

The following minimum personnel requirements determine the level at which a nursing home will be classified. As used below, the term "registered nurse" means a nurse currently licensed by the State of Washington to practice as a registered nurse; and the term "licensed practical nurse" means a nurse currently licensed by the State of Washington to practice as a practical nurse. The nursing-home operator is responsible for verifying the license status of his employees.

1. Group I licensed nursing home

A licensed nursing home to be classified as a group I home shall employ the following full-time active staff:

(*a*) One registered nurse employed as supervising nurse, on day duty, who shall direct all nursing care given in the home; and who shall be employed full-time (minimum 8-hour day, 40-hour week).

(*b*) One registered nurse on afternoon or evening duty.

(*c*) One licensed practical nurse on night duty.

(*d*) One registered nurse for relief duty.

(*e*) Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home.

(*f*) Arrangements must be made so that at all times there is either a registered or a licensed practical nurse on duty.

2. Group II licensed nursing home

A licensed nursing home to be classified as group II shall employ the following full-time active staff:

(*a*) One registered nurse employed as supervising nurse, on day duty, who shall direct all nursing care given in the home, and who shall be employed full-time (minimum 8-hour day, 40-hour week).

(*b*) One licensed practical nurse on afternoon or evening duty.

(*c*) One licensed practical nurse on night duty.

(*d*) One licensed practical nurse for relief duty.

(*e*) Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home.

(*f*) Arrangements must be made so that at all times there is either a registered or a licensed practical nurse on duty.

3. Group III licensed nursing home

A licensed nursing home to be classified as a group III home shall employ the following active staff:

(*a*) One licensed practical nurse on day duty who shall direct all nursing care given in the home, who shall be employed full-time (minimum 8-hour day, 40-hour week).

(*b*) One licensed practical nurse for relief duty must be employed full-time to cover vacations or sick leave periods.

(*c*) Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home.

4. Group IV licensed nursing home

A licensed nursing home to be classified as a group IV home shall employ the following full-time active staff:

(*a*) One licensed practical nurse employed full-time on day duty who shall direct all nursing care given in the home.

(*b*) Sufficient additional personnel to adequately care for the type and number of patients in the nursing home.

The present rates of payment for the care of public assistance recipients in licensed private nursing homes are based upon a cost study conducted for the calendar year 1959 with the finding updated through 1960. This study was in compliance with a 1959 State senate resolution directing the legislative budget committee to conduct a study to determine the amount the State should pay for each type of nursing-home care. The legislative budget committee in turn assigned the responsibility of the study to the department of public assistance. The 1959 legislature also earmarked a special appropriation to be disbursed at the rate of 40 cents per public assistance patient-day to those homes cooperating with the department in furnishing information concerning costs. Since the 40 cents did not represent an increase in rates over the previous biennium, failure to cooperate would result in a decrease in rates for the home involved.

The 1959 senate resolution reflected the longtime concern of the Washington State Department of Public Assistance and the State legislature over the rates paid for public assistance recipients in licensed private nursing homes. Basically, the rates were established and altered by negotiation without reference to any firm framework of costs. The process was satisfactory neither to the department nor to the industry and the results were subject to question in terms of equity both to the taxpayers and to the nursing home operators. Legislative concern had been heightened by the steady increase in the number of OAA recipients in nursing homes despite the decline in the number of OAA cases. This subject is discussed in detail in the report "Analysis of Increase in Nursing Home Caseload." In brief, the findings are that an estimated 20 percent of the discrepancy between the changes in OAA caseload and OAA nursing home caseload is due to the increasing average age of recipients, 15 percent to transfers from State mental hospitals and between 40 and 60 percent to increased costs of medical care, with the residual discrepancy attributable to social factors.

The department conceived of the nursing home cost study as a twofold one. Although selective information was available, representative data were lacking on the characteristics and service needs of nursing home cases. In order properly to evaluate the results of a cost study, it appeared advisable to undertake a characteristics study of a random sample of public assistance recipients in nursing homes. Such a study was conducted in December 1959 on the basis of a 5 percent sample. The schedules were completed by registered nurses from the medical care division of the department. In each instance the nurse visited the nursing home, observed the patient, reviewed the patient's records and consulted with the charge nurse of the home. During the same period and for the same cases, a social characteristics schedule was completed in the department's county offices. Although not immediately related to the cost study as such, the social characteristics study was designed to ascertain the relationship between the need for public assistance and the need for nursing home care as well as to obtain information on the events precipitating nursing home placement.

The cost study proper had two major objectives. The first was to determine an initial rate structure that bore a reasonable and defensible relationship to reported costs. The second was to obtain costs in such a form that adjustments could be made in the future for changes in prices, wage rates, and staffing requirements. The latter objective entailed a longer and more complicated schedule than the first objective alone. Since even a relatively simple cost study is costly to the department and the industry, the advantage of averting an additional study in the visible future was considered to outweigh the immediate disadvantages and the more comprehensive study was undertaken.

In developing the study plan the department consulted not only with the legislative budget committee but also with representatives of the nursing home industry. All parties involved were concerned that the results be valid and the consultations were productive. The main, though not the only, problem areas were:

(1) Selecting the homes to participate in the study;

(2) Assuring the validity of the reported cost data;

(3) Determining the extent to which cost breakdowns desirable from the standpoint of flexibility were practicable from an accounting standpoint;

(4) Determining a reasonable return on invested capital;

(5) Determining the allowances to be made for the unpaid labor of operators and families, including administrative allowances;

(6) Allocating costs among different classes of care in homes providing more than one class of care; and

(7) Determining the adjustments to be made for changes in taxes, prices, and wage rates during and subsequent to the reporting period.

The detail of these problems and the methods adopted in solving them are given in the report "Nursing Home Cost Study."

The cost study was based on calendar year 1959. Most of the homes included in the study cooperated with the department and submitted schedules promptly. The department, with considerable success, made every effort to secure the voluntary compliance of the remaining homes. In some cases, however, it proved necessary to revoke the 40 cents per diem payment in order to obtain cost information.

The main findings of the characteristics study are given in part II of the report "Nursing Home Cost Study." The main procedures and techniques used in the cost study as well as a summary of the results are given in part III. The schedules and instructions used in both studies are included in appendix A.

Some of the highlights of our characteristics study will be of interest to this committee:

The public assistance recipients in nursing homes are predominantly a very aged group—as of December 1959, 53 percent were at least 80 years, 24 percent were at least 85, and 10 percent were 90 or over.

Sixty-two percent of all the nursing home recipients were women.

Most of the recipients suffered from multiple impairments. The most frequent impairments were strokes, other heart or circulatory disease, arthritis or rheumatism, debility and senile behavior disorders.

Only 26 percent of the recipients were always clear mentally. Thirty-four percent were mildly confused and 37 percent were seriously disoriented at least part of the time. The remaining 3 percent were mentally retarded.

Thirty percent of the recipients were bedridden most or all of the time and another 10 percent were bedridden part of the time.

Fifty percent of the recipients had bladder continence all of the time. Twenty-six percent were occasionally incontinent and the remaining 24 percent were frequently or always incontinent.

Sixty-two percent of the recipients had bowel continence all of the time. Sixteen percent were occasionally incontinent and the remaining 22 percent were frequently or always incontinent.

In general the recipients needed and received a variety of personal services though relatively few required such specialized services as intravenous feeding and complex or extensive dressings.

Incidentally, the data on services proved invaluable in the cost study proper in helping to solve the problem of allocating costs among different classes of care.

The median costs for each class of care as well as the breakdown by type of cost, e.g., food for patients, return on investment, are shown in the "Nursing Home Cost Study" report. We are convinced that our study has been a useful and objective tool in arriving at equitable rates. We have published our methods and results in full detail not only because we are anxious to share our experience with other agencies but because we welcome suggestions and constructive criticism. We ourselves hope to refine our techniques further prior to the next rate adjustments. In short, we regard the study as a first rather than a final step in solving the problem of determining equitable vendor rates.

C O N T R A C T

This contract is made and entered into this _____ day of _____19___ by and between _____, a licensed nursing home in the State of Washington hereinafter called "Home", and the Division of Medical Care of the Department of Public Assistance, State of Washington, hereinafter called "Department" acting pursuant to authority contained in R.C.W. 74.09.120 which provides that the Division of Medical Care shall purchase nursing home care by contract or at not more than the minimum ward rate of each nursing home.

"Recipient" as used herein, shall mean a person determined eligible to receive assistance under any of the categorical programs, in accordance with R.C.W. Chapter 74, and certified as eligible for nursing home care under the provisions of R.C.W. 74.09.

WITNESSETH:

It is hereby agreed by and between the parties hereto as follows:

1. The Home agrees to provide nursing home care in accordance with the present rules, regulations, and policies of the Department and Schedule I which is attached hereto and made a part hereof as fully as if set forth in full herein, to those recipients of public assistance accepted by the Home for such care, the Home reserving at all times the right to refuse to admit or continue to care for recipients whose care is found undesirable by the Home.

Nothing in this contract will be construed to prevent a recipient from exercising his right to request and be moved, when authorized by the Department, from one nursing home to another.

2. The Home further agrees to provide, upon reasonable request from the Department, such information as necessary to justify the rate of payment in accordance with R.C.W. 74.09.120 and to file with the local Medical Care Field Office, State Department of Public Assistance, all fees and rates charged patients for personal care services including, but not limited to, charges for hair cuts, shave, and personal laundry.

3. The Home further agrees to provide, at no additional charge to the Department or patient, clinitest tablets, aspirin, mineral oil, body lotions including alcohol, milk of magnesia, and antidiarrhetics.

4. The Home further agrees to provide reasonable care and attention for the safety of recipient patients as their mental and physical condition may require which shall be in proportion to the physical or mental ailments of recipient patients unable to look after their own safety.

5. The Department agrees to pay the Home on a monthly basis for such care as follows:

(a) For Recipients receiving Group I care, the sum of $6.38 per patient day less income available to the Recipient as determined by the Department to be available to meet nursing home cost.

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(b) For Recipients receiving Group II care, the sum of $5.27 per patient day less income available to the Recipient as determined by the Department to be available to meet nursing home cost.

(c) For Recipients receiving Group III care, the sum of $4.66 per patient day less income available to the Recipient as determined by the Department to be available to meet nursing home cost.

(d) For Recipients receiving Group IV care, the sum of $4.14 per patient day less income available to the Recipient as determined by the Department to be available to meet nursing home cost.

6. The Department agrees to classify recipients in need of nursing home care on four levels, i.e., Group I, Group II, Group III, and Group IV. Patient classification will be accomplished by Departmental screening physicians and classification nurses in accordance with their professional judgment, taking into consideration information supplied by attending physicians, supervising and/or attending nurses, nursing home records, personal observation by screeners, and ulitizing Schedule II as a guide which is attached hereto and made a part hereof as fully as set forth herein.

7. The Home agrees that, in consideration of such payments by the Department, the Home shall not seek or accept any additional compensation for such services, the extent of these services being limited to those services set forth in Schedule I attached hereto and not to include any of the following:

(a) The furnishing of toilet articles, comb and brush, cosmetics, smoking materials, stamps, writing paper, post cards, pen or pencil, shaving materials, notions and incidentals, newspapers or periodicals, transportation, personal clothing, wheel chairs, walkers, crutches and other aids or appliances for the individual personal use of patients.

(b) Hair cuts, shave, hair care (other than shampooing), dry cleaning, personal laundry and long distance telephone, for which service charges are made by the nursing home when provided by the Home, or these services may be purchased directly by the patient from sources outside the Home.

8. The Department shall furnish the Home, as soon as is practicable after the first day of each month, a statement showing the name, number, and class of care of all recipients who have been certified by the Department to receive nursing home care in the Home during the preceding month, the dates of such eligibility, together with the dates of admission and/or discharge, and the amount of money which the Department believes is owing to the Home on account of nursing home care furnished to the said recipients during the said month. The Home agrees, upon receipt of the said statement from the Department, to verify the same with the records of the Home and to promptly inform the Department of any differences between the said statement and the records of the Home, and to simultaneously forward to the Department a billing in such form as the Department may require for services rendered during the said month. As soon as reasonably possible after the exchange of reports as provided for in this paragraph, the Department shall make payment to the Home for the Services rendered.

9. The parties hereto mutually agree that the Home shall be designated by the Department as a Group _____ Home, the said designation being based upon the representation of the Home that they presently are in compliance with the staffing requirements for a Group _____ Home as shown on Schedule III which is attached hereto and made a part hereof as fully as if set forth herein, and the further representation that the Home will during the entire life of this contract continue to employ staff in compliance with the requirements for the said classification.

10. The Home agrees at all time during the life of this contract to have a currently valid license issued by the Washington State Department of Health and to comply with all rules and regulations of said Department pertaining to the licensure of nursing homes.

11. A signed copy of this contract shall be kept available at all times in the Nursing Home.

12. This contract shall become effective on _____, 19____, and shall remain in full force and effect until December 31, 1962, subject to the right of either party to cancel at the expiration of any calendar month during the life of this contract upon giving thirty days written notice of such cancellation to the other party.

Dated this _____ day of _____, 19_____.

_____
(Name of Home)

By_____

DIVISION OF MEDICAL CARE OF THE
DEPARTMENT OF PUBLIC ASSISTANCE OF THE STATE
OF WASHINGTON

By_____

Schedule I

ADEQUATE NURSING HOME CARE

Adequate care of the nursing home patient means responsible, knowledgeable, kind and understanding care which includes: (1) medical supervision; (2) medications and treatments competently administered; (3) personal hygiene; (4) promotion of self help; (5) meeting emotional needs and/or behavior problems; and (6) safeguarding personal possessions.

1. Medical supervision signifies the responsibility of the home to:
   a. secure from attending physician the admission diagnosis and treatment orders for each patient;
   b. report to physician any change in the patient's condition;
   c. record in proper manner the physician's orders on "Doctor's Orders" sheet in the patient's chart, securing the physician's signature at first opportunity if orders were given by telephone;
   d. request physician to visit in case of emergency or critical change in patient's condition;
   e. allocate to nursing personnel the function of communication with physician and the recording of his orders; and allocate in this order of priority; supervising RN, the registered nurse on duty, the LPN, or the aide in charge on a shift not covered by a licensed nurse.

2. Medications and Treatments means the responsibility of the home to:
   a. provide the equipment and secure the supplies and drugs needed to carry out the physician's orders for medication and/or treatments (Limited by the Department's rules and regulations as interpreted by screening physician);
   b. provide the following equipment and supplies (according to classification of home):
      1) hot water and ice bags, rectal tubes (including enema equipment), catheterization sets, rubber gloves, thermometers, hypodermic syringes and needles, equipment for taking blood pressure, intravenous, oxygen and aspiration equipment where needed;
      2) a dressing tray with standard equipment and supplies such as adhesive, band-aids, gauze, bandage, cotton, burn ointment, one or more antiseptics;
   c. allocate to the supervising nurse the responsibility for insuring that all medications and treatments are administered and recorded by staff members with requisite knowledge and skill for the particular medication or treatment. The supervising nurse is to be aware of medications continued over a long period of time, and to check with attending physician at periodic intervals regarding continuance.
   d. insure that labels on containers of all medications, whether prescriptions or over-the-counter items, clearly state the drug(s) as well as the dosage and directions.

3. Personal Hygiene includes all aspects of personal care which promote a healthy condition of body surface, including orifices, and improve body functioning. This care may be given wholly or partly by staff or may be almost entirely a matter of supervised self-care. Personal hygiene means the responsibility of the home to provide a competently supervised nursing staff of sufficient number to insure for each patient:
   a. daily care of teeth or dentures;
   b. clean skin and hair, with complete bath and shampoo spaced at sufficient

intervals to prevent deterioration of skin from too frequent application of soap and water;
c. cleansing of body area affected in incontinence or drainage at sufficiently frequent intervals to prevent, so far as possible, excoriation or ulceration;
d. clean and trimmed fingernails;
e. care of feet and toe-nails, with sufficient soaking, lubrication and use of nail clippers to prevent, so far as feasible, deterioration of skin and nails;
f. handwashing, according to need;
g. and to make available for each patient haircuts and shaves at intervals required for comfort, physical and/or mental.

4. Promotion of self-help implies the rehabilitative component in nursing care of the patient, thus meaning the responsibility of the home to:
a. encourage and promote patient interest in simple tasks within the patient's ability to perform, which contribute to his psychological and emotional well-being;
b. secure a nursing service characterized by such practices as: (1) bed patients able to be moved are gotten up each day; (2) incontinent care is by change of pads and cleansing of skin, rather than retention catheters; (3) bedpan training by anticipation of need; (4) emphasizing self-help activities and exercises which will encourage mobility and ambulation.

5. Meeting emotional needs and/or behavior problems signifies the responsibility of the home to:
a. provide an environment of comfortable and comforting interpersonal relationships, an environment which insures kind and friendly attitude of staff toward each patient, an atmosphere where warmth in staff-patient relationships is unmistakable;
b. provide for a certain amount of diversional activity for patients, encouraging friends, relatives and organizations to contribute to this phase of care;
c. encourage visitors and facilitate visits to patients;
d. secure personnel capable of caring for the senile patient or the patient with severe behavior problem with patience, understanding and kindness;
e. make clear to all personnel a philosophy based on respect for the individual patient and his possessions which will protect, so far as possible, the patient's right to privacy.

6. Safeguarding personal possessions (including money) means the responsibility of the home to:
a. provide a method of identification of the patient's suitcases, clothing and other personal effects, and a listing of these on a sheet attached to patient's chart when the patient is admitted to the home;
b. provide adequate storage facilities for the patient's personal effects, and these facilities accessible to the patient if ambulatory;
c. provide reasonable protection of patient's possessions, particularly clothes, against theft, and damage from moths, mildew, and destruction;
d. provide an accounting system (adequate for audit) of expenditures from the patient's allowance for clothing and incidentals -- this accounting system being a service to those patients unable to handle their own money.

e. insure that all mail is delivered unopened to the patient to whom it is addressed, except for those patients too confused to receive it. Assistance in opening and reading personal mail should be given only on the basis of the patient's need or request.

Schedule II

NURSING CRITERIA FOR THE PLACEMENT OF WELFARE PATIENTS IN NURSING HOMES

1. Hard and fast rules cannot be laid down for the classification of all nursing problems into four categories of care.

2. Good judgment and interpretation will be observed by the Department's screening personnel when using the guide outlined below in the classification of nursing home patients.

   Classification decisions will be rendered in accordance with best professional judgment. Such judgment will be based upon information supplied by the supervising and/or attending nurse(s), the attending physician where indicated, the nursing home record, and personal observations made by the screener.

NURSING CRITERIA

GROUP I

STATUS A

1. Confined to bed
2. Helpless

STATUS B

1. Confined to bed
2. Semi-mobile
3. Additional problems must be (one or combination of)
   a. Complete incontinence (urinary and/or fecal)
   b. Tube feedings
   c. Medications and treatments of maximum complexity (includes dressings)
   d. Severe behavior problem due to (one or combination of)
      1) Mental confusion
      2) Communication problem(s)
   e. Feeding problem - maximum or complete

STATUS C

1. Semi-ambulatory
2. Additional problems must be (one or combination of)
   a. Complete incontinence (urinary and/or fecal)
   b. Tube feedings
   c. Medications and treatments of maximum complexity (includes dressings)
   d. Severe behavior problem due to (one or combination of)
      1) Mental confusion
      2) Communication problem(s)
   e. Feeding problem - maximum or complete

NURSING CRITERIA

GROUP II

STATUS A

1. Confined to bed
2. Semi-mobile

STATUS B

1. Semi-ambulatory or ambulatory
2. Additional problems must be (one or combination of)
   a. Frequent incontinence (urinary and/or fecal)
   b. Major modification of regular diet
   c. Medications and treatments of moderate complexity (includes dressings)
   d. Moderately severe behavior problem due to:
      1) Mental confusion
      2) Communication problem(s)
   e. Feeding problem - moderate or partial

GROUP III

STATUS A

1. Bedrest (intermittent, daily)

STATUS B

1. Semi-ambulatory or ambulatory
2. Additional problems must be (one or combination of)
   a. Infrequent incontinence (urinary and/or fecal)
   b. Minor modification of regular diet
   c. Medications and treatments of moderate to minimal complexity (includes dressings)
   d. Moderate to minimal behavior problem due to (one or combination of)
      1) Mental confusion
      2) Communication problem(s)
   e. Feeding problem - minimal

GROUP IV

STATUS

1. Ambulatory or semi-ambulatory
2. Additional problems must be (one or combination of)
   a. Oral medications
   b. Treatments of minimal complexity (includes dressings)
   c. Mild behavior problem due to (one or combination of)
      1) Senility
      2) Communication problem(s)
   d. Requires supervised care

Schedule III

PERSONNEL REQUIREMENTS FOR CLASSIFICATION OF NURSING HOMES

The following minimum personnel requirements determine the level at which a nursing home will be classified. As used below, the term "registered nurse" means a nurse currently licensed by the State of Washington to practice as a registered nurse; and the term "licensed practical nurse" means a nurse currently licensed by the State of Washington to practice as a practical nurse. The nursing home operator is respons ible for verifying the license status of his employees.

1. GROUP I LICENSED NURSING HOME

A licensed nursing home to be classified as a Group I home shall employ the following full-time active staff:

a. One registered nurse employed as Supervising Nurse, on day duty, who shall direct all nursing care given in the home; and who shall be employed full-time (minimum 8-hour day, 40-hour week)

b. One registered nurse on p.m. or evening duty

c. One licensed practical nurse on night duty

d. One registered nurse for relief duty

e. Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home

f. Arrangements must be made so that at all times there is either a registered or a licensed practical nurse on duty.

2. GROUP II LICENSED NURSING HOME

A licensed nursing home to be classified as a Group II home shall employ the following full-time active staff:

a. One registered nurse employed as Supervising Nurse, on day duty, who shall direct all nursing care given in the home, and who shall be employed full-time (minimum 8-hour day, 40-hour week)

b. One licensed practical nurse on p.m. or evening duty

c. One licensed practical nurse on night duty

d. One licensed practical nurse for relief duty

e. Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home

f. Arrangements must be made so that at all times there is either a registered or a licensed practical nurse on duty.

Schedule III

PERSONNEL REQUIREMENTS FOR CLASSIFICATION OF NURSING HOMES (cont.)

3. GROUP III LICENSED NURSING HOME

A licensed nursing home to be classified as a Group III home shall employ the following active staff:

a. One licensed practical nurse on day duty who shall direct all nursing care given in the home, who shall be employed full-time (minimum 8-hour day, 40-hour week)

b. One licensed practical nurse for relief duty must be employed full-time to cover vacations or sick leave periods

c. Sufficient additional nursing personnel to adequately care for the type and number of patients in the nursing home.

4. GROUP IV LICENSED NURSING HOME

A licensed nursing home to be classified as a Group IV home shall employ the following full-time active staff:

a. One licensed practical nurse employed full-time on day duty who shall direct all nursing care given in the home

b. Sufficient additional personnel to adequately care for the type and number of patients in the nursing home.

Exhibit B - NURSING HOME COST STUDY

State of Washington
Department of Public Assistance
Research and Statistics Unit
Olympia, Washington
February 1961

I. Introduction

For some years the Washington State Department of Public Assistance and the State Legislature have been concerned about the rates paid for the care of public assistance recipients in licensed private nursing homes. Basically, the rates were established and altered by negotiation without reference to any firm framework of costs. The process was satisfactory neither to the Department nor to the industry and the results were subject to question in terms of equity both to the taxpayers and to the nursing home operators. In 1959 the State Senate passed a resolution directing the Legislative Budget Committee to conduct a study to determine the amount the State should pay for each type of nursing home care. The Legislative Budget Committee in turn assigned the responsibility for the study to the Department of Public Assistance. The 1959 Legislature also earmarked a special appropriation to be disbursed at the rate of forty cents per public assistance patient-day to those homes cooperating with the Department in furnishing information concerning costs. Since the forty cents per patient-day did not represent an increase in rates over the previous biennium, failure to cooperate would result in a decrease in rates for the home involved.

The Department conceived of the study as a twofold one. Although selective information was available, representative data were lacking on the characteristics and service needs of nursing home cases. In order properly to evaluate the results of a cost study, it appeared advisable to undertake a characteristics study of a random sample of public assistance recipients in nursing homes. Such a study was conducted in December 1959 on the basis of a five percent sample. The schedules were completed by registered nurses from the Medical Care Division of the Department. In each instance the nurse visited the nursing home, observed the patient, reviewed the patient's records and consulted with the charge nurse of the home. During the same period and for the same cases, a social characteristics schedule was completed in the Department's County Offices. Although not immediately related to the cost study as such, the social characteristics study was designed to ascertain the relationship between the need for public assistance and the need for nursing home care as well as to obtain information on the events precipitating nursing home placement.

The cost study proper had two major objectives. The first was to determine an initial rate structure that bore a reasonable and defensible relationship to reported costs. The second was to obtain costs in such a form that adjustments could be made in the future for changes in prices, wage rates and staffing requirements. The latter objective entailed a longer and more complicated schedule than the first objective alone. Since even a relatively simple cost study is costly to the Department and the industry, the advantage of averting an additional study in the visible future was considered to outweigh the immediate disadvantages and the more comprehensive study was undertaken.

In developing the study plan the Department consulted not only with the Legislative Budget Committee but also with representatives of the nursing

home industry. All parties involved were concerned that the results be valid and the consultations were productive. The main -- though not the only -- problem areas were:

1. Selecting the homes to participate in the study
2. Assuring the validity of the reported cost data
3. Determining the extent to which cost breakdowns desirable from the standpoint of flexibility were practicable from an accounting standpoint 1/
4. Determining a reasonable return on invested capital
5. Determining the allowances to be made for the unpaid labor of operators and families, including administrative allowances
6. Allocating costs among different classes of care in homes providing more than one class of care 2/
7. Determining the adjustments to be made for changes in taxes, prices and wage rates during and subsequent to the reporting period.

The cost study was based on calendar year 1959. Schedules were transmitted to the homes included in the study in the late spring of 1960. Most of the homes cooperated with the Department and submitted schedules promptly. The Department, with considerable success, made every effort to secure the voluntary compliance of the remaining homes. In some cases, however, it proved necessary to revoke the forty cents per diem payment in order to obtain cost information.

The main findings of the characteristics study are given in Part II of this report. The main procedures and techniques used in the cost study as well as a summary of the results are given in Part III. The schedules and instructions used in both studies are included in Appendix A.

1/ No uniform system of accounts is prevalent in the Washington nursing home industry.

2/ Prior to entering a nursing home or to receiving assistance while in a nursing home, a public assistance recipient is certified by a departmental screening physician or screening nurse as requiring one of four classes of care. Class I care is the most complex and extensive and Class IV the least. In order to receive payment for a specified class of care nursing homes must be licensed by the Department of Health and meet the staffing requirements of the Department of Public Assistance. Since staffing requirements increase in stringency with the level of care, a Class I home may care for Class II, III and IV as well as Class I patients, a Class II home may care for Class III and IV as well as Class II patients and a Class III home may care for both Class III and IV patients.

II. Characteristics of Public Assistance Recipients in Licensed Private Nursing Homes, December 1959

Age and sex Public assistance recipients in licensed private nursing homes are predominantly a very aged group. (Table II-1) As of December 1959, 53 percent were at least 80 years, 24 percent were at least 85 and 10 percent were 90 years of age or over.

Sixty-two percent of all the nursing home recipients were women. While men outnumbered women in the age group under 65, the majority of older recipients were female. In general, the percentage of women increased with age group from 44 percent of the recipients under 65 to 70 percent of those 90 or over.

Impairments Most of the recipients suffered from multiple impairments.1/ (Table II-2) Only 9 percent had but one impairment as compared with 27 percent with two impairments, 25 percent with three and 39 percent with four or more.

The most frequent impairments were strokes, other heart or circulatory disease, arthritis or rheumatism, debility and senile behavior disorders. (Table II-3) Other impairments incurred by at least 10 percent of the caseload were paralysis or palsy, gastro-intestinal disease, genito-urinary disease, blindness, deafness and behavior disorders other than senile.

Mental condition Only 26 percent of the recipients were always clear mentally. (Table II-4) Thirty-four percent were mildly confused and thirty-seven percent were seriously disoriented at least part of the time. The remaining 3 percent were mentally retarded.

Twenty-seven percent of the recipients displayed eccentric behavior at least part of the time. Three percent of all recipients, though not incontinent, were disoriented with respect to toilet facilities.

By class of care only 17 percent of the Class I patients, 26 percent of the Class II patients and 25 percent of the Class III patients were clear all of the time. Even among the Class IV patients 46 percent were at least mildly confused. Substantial percentages of all classes of patients were seriously disoriented at least part of the time, ranging from 53 percent of the Class I and 41 percent of the Class II patients to 30 percent of the Class III and 18 percent of the Class IV.

Bed status Thirty percent of the recipients were bedridden most or all of the time and another 10 percent were bedridden part of the time. (Table II-5) Eighty-four percent of the Class I patients and 36 percent of the Class II patients were bedridden most or all of the time. Although few patients in other classes were bedfast as such, seven percent of Class III and IV patients were bedridden part of the time.

Mobility Forty-eight percent of the recipients were able to walk alone or with no more help than cane or crutch. (Table II-6) The mobility of the other recipients was substantially limited. Thirty-seven percent of all the patients were unable, at least part of the time, to walk or be moved in a wheelchair. The remaining 16 percent, though never so severely restricted, needed a walker, wheelchair or the help of an attendant.

1/ Impairments are restricted to those contributing to the need for nursing home care and/or affecting the type of care required.

Only four percent of the Class I patients were able to move about without the help of an attendant as compared with 40 percent of the Class II, 85 percent of the Class III and 93 percent of the Class IV patients.

Bladder continence — Fifty percent of the recipients were continent (bladder) all of the time. (Table II-7) Twenty-six percent were occasionally incontinent and the remaining 24 percent were frequently or always incontinent.

Eighty-eight percent of the Class I patients, 53 percent of the Class II patients, 33 percent of the Class III patients and 14 percent of the Class IV patients were incontinent (bladder) at least part of the time.

Bowel continence — Sixty-two percent of the recipients were continent (bowel) all of the time. (Table II-7) Sixteen percent were occasionally incontinent and the remaining 22 percent were frequently or always incontinent.

Seventy-two percent of the Class I patients, 45 percent of the Class II patients, 19 percent of the Class III patients and 11 percent of the Class IV patients were incontinent (bowel) at least part of the time.

Services — In general the recipients needed and received a variety of personal services though relatively few required such specialized services as intravenous feeding, parenteral medications and complex or extensive dressings. (Table II-8)

The percentages of recipients needing and receiving (without extra charge) assistance or supervision on a regular or occasional basis in the activities of daily living were:

Washing face, hands, teeth and/or dentures	68%
Care of fingernails	82
Care of feet and toenails	90
Combing hair	47
Washing hair	82
Shaving	21
Dressing (clothing, nightwear, appliances)	68
Feeding	62
Bathing	91
Toilet	46

Although relatively more Class I and II patients required assistance in these activities, substantial percentages of Class III patients also needed help, e.g., 97 percent of the Class I patients, 88 percent of the Class II patients and 50 percent of the Class III patients needed help in dressing; 91 percent of the Class I patients, 77 percent of the Class II patients and 46 percent of the Class III patients needed at least some assistance in feeding. With the exception of nail care and bathing, Class IV patients were relatively independent in personal care needs.

Sixty percent of the recipients needed routine oral medication and 35 percent needed "critical" oral medication requiring observation. The relative number of patients receiving routine and critical medications respectively varied little between Class I, II and III care. Routine medication was relatively more frequent and critical medication less frequent among Class IV patients than in the other classes of care.

The major specialized services required by the patients were taking blood pressure, subcutaneous and intramuscular medications and dressings. Specifically the percentages of recipients requiring such specialized services were:

Take blood pressure	37%
Subcutaneous medications	7
Intramuscular medications	7
Complex and/or extensive dressings	1
Other dressings	6
Administration of oxygen	2
Retention catheterization 1/	2
Other catheterization	2
Aspiration	1

Intravenous medication and intravenous feeding were required by less than one percent of the recipients.

Of the services required most frequently, taking of blood pressure ranged from 47 percent of the Class I patients to about 30 percent of Class III and IV patients. Dressings were required by 11 percent of the Class I patients, 7 percent of the Class II and III and 4 percent of the Class IV patients. Subcutaneous medications were needed by 12 percent of the Class I patients, 7 percent of the Class II and 4 percent of the Class III and IV. Intramuscular medication ranged from 10 percent of the Class I and II to 5 percent of the Class III patients.

Ability to purchase clothing and personal incidentals

Only 18 percent of the recipients were able both to manage their clothing and personal incidentals money and to make their purchases. (Table II-9) Thirty percent were able to manage their money but unable to make their own purchases and the remaining 52 percent were unable even to manage their money. In 36 percent of all the cases the nursing home operator managed the money and/or made the purchases.

Length of time in present nursing home

Nursing home care is a long-term "living arrangement" for an important number of public assistance recipients. (Table II-10) Twenty-seven percent of the recipients had been in their present nursing home for at least 3 years and 12 percent had been in the same home for 5 years or more. The length of stay increased with age group. Thirty-five percent of the recipients aged 85 years or over and 30 percent of those aged 75 through 84 had been in the present home for at least 3 years as compared with 22 percent of the recipients under 75 years of age.

Estimated period for which care required

Most of the recipients were expected to require nursing home care on a continuing basis. (Table II-11) Including cases in which care was expected to be terminal, 96 percent of all the recipients were expected to remain in nursing home care for an indefinite period. Only 2 percent were expected to need care for less than a year.

Note: Because the Social Characteristics study was not directly related to the cost study, no narrative material on social characteristics is presented. Tabular summaries of the data are given in Appendix.

1/ Reported only for cases in which retention catheters were used because of medical order.

TABLE II-1: AGE AND SEX OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959 1/

Age in years	Number of recipients			Percent distribution by age 2/			Percent distribution by sex		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Total	8,471	3,249	5,222	100.0	100.0	100.0	100.0	38.4	61.6
Less than 55	336	201	135	4.0	6.2	2.6	100.0	59.8	40.2
55, less than 65	627	336	291	7.4	10.3	5.6	100.0	53.6	46.4
65, less than 75	1,434	650	784	16.9	20.0	15.0	100.0	45.3	54.7
65, less than 70	403	179	224	4.8	5.5	4.3	100.0	44.4	55.6
70, less than 75	1,031	471	560	12.2	14.5	10.7	100.0	45.7	54.3
75, less than 85	4,079	1,412	2,667	48.1	43.5	51.1	100.0	34.6	65.4
75, less than 80	1,569	560	3/ 1,009	18.5	17.2	19.3	100.0	35.7	64.3
80, less than 85	2,510	852	1,658	29.6	26.2	31.8	100.0	33.9	66.1
85 or over	1,995	650	1,345	23.6	20.0	25.8	100.0	32.6	67.4
85, less than 90	1,165	403	762	13.7	12.4	14.6	100.0	34.6	65.4
90 or over	830	247	583	9.8	7.6	11.2	100.0	29.8	70.2

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases.
2/ Because of rounding, detail does not necessarily add to totals.
3/ Forced to balance total.

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TABLE II-2: COUNT OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES BY NUMBER OF IMPAIRMENTS, DECEMBER 1959 1/

Number of impairments 2/	Number of recipients	Percent of total
Total	8,471	100.0
One impairment only	740	8.7
Two or more impairments	7,731	91.3
Two	2,263	26.7
Three	2,151	25.4
Four or more	3,317	39.2

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases.
2/ Impairments are restricted to those contributing to recipient's need for nursing home care and/or affecting the type of care required.

TABLE II-3: MAJOR IMPAIRMENTS OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED, PRIVATE NURSING HOMES, DECEMBER 1959 1/

Major impairment 2/	Number of recipients 3/	Percent of total 3/
Total	8,471	100.0
Stroke, total 4/	2,219	26.2
Nonparalytic	628	7.4
Paralytic	1,591	18.8
Multiple sclerosis	538	6.3
Other paralysis or palsy	941	11.1
Other heart or circulatory disease	4,280	50.5
Arthritis or rheumatism	2,488	29.4
Amputation of lower limb(s)	291	3.4
Fracture of hip	583	6.9
Other fracture	247	2.9
Diabetes	515	6.1
Cancer or other neoplasms	359	4.2
Other gastrointestinal disease or impairment	1,322	15.6
Other genitourinary disease or impairment	1,524	18.0
Dermatitis and related	381	4.5
Asthma or bronchitis	695	8.2
Blindness	1,457	17.2
Deafness	1,434	16.9
Debility	3,137	37.0
Epilepsy	224	2.6
Mental retardation	247	2.9
Senile behavior disorders	3,563	42.0
Other behavior disorders	1,345	15.9
Other	1,412	16.7

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. 2/ Restricted to impairments contributing to recipient's need for nursing home care and/or affecting the type of care required.
3/ Since some recipients had more than one impairment, the sum of the components exceeds the (net) total recipient count. 4/ Includes 515 cases (representing 6 percent of the total nursing home caseload) in which aphasia was reported.

TABLE II-4: MENTAL CONDITION OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES BY CLASS OF CARE, DECEMBER 1959 1/

Mental condition	Number of recipients					Percent distribution by mental condition 2/				
	All classes	Class I	Class II	Class III	Class IV	All classes	Class I	Class II	Class III	Class IV
Total	8,471	1,994	2,308	3/ 3,542	627	100.0	100.0	100.0	100.0	100.0
Always clear	2,174	336	605	3/ 897	336	25.7	16.8	26.2	25.3	53.6
Mildly confused at least part of the time but never seriously disoriented	3/ 2,890	515	762	1,479	134	34.1	25.8	33.0	41.8	21.4
Seriously disoriented at least part of the time, total	3,160	1,053	941	3/ 1,054	112	37.3	52.8	40.8	29.8	17.9
Without eccentric behavior	852	381	157	269	45	10.1	19.1	6.8	7.6	7.2
With eccentric behavior	2,308	672	784	3/ 785	67	27.2	33.7	34.0	22.2	10.7
Mentally retarded	247	90	0	112	45	2.9	4.5	0	3.2	7.2

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Class of care refers to class of care recipient was receiving.
2/ Because of rounding, detail does not necessarily add to totals.
3/ Forced to balance total.

TABLE II-5: BED STATUS OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES BY CLASS OF CARE, DECEMBER 1959 1/

Bed status	Number of recipients					Percent distribution by bed status 2/				
	All classes	Class I	Class II	Class III	Class IV	All classes	Class I	Class II	Class III	Class IV
Total	8,471	1,994	2,308	3/ 3,542	627	100.0	100.0	100.0	100.0	100.0
Not bedridden	5,065	157	1,098	3/ 3,228	3/ 582	59.8	7.9	47.6	91.1	92.8
Bedridden part of the time	829	3/ 156	381	247	45	9.8	7.8	16.5	7.0	7.2
Bedridden most or all of the time, total	2,577	1,681	829	67	0	30.4	84.3	35.9	1.9	0
Most of the time	986	515	426	45	0	11.6	25.8	18.5	1.3	0
All of the time	1,591	3/ 1,166	403	22	0	18.8	58.5	17.5	.6	0

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Class of care refers to class of care recipient receiving.
2/ Because of rounding detail does not necessarily add to totals.
3/ Forced to balance total.

TABLE II-6: COUNT OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES BY MAXIMUM RESTRICTION ON MOBILITY BY CLASS OF CARE, DECEMBER 1959 1/

Maximum restriction on mobility 2/	Number of recipients					Percent distribution by restriction of mobility 3/				
	All classes	Class I	Class II	Class III	Class IV	All classes	Class I	Class II	Class III	Class IV
Total	8,471	1,994	2,308	4/ 3,542	627	100.0	100.0	100.0	100.0	100.0
Walks alone or with no more help than cane or crutch	4,034	22	4/ 739	4/ 2,691	4/ 582	47.6	1.1	32.0	76.0	92.8
Moves himself about with a mechanical aid such as walker or wheelchair	560	67	179	314	0	6.6	3.4	7.8	8.9	0
Able to walk or move in wheelchair only with help of attendant	762	90	359	4/ 313	0	9.0	4.5	15.6	8.8	0
Unable to walk or be moved about in wheelchair, total	3,115	1,815	1,031	224	45	36.8	91.0	44.7	6.3	7.2
Able to turn and/or sit on bedside by self	1,210	403	583	179	45	14.3	20.2	25.3	5.1	7.2
Helpless, must be turned or lifted	1,905	1,412	448	45	0	22.5	70.8	19.4	1.3	0

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Class of care refers to class of care recipient receiving.

2/ A recipient whose mobility status varies is reported only under the most restricted mobility, e.g., a recipient able to walk alone part of the time but needing help of an attendant the rest of the time is reported only under the latter status.

3/ Because of rounding, detail does not necessarily add to totals.

4/ Forced to balance total.

TABLE II-7: CONTINENCE OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES BY CLASS OF CARE, DECEMBER 1959 1/

	Number of recipients					Percent distribution by continence 2/				
	All classes	Class I	Class II	Class III	Class IV	All classes	Class I	Class II	Class III	Class IV
I. Bladder continence										
Total	8,471	1,994	2,308	3/ 3,542	627	100.0	100.0	100.0	100.0	100.0
Always continent	4,234	3/ 246	3/ 1,075	2,375	538	50.0	12.3	46.6	67.1	85.8
Occasionally incontinent	1,546	448	448	605	45	18.2	22.5	19.4	17.1	7.2
Dribbling	3/ 696	67	247	3/ 338	3/ 44	8.2	3.4	10.7	9.5	7.0
Frequently or always incontinent	3/ 1,995	1,233	538	224	0	23.6	61.8	23.3	6.3	0
Frequently incontinent	695	202	359	134	0	8.2	10.1	15.6	3.8	0
Always incontinent	1,300	1,031	179	90	0	15.3	51.7	7.8	2.5	0
II. Bowel continence										
Total	8,471	1,994	2,308	3/ 3,542	627	100.0	100.0	100.0	100.0	100.0
Always continent	5,267	3/ 559	3/ 1,278	3/ 2,870	560	62.2	28.0	55.4	81.0	89.3
Occasionally incontinent	1,233	247	448	493	45	14.6	12.4	19.4	13.9	7.2
Dribbling	134	0	67	45	22	1.6	0	2.9	1.3	3.5
Frequently or always incontinent	1,837	1,188	515	134	0	21.7	59.6	22.3	3.8	0
Frequently incontinent	650	224	336	90	0	7.7	11.2	14.6	2.5	0
Always incontinent	1,187	964	179	3/ 44	0	14.0	48.3	7.8	1.2	0

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Class of care refers to class of care recipient receiving.
2/ Because of rounding, detail does not necessarily add to totals.
3/ Forced to balance total.

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1959 1/

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
1. Washing face, hands, teeth and/or dentures	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
No assistance or supervision	2,757	32.5	45	2.3	269	11.7	1,860	52.5	583	93.0
Assistance and/or supervision, total 3/	5,714	67.5	1,949	97.7	2,039	88.3	1,682	47.5	44	7.0
Supervision only: Occasionally	335	4.0	67	3.4	67	2.9	179	5.1	22	3.5
Frequently or routinely	1,031	12.2	90	4.5	314	13.6	605	17.1	22	3.5
Some assistance: Occasionally	89	1.1	22	1.1	0	0	67	1.9	0	0
Frequently or routinely	1,434	16.9	90	4.5	717	31.1	627	17.7	0	0
Washed by attendant: Occasionally	22	.3	0	0	0	0	22	.6	0	0
Frequently or routinely	2,936	34.7	1,748	87.7	964	41.8	224	6.3	0	0
2. Care of fingernails	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
No care or supervision	1,502	17.7	67	3.4	179	7.8	2/ 875	24.7	381	60.8
Care and/or supervision, total 3/	2/ 6,969	82.3	1,927	96.6	2,129	92.2	2/ 2,667	75.3	246	39.2
Supervision only: Occasionally	0	0	0	0	0	0	0	0	0	0
Frequently or routinely	224	2.6	22	1.1	112	4.9	90	2.5	0	0
Care by attendant: Occasionally	89	1.1	0	0	0	0	67	1.9	22	3.5
Frequently or routinely	6,678	78.8	1,927	96.6	2,017	87.4	2,510	70.9	224	35.7

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1950 1/ - CONTINUED

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
3. Care of feet and toenails	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
No care or supervision	829	9.8	134	6.7	90	3.9	426	12.0	179	28.5
Care and/or supervision, total 3/	7,642	90.2	1,860	93.3	2,218	96.1	3,116	88.0	448	71.5
Supervision only:										
Occasionally	22	.3	0	0	0	0	0	0	22	3.5
Frequently or routinely	44	.5	0	0	22	1.0	22	.6	0	0
Nail care by attendant:										
Occasionally	157	1.9	0	0	45	1.9	90	2.5	22	3.5
Frequently or routinely	7,261	85.7	1,860	93.3	2,129	92.2	2,913	82.2	359	57.3
Special podiatric care:										
Occasionally	44	.5	22	1.1	22	1.0	0	0	0	0
Frequently or routinely	179	2.1	0	0	22	1.0	112	3.2	45	7.2
4. Combing hair	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
Not combed by attendant	4,504	53.2	336	16.8	1,053	45.6	2,488	70.2	627	100.0
Combed by attendant, total	3,967	46.8	1,658	83.1	1,255	54.4	1,054	29.8	0	0
Occasionally	381	4.5	22	1.1	45	1.9	314	8.9	0	0
Frequently or routinely	3,586	42.3	1,636	82.0	1,210	52.4	740	20.9	0	0
5. Washing hair	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
Not washed by attendant	1,501	17.7	112	5.6	179	7.8	852	24.1	358	57.1
Washed by attendant, total	6,970	82.3	1,882	94.4	2,129	92.2	2,690	75.9	269	42.9
Occasionally	89	1.1	22	1.1	0	0	67	1.9	0	0
Frequently or routinely	6,881	81.2	1,860	93.3	2,129	92.2	2/ 2,623	74.1	269	42.9

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1959 1/ - CONTINUED

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
6. Shaving	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
No assistance or supervision	6,724	79.4	1,479	74.2	1,681	72.8	2,982	84.2	2/ 582	92.8
Assistance and/or supervision, total	1,747	20.6	515	25.8	627	27.2	560	15.8	2/ 45	7.2
Supervision only:										
Occasionally	0	0	0	0	0	0	0	0	0	0
Frequently or routinely	89	1.1	22	1.1	22	1.0	0	0	45	7.2
Some assistance:										
Occasionally	0	0	0	0	0	0	0	0	0	0
Frequently or routinely	90	1.1	0	0	90	3.9	0	0	0	0
Shaved by attendant:										
Occasionally	67	.8	45	2.3	0	0	22	.6	0	0
Frequently or routinely	1,501	17.7	448	22.5	515	22.3	538	15.2	0	0
7. Dressing (clothing, nightwear, appliances)	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
No help or supervision	2,668	31.5	67	3.4	269	11.7	2/ 1,772	50.0	560	89.3
Help and/or supervision, total 3/	5,803	68.5	1,927	96.6	2,039	88.3	2/ 1,770	50.0	67	10.7
Supervision only:										
Occasionally	67	.8	0	0	0	0	67	1.9	0	0
Frequently or routinely	516	6.1	0	0	157	6.8	359	10.1	0	0

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1955 1/ - CONTINUED

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
7. (Continued)										
Help with difficult items only:										
Occasionally	247	2.9	0	0	90	3.9	112	3.2	45	7.2
Frequently or routinely	1,008	11.9	67	3.4	359	15.6	560	15.8	22	3.5
General help:										
Occasionally	0	0	0	0	0	0	0	0	0	0
Frequently or routinely	1,255	14.8	291	14.6	605	26.2	359	10.1	0	0
Dressed by attendant:										
Occasionally	44	.5	0	0	22	1.0	22	.6	0	0
Frequently or routinely	2,689	31.7	1,569	78.7	829	35.9	291	8.2	0	0
8. Feeding	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
No help needed	3,182	37.6	179	9.0	538	23.3	1,905	53.8	560	89.3
Help needed, total	5,289	62.4	1,815	91.0	1,770	76.7	1,637	46.2	67	10.7
Tray in room:										
Occasionally	224	2.6	22	1.1	45	1.9	112	3.2	45	7.2
Frequently or routinely	3,004	35.5	695	34.9	1,188	51.5	1,076	30.4	45	7.2
Help in cutting food:										
Occasionally	135	1.6	0	0	45	1.9	90	2.5	0	0
Frequently or routinely	1,905	22.5	538	27.0	829	35.9	538	15.2	0	0

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1959 1/ - CONTINUED

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
8. (Continued)										
Fed some food(s) or meals:										
Occasionally	268	3.2	134	6.7	67	2.9	67	1.9	0	0
Frequently or routinely	470	5.5	314	15.7	134	5.8	22	.6	0	0
Fed all meals:										
Occasionally	0	0	0	0	0	0	0	0	0	0
Frequently or routinely	829	9.8	717	36.0	112	4.9	0	0	0	0
Intravenous feeding:										
Occasionally	22	.3	22	1.1	0	0	0	0	0	0
Frequently or routinely	0	0	0	0	0	0	0	0	0	0
9. Bathing	8,471	100.0	1,994	100.0	2,308	100.0	2/ 3,542	100.0	627	100.0
No help needed	739	8.7	45	2.3	22	1.0	448	12.6	224	35.7
Help needed, total 3/	7,732	91.3	1,949	97.7	2,286	99.0	3,094	87.4	403	64.3
Help in or out of tub or shower:										
Occasionally	67	.8	0	0	0	0	67	1.9	0	0
Frequently or routinely	1,322	15.6	22	1.1	202	8.8	896	25.3	202	32.2
Back and/or feet:										
Occasionally	0	0	0	0	0	0	0	0	0	0
Frequently or routinely	1,367	16.1	45	2.3	269	11.7	896	25.3	157	25.0

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1959 1/ - CONTINUED

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
9. (Continued)										
General help:										
Occasionally	44	.5	0	0	22	1.0	22	.6	0	0
Frequently or routinely	1,748	20.6	112	5.6	695	30.1	919	25.9	22	3.5
Shower or chair bath, unable to help:										
Occasionally	134	1.6	67	3.4	45	1.9	22	.6	0	0
Frequently or routinely	1,030	12.2	336	16.8	403	17.5	269	7.6	22	3.5
Bed bath:										
Occasionally	66	.8	22	1.1	22	1.0	22	.6	0	0
Frequently or routinely	2,375	28.0	1,457	73.1	784	34.0	134	3.8	0	0
10. Toilet	8,471	100.0	1,994	100.0	2,308	100.0	3,542	100.0	627	100.0
No help needed	4,548	53.7	403	20.2	874	37.9	2,644	74.6	627	100.0
Help needed, total 3/	3,923	46.3	1,591	79.8	1,434	62.1	898	25.4	0	0
Help to and from toilet:										
Occasionally	291	3.4	22	1.1	67	2.9	202	5.7	0	0
Frequently or routinely	762	9.0	112	5.6	359	15.6	291	8.2	0	0
Commode, no help:										
Occasionally	157	1.9	0	0	67	2.9	90	2.5	0	0
Frequently or routinely	89	1.1	0	0	22	1.0	67	1.9	0	0

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1959 1/ - CONTINUED

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
10. (Continued)										
Help to and from commode:										
Occasionally	314	3.7	22	1.1	247	10.7	45	1.3	0	0
Frequently or routinely	471	5.6	157	7.9	269	11.7	45	1.3	0	0
Bed pan and/or urinal:										
Occasionally	606	7.2	269	13.5	247	10.7	90	2.5	0	0
Frequently or routinely	1,972	23.3	1,165	58.4	605	26.2	202	5.7	0	0
11. Take pulse or temperature	3,093	36.5	852	42.7	874	37.9	1,188	33.5	179	28.5
12. Take respiration	2,779	32.8	808	40.5	785	34.0	1,030	29.1	156	24.9
13. Take blood pressure	3,093	36.5	942	47.2	874	37.9	1,076	30.4	201	32.1
14. Clinitest	246	2.9	67	3.4	45	1.9	134	3.8	0	0
15. Oral medications										
Routine	4,997	59.0	1,255	62.9	1,322	57.3	2,017	56.9	403	66.4
Critical, observation necessary	3,002	35.4	694	34.8	919	39.8	1,277	36.1	112	17.9
16. Retention catheterization	134	1.6	134	6.7	0	0	0	0	0	0
17. Catheterization (other than retention)	134	1.6	112	5.6	0	0	22	.6	0	0
18. Dressings or bandages										
Complex and/or extensive	112	1.3	90	4.5	22	1.0	0	0	0	0
Other	537	6.3	134	6.7	135	5.8	246	6.9	22	3.5

TABLE II-8: SERVICES NEEDED BY PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES (AND PROVIDED BY STAFF OF HOME WITHOUT ADDITIONAL CHARGE) BY CLASS OF CARE, DECEMBER 1959 1/ - CONTINUED

Service	Total		Class of care receiving							
			I		II		III		IV	
	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total	Number of recipients	Percent of total
19. Parenteral medications										
Subcutaneous	581	6.9	246	12.3	157	6.8	156	4.4	22	3.5
Intravenous	22	.3	22	1.1	0	0	0	0	0	0
Intramuscular	605	7.1	202	10.1	224	9.7	179	5.1	0	0
20. Administration of oxygen	200	2.4	156	7.8	22	1.0	22	.6	0	0
21. Aspiration	67	.8	67	3.4	0	0	0	0	0	0
22. Extra supervision because of confusion	1,746	20.6	582	29.2	425	18.4	695	19.6	44	7.0
23. Extra care or supervision because of (other) eccentricities of behavior	2,218	26.2	426	21.4	739	32.0	896	25.3	157	25.0
24. Other	1,099	13.0	359	18.0	314	13.6	359	10.1	67	10.7

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Class of care refers to class of care recipient receiving.
2/ Forced to balance total.
3/ Since for this group of services some recipients required one type of service routinely or frequently and another type occasionally, the sum of the components may exceed the net count of cases requiring service.

TABLE II-9: ABILITY OF PUBLIC ASSISTANCE RECIPIENTS IN LICENSED PRIVATE NURSING HOMES TO PURCHASE OWN CLOTHING AND PERSONAL INCIDENTALS, DECEMBER 1959 1/

Ability to purchase clothing and personal incidentals	Number of cases	Percent of total 2/
Total	8,471	100.0
Able to manage money and purchase own clothing and personal incidentals	1,546	18.2
Able to manage money but unable to purchase clothing and personal incidentals, total	2,533	29.9
Purchases made by -		
Relative	1,412	16.7
Friend	269	3.2
Operator and/or staff of nursing home	852	10.1
Unable to manage money, total	4,392	51.8
Money managed and purchases made by -		
Relative	2,017	23.8
Friend	224	2.6
Operator and/or staff of nursing home	2,151	25.4

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases.
2/ Because of rounding, detail does not necessarily add to totals.

TABLE II-10: LENGTH OF TIME IN PRESENT NURSING HOME BY AGE OF RECIPIENT, DECEMBER 1959 1/

Length of time in present nursing home	Number of cases				Percent distribution by length of time in present nursing home 2/			
	All ages	Less than 75 years	75, less than 85 years	85 years or over	All ages	Less than 75 years	75, less than 85 years	85 years or over
Total	8,471	2,397	4,079	1,995	100.0	100.0	100.0	100.0
Less than one year	3,474	1,120	1,637	717	41.0	46.7	40.1	35.9
Less than 3 months	874	269	471	134	10.3	11.2	11.5	6.7
3, less than 6 months	1,165	403	560	202	13.7	16.8	13.7	10.1
6 months, less than one year	1,435	448	3/ 606	381	16.9	18.7	14.9	19.1
One year, less than 3	2,734	762	1,389	583	32.3	31.8	34.0	29.2
1 year, less than 2	1,703	538	874	291	20.1	22.4	21.4	14.6
2, less than 3 years	1,031	224	515	3/ 292	12.2	9.3	12.6	14.6
3, less than 5 years	1,277	336	627	314	15.1	14.0	15.4	15.7
3, less than 4 years	896	202	515	179	10.6	8.4	12.6	9.0
4, less than 5 years	381	134	112	3/ 135	4.5	5.6	2.7	6.8
5 years or more	986	179	426	381	11.6	7.5	10.4	19.1

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases.
2/ Because of rounding, detail does not necessarily add to totals.
3/ Forced to balance total.

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TABLE II-11: ESTIMATED PERIOD FOR WHICH RECIPIENT WILL REQUIRE NURSING HOME CARE 1/

Estimated period recipient will require nursing home care	Number of recipients	Percent of total 2/
Total	8,449	100.0
Indefinite period 3/	8,135	96.3
Less than one year	202	2.4
Less than 3 months	112	1.3
3, less than 6 months	45	.5
6 months, less than one year	45	.5
One year or more	112	1.3

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Excludes cases for which information not available or not reported.
2/ Because of rounding, detail does not necessarily add to totals.
3/ Includes all cases in which care is expected to be terminal as well as all cases in which care, though not necessarily terminal, is expected to continue for an indefinite period.

III. Cost Study

Selection of homes — Nursing home care in the State of Washington is provided by three types of private agencies: (1) those that, with the possible exception of an occasional board and room case, provide only nursing home care; (2) hospitals; (3) retirement homes. The first group represented 84 percent of the private agencies caring for public assistance nursing home patients during 1959 and provided 87 percent of all public assistance patient-days. Because of the predominance of this group of agencies and because of the cost allocation problems involved for hospitals and retirement homes, the cost study to determine rates was restricted to homes providing only nursing home care. 1/

With the exception of certain exclusions, all homes providing only nursing home care during 1959 were requested to participate in the study. The exclusions were based on objective criteria that were applied "across-the-board". The bases of exclusion and the reasons therefore are:

1. Facility closed during part of 1959. Reason: 1959 costs incomplete.
2. Facility open during 1959 but closed at the time of the study. Reason: 1959 financial data not available and home no longer providing care.
3. Change of operator during or subsequent to 1959. Reason: 1959 financial data incomplete or not available.
4. Facility not in existence as of July 1, 1958. Reason: To avoid cost distortion due to atypical costs during first year of operation.
5. Home judged "marginal" by the Washington State Department of Health 2/. Reason: To avoid downward distortion of costs due to substandard operation.
6. Public assistance recipients represented less than 40 percent of capacity during 1959. Reason: To avoid possible upward distortion of costs due to "luxury" operation.
7. Home not classified by the Department during part of 1959. Reason: Since home not eligible for public assistance payments during part of 1959, not properly within sphere of study; also to avoid cost distortion due to possibility of "luxury" or substandard operation.
8. Home not classified by the Department at the time of the study. Reason: Since home no longer eligible for public assistance payments, not properly within sphere of study; also to avoid possible cost distortion due to "luxury" or substandard operation.

1/ Because of the considerable interest in "multiple-function" institutions, selected hospitals and retirement homes were requested to complete cost schedules parallel to those used in the basic study. These institutions are, however, excluded from the present report.

2/ The Department of Public Assistance requested that the Department of Health in making its determinations consider only those currently licensed homes as marginal to which written notices of substantive violations of law, rules and/or regulations had been sent during the period January 1, 1958 to the time of the Health Department review. Trivial or temporary and accidental violations were not to be included.

Schedules were sent to all of the 184 homes that met none of the above criteria for exclusion from the study. All of these homes completed and returned schedules. Seven of these schedules were not received in time to be included in the data processing and in four additional cases, despite the cooperation of the operators involved, the cost records of the home were too incomplete to warrant inclusion. Thus of a possible 184 homes, 173 or 94 percent are included in the analysis. 1/

Assuring accuracy of reported data

Fundamental to the validity of the study was reasonable assurance that the reported cost data were complete and accurate. Three steps were taken to achieve such assurance:

1. The basic cost schedule was required to be acknowledged not only by the operator but by a public accountant.

2. In meetings with representatives of the nursing home industry the reasons for requesting certain information were explained and discussed and the importance of accuracy was stressed.

3. The schedules were reviewed carefully by the Department for inconsistencies, arithmetic errors and apparently unreasonable entries (e.g., level of payroll taxes relative to payroll). Any error or question was referred back for correction or explanation. Because of the care in editing and the cooperation of the individual nursing homes in reviewing their reports on request, it would appear that recording errors and inadvertent omissions or duplications were minimized.

Determining cost breakdowns

In order to facilitate future adjustments of the current findings to avoid without repetition of a full-scale cost study, considerable cost detail was desirable. On the other hand, the practical limitations inherent in a variety of accounting systems and the expense involved in re-allocating the costs of a past accounting period necessitated some modification of the theoretical ideal. In general, the cost breakdowns adopted proved workable. In particular, the reporting of payroll by type of personnel as well as the additional information on both wages and hours for selected months proved invaluable.

Adjustment for underutilization of capacity

Since a low ratio of patients to capacity would artificially increase the per diem costs of a home, an adjustment was made for underutilization of capacity. On the average, the homes operated at 93 percent of capacity, an average that was remarkably stable among the different classes of homes. (Table III-1) Since 80 percent of all homes operated at 85 percent of capacity or more, the adjustment for underutilization of capacity consisted of increasing reported days care to 85 percent of capacity for those homes operating below this level. In determining per diem costs the separate cost items were related to capacity-days, days care or adjusted days care as appropriate, e.g., taxes, depreciation and rent on land, building and equipment were related to capacity-days since these costs can be considered fixed irrespective of occupancy; food for patients was related to patient-days with no adjustment for underutilization of capacity; housekeeping and maintenance costs were related to adjusted days care.

1/ In two instances the accounts of two separate homes under the same ownership were merged so that only consolidated reports could be submitted. Thus the count of "homes" in this report balances to 171 rather than 173.

Return on invested capital

Since return on invested capital is a legitimate cost of operation, the data requested in the basic cost schedule included gross investment in land, building and equipment, accumulated depreciation, mortgage interest and outstanding mortgages. Gross investment was defined as acquisition cost to present owner plus special local improvement assesments, expenditures by present owner for permanent improvements and/or betterments and allowances for the unpaid labor of owner and family in connection with original construction, permanent improvements and/or betterments. 1/ Since the current rates of return permitted to utilities by the Washington Public Service Commission ranges from 5.9 to 6.5 percent of acquisition cost, the return on invested capital used in the cost study was mortgage interest plus six percent of unmortgaged net investment.

Administrative salary allowances

Forty homes included in the cost study had a paid administrator only, i.e., had no unpaid administrative services. (Table III-2) These homes represented 23 percent of all homes in the study but 54 percent of all homes with 50 beds or more and 32 percent of all homes with 25 beds or more. Weighting by beds, the average administrative salary cost was about $8.20 per bed per month. Since this average was unduly influenced by a few very large homes and since the average cost was $9.40 both for homes with 50 but less than 80 beds and for homes with 25 but less than 50 beds, a base administrative salary allowance of $9.40 per bed per month was used. 2/

Allowances for other services of operator and family

Each operator reported the number of unpaid hours of own and family labor by type of function. The nursing hours were further broken down into RN time, LPN time and time of unlicensed personnel. Wages and hours for paid employees were also reported by personnel category for April and December 1959. On the premise that family labor typically assumes more responsibility than a paid employee (e.g., the operator-nurse would usually act as charge nurse), the third quartiles of the relevant wage rate distributions for December 1959 were used, together with reported hours, to determine for each home the base costs of unpaid family labor. 3/ (Tables III-3 and III-4) The wage rate distributions used were those for (1) registered nurses, (2) licensed practical nurses, (3) unlicensed nursing personnel and (4) personnel other than nursing personnel and administrator. December 1959 data were used to allow for wage rate changes during the calendar year.

1/ The Department recommended that in computing these allowances, the going rates be used for unskilled and semi-skilled work and 80 percent of the going rate for skilled work. If not practicable or if special circumstances existed (e.g., if the individual were a member of the skilled trade involved), the method used was to be indicated. Most homes with such unpaid family labor used the recommended method.

2/ The $9.40 was a base allowance in the sense that a subsequent adjustment was made for salary changes since 1959. In computing base allowances, a "ceiling" of $940 per month per home was used but because of the small number of homes with more than 100 beds, the average costs for the industry were not affected.

3/ Base costs in the sense that subsequent adjustments were made for changes in wage rates since December 1959.

Allocation of costs among different classes of care

Most nursing homes in the State of Washington provide more than one class of care. Although only 22 Class II homes were included in the study, 102 study homes provided Class II care. Similarly, of the 153 homes providing Class III care, only 68 were Class III homes and the rest were Class I and II. Of the 86 homes providing Class IV care, only 2 were Class IV homes. Forty-one percent of the Class III and IV patient-days provided by the study homes during 1959 were provided by Class I and II homes.

Allocation of costs among the different classes of care poses a particularly difficult problem. Allocation according to days of care provided can be considered inequitable since more complex and extensive care (e.g., Class I) is presumably more costly than lighter care (e.g., Class III). No defensible a priori formula is available. For example, weighting care by existing rates of payment not only implies that an existing rate structure, even though evolved by negotiation, accurately reflects cost differentials but perpetuates a given structure into the indefinite future regardless of changes in the content and relative cost of different types of care.

Findings of the Characteristics study were used in allocating the costs of nursing personnel among different classes of care. A committee composed of nursing home operators (representing Class I, II and III homes respectively) and two representatives from the Department's Division of Medical Care (both of whom were registered nurses) assigned relative weights to characteristics and services included in the schedule used in the Characteristics study. 1/ In developing the weights consideration was given both to the length of time required by the various conditions and services and to the level of skill involved. The relative weights were multiplied by the number of recipients in each class of care having the specified characteristic or requiring the specified service 2/ and average service-points per recipient were computed for each class of care. (Tables III-5 and III-6) The costs of nursing personnel in any home were allocated in proportion to patient-days weighted by average service-points. Other costs were allocated in proportion to unweighted patient-days. It is hoped that prior to the next adjustment in rate structure further refinements can be made in the methods of cost allocation.

Determining adjustments for changes in taxes, prices and wage rates

Since the data on the schedules referred to calendar year 1959, it was necessary to update costs. Payrolls were first brought to the December 1959 level by applying the wage rates reported for December 1959 to estimated hours for the January-June period. 3/ The wages of nursing personnel were adjusted to a 1960 level on the basis of wage rate changes between 1959 and 1960 for the same categories of personnel in hospitals in the State. The increases used were five percent for registered nurses and licensed practical nurses and six percent for unlicensed personnel. Wages for other than nursing personnel and administrator were adjusted on the basis of changes in average gross hourly earnings in "service and miscellaneous industries" as reported by the U. S. Bureau of Labor Statistics.

1/ A table of the relative weights by characteristics and service is given in the Appendix. To minimize conscious or unconscious bias neither the nursing home operators nor the Department's nurses had been given the results of the Characteristics study at the time the weights were assigned.
2/ Data from the Characteristics Study.
3/ Hours were estimated by dividing January-June payrolls by April wage rates.

The increase used was four percent. Although the base earnings reported by the BLS were not dissimilar to the 1959 wage rates in the nursing home cost study, the former refer to the U. S. as a whole and hence are of limited applicability to Washington. Prior to the next rate adjustment, it is hoped that wage rates for this type of personnel can be obtained by the Employment Security Department for hospitals and nursing homes in the Seattle area. Such information will permit more precise updating of costs.

Since no uniform pattern in changes in the salaries of hospital administrators in the State is presently apparent, administrative salary allowances were adjusted upward by four percent, i.e., by the lower limit percentagewise of the other wage rate increases -- a choice which appeared appropriate in view of the higher base salary level.

Although no completely satisfactory index was available for price changes other than wages, the Consumers Price Index for the City of Seattle appeared most practicable to use. On the basis of 1959-1960 changes in the components of the index, food costs were increased by 0.8 percent and no changes were made in other items. Prior to the next rate adjustment it is hoped to review the changes in certain costs, e.g., property taxes, and their relative importance in more detail.

It was also necessary to adjust the findings of the study for increases in the business and occupation and sales taxes during the course of 1959 and for the increase in Social Security tax effective January 1, 1960. Because of the cost breakdowns used in the schedule, these adjustments involved only arithmetic rather than methodological problems.

Summary of results

The median costs for each class of care as well as the breakdown by type of cost are shown in Tables III-7 through III-10. By class of care median per diem 1960 costs (1959 reported costs adjusted for tax, wage rate and price level changes during and since 1959) totalled:

I	$6.07
II	5.27
III	4.66
IV	4.14

On the assumption that prices and wages will change at the same rate as between 1959 and 1960 median per diem costs as of July 1962 will be:

I	$6.38
II	5.51
III	4.86
IV	4.29

For comparison the per diem rates in effect prior to January 1, 1961 were:

I	$6.38
II	5.23
III	4.25
IV	3.42

The smaller cost differentials between classes of care as compared to the 1960 rate structure reflect in part the extent to which the homes provide multi-level care and in part a "hard-core" of maintenance and service costs involved in providing any class of nursing home care.

TABLE III-1: DAYS CARE AS PERCENT OF CAPACITY BY CLASS OF HOME, 1959

Days care as percent of capacity	All classes	Class of home I	II	III	IV
Number of homes					
Total	171	79	22	68	2
Less than 80	24	8	1	14	1
80, less than 85	11	7	2	2	0
85, less than 90	23	7	4	12	0
90, less than 95	42	23	5	14	0
95, less than 100	52	27	7	17	1
100 or over	19	7	3	9	0
Percent of total 1/					
Total	100.0	100.0	100.0	100.0	100.0
Less than 80	14.0	10.1	4.5	20.6	50.0
80, less than 85	6.4	8.9	9.1	2.9	0
85, less than 90	13.4	8.9	18.2	17.6	0
90, less than 95	24.6	29.1	22.7	20.6	0
95, less than 100	30.4	34.2	31.8	25.0	50.0
100 or over	11.1	8.9	13.6	13.2	0
Median	93	93	92	92	-

1/ Because of rounding, detail does not necessarily add to totals.

TABLE III-2: HOMES WITH PAID ADMINISTRATOR ONLY: AVERAGE ADMINISTRATIVE SALARY PER BED PER MONTH BY SIZE OF HOME, DECEMBER 1959

Size of home	Homes with paid administrator only	
	Number	Average administrative salary per bed per month 1/
Total	40	$8.18
80 beds or more	5	5.15
50, less than 80	14	9.40
25, less than 50	20	9.40
Less than 25 beds	1	5.26

1/ Each bed weighted equally.

TABLE III-3: MEDIAN AND THIRD QUARTILE HOURLY WAGE RATES PAID TO NURSING PERSONNEL BY CLASS OF HOME, APRIL AND DECEMBER 1959

	All classes	Class of home			
		I	II	III	IV
Median					
Registered nurses:					
April	$1.80	$1.83	$1.80	$1.68	-
December	1.88	1.89	1.83	1.83	-
Licensed practical nurses:					
April	1.24	1.25	1.24	1.24	-
December	1.28	1.31	1.24	1.25	-
Unlicensed personnel:					
April	1.00	1.02	1.03	.98	-
December	1.03	1.04	1.05	1.00	-
Third quartile					
Registered nurses:					
April	1.98	1.99	1.98	1.96	-
December	2.00	2.05	2.00	1.90	-
Licensed practical nurses:					
April	1.38	1.38	1.30	1.43	-
December	1.41	1.41	1.28	1.45	-
Unlicensed personnel:					
April	1.08	1.07	1.13	1.06	-
December	1.12	1.10	1.15	1.10	-

TABLE III-4: MEDIAN AND THIRD QUARTILE HOURLY WAGE RATES PAID TO OTHER THAN NURSING PERSONNEL AND ADMINISTRATOR BY CLASS OF HOME, APRIL AND DECEMBER 1959

	All classes	Class of home			
		I	II	III	IV
Median					
April	1/	$1.11	$1.08	$1.02	-
December	1/	1.15	1.12	1.08	-
Third quartile					
April	$1.22	1.22	1.23	1.21	-
December	1.24	1.25	1.25	1.23	-

1/ Not computed.

TABLE III-5: TOTAL SERVICE-POINTS BY CONDITION, SERVICE AND CLASS OF CARE 1/

	Class of care			
	I	II	III	IV
A. Mental condition				
1. Always clear	0	0	0	0
Confused:				
2. Mildly confused only	1,545	2,286	4,437	402
3. Seriously disoriented but without eccentric behavior	2,667	1,099	1,883	315
4. Seriously disoriented with eccentric behavior 2/	6,720	7,840	7,850	670
5. Mentally retarded	720	0	896	360
B. Mobility within nursing home				
1. Walks alone or with no more help than cane or crutch	44	1,478	5,382	1,164
2. Moves himself about with a mechanical aid such as a walker or wheelchair	335	895	1,570	0
3. Able to walk or move in wheelchair only with help of attendant	810	3,231	2,817	0
Unable to walk or be moved about in wheelchair:				
4. Able to turn and/or sit on bedside by self	3,224	4,664	1,432	360
5. Helpless, must be turned or lifted	14,120	4,480	450	0
C. Continence				
Bladder:				
1. Always continent	0	0	0	0
2. Occasionally incontinent	896	896	1,210	90
3. Dribbling	335	1,235	1,690	220
4. Frequently incontinent	1,616	2,872	1,072	0
5. Always incontinent	10,310	1,790	900	0
Bowel:				
1. Always continent	0	0	0	0
2. Occasionally incontinent	494	896	986	90
3. Dribbling	0	0	0	0
4. Frequently incontinent	1,792	2,688	720	0
5. Always incontinent	9,640	1,790	440	0

TABLE III-5: TOTAL SERVICE-POINTS BY CONDITION, SERVICE AND CLASS OF CARE 1/ (CONTINUED)

	Class of care			
	I	II	III	IV
D. Services needed by recipient and provided by staff of home				
Washing face, hands, teeth and/or dentures:				
1. Supervision only	157	381	784	44
2. Some assistance, e.g., help to and from wash basin, collecting and carrying toilet articles	336	2,151	2,082	0
3. Face, hands, teeth and/or dentures washed by attendant	12,236	6,748	1,722	0
Care of fingernails:				
4. Supervision only	22	112	90	0
5. Nail care by attendant	7,708	8,068	10,308	984
Care of feet and toenails:				
6. Supervision only	0	66	66	66
7. Routine nail care by attendant	13,020	15,218	21,021	2,667
8. Special podiatric care	220	440	1,120	450
Care of hair:				
9. Combing	8,290	6,275	5,270	0
10. Washing	9,410	10,645	13,450	1,345
Shaving:				
11. Supervision only	22	22	0	45
12. Some assistance, e.g., help to and from wash basin, collecting and carrying toilet articles	0	360	0	0
13. Shaved by attendant	2,958	3,090	3,360	0
Dressing (clothing, nightwear, appliances):				
14. Supervision only	0	314	852	0
15. Help with difficult items only	402	2,694	4,032	402
16. General help	1,746	3,630	2,154	0
17. Completely dressed by attendant	6,950	8,510	3,130	0

TABLE III-5: TOTAL SERVICE-POINTS BY CONDITION, SERVICE AND CLASS OF CARE 1/ (CONTINUED)

D. (Continued)	Class of care I	II	III	IV
Feeding and diet:				
18. Tray in room	1,434	2,466	2,376	180
19. Help in cutting food	1,614	2,622	1,884	0
20. Fed some food(s) or meals	2,688	1,206	534	0
21. Fed all meals	7,170	1,120	0	0
22. Intravenous feeding	220	0	0	0
23. Dietary requirements (other than "normal" diet)	3/	3/	3/	3/
Bathing:				
24. Help in or out of tub or shower only	44	404	1,926	404
25. Back and/or feet washed	135	807	2,688	471
26. General help needed	672	4,302	5,646	132
27. Shower or chair bath, unable to help	4,030	4,480	2,910	220
28. Bed bath	10,353	5,642	1,092	0
Toilet:				
29. Help to and from toilet	670	2,130	2,465	0
30. Commode, no help	0	267	471	0
31. Help to and from commode	1,074	3,096	540	0
32. Bed pan and/or urinal	7,170	4,260	1,460	0
33. Take pulse or temperature	4/	4/	4/	4/
34. Take respiration	4/	4/	4/	4/
35. Take blood pressure	2,826	2,622	3,228	603
36. Catheterization (other than retention)	1,120	0	220	0
37. Retention catheterization	1,340	0	0	0
Dressings or bandages:				
38. Complex and/or extensive	900	220	0	0
39. Other	670	675	1,230	110
Oral medication:				
40. Routine	2,510	2,644	4,034	806
41. Critical, observation necessary	4,164	5,514	7,662	672

TABLE III-5: TOTAL SERVICE-POINTS BY CONDITION, SERVICE AND CLASS OF CARE 1/ (CONTINUED)

	Class of care			
	I	II	III	IV
D. (Continued)				
Parenteral medications:				
42. Subcutaneous	1,476	942	936	132
43. Intravenous	220	0	0	0
44. Intramuscular	1,616	1,792	1,432	0
45. Administration of oxygen	1,248	176	176	0
46. Aspiration	603	0	0	0
47. Extra supervision because of confusion	4/	4/	4/	4/
48. Extra care or supervision because of (other) eccentricities of behavior	4/	4/	4/	4/
49. Other	1,680	1,235	1,565	225
E. Recipient currently moribund	70	20	0	0
Total service-points	176,462	155,641	147,876	13,739
Average service-points per recipient	88.5	67.5	41.7	21.9
Index of average service-points (Class I = 100.0)	100.0	76.3	47.1	24.7

1/ Based on (1) condition and service weights of 0 to 10 and (2) December 1959 counts of recipients in each class of care having the specified condition or requiring and receiving the specified service without additional charge.
2/ Includes cases not incontinent but disoriented with respect to toilet facilities.
3/ Not weighted. Costs included in items other than nursing personnel.
4/ Included in weights for other services and conditions.

TABLE III-6: SUMMARY OF AVERAGE SERVICE-POINTS PER RECIPIENT BY CONDITION, SERVICE AND CLASS OF CARE 1/

Condition and service	Class of care			
	I	II	III	IV
Total 2/	88.5	67.5	41.7	21.9
Index (Class I = 100.0)	100.0	76.3	47.1	24.7
Mental condition	5.8	4.9	4.3	2.8
Mobility within nursing home	9.3	6.4	3.3	2.4
Continence, bladder	6.6	2.9	1.4	.5
Continence, bowel	6.0	2.5	.7	.3
Recipient currently moribund	3/	3/	0	0
Washing face, hands, teeth and/or dentures	6.4	4.0	1.3	.1
Care of fingernails	3.9	3.5	2.9	1.6
Care of feet and toenails	6.6	6.8	6.3	5.1
Care of hair	8.9	7.3	5.3	2.1
Shaving	1.5	1.5	.9	.1
Dressing (clothing, nightwear, appliances)	4.6	6.6	2.9	.6
Feeding and diet	6.6	3.2	1.4	.3
Bathing	7.6	6.8	4.0	2.0
Toilet	4.5	4.2	1.4	0
Take blood pressure	1.4	1.1	.9	1.0
Catheterization (other than retention)	.6	0	.1	0
Retention catheterization	.7	0	0	0
Dressings or bandages:				
Complex and/or extensive	.5	.1	0	0
Other	.3	.3	.3	.2
Oral medications:				
Routine	1.3	1.1	1.1	1.3
Critical, observation necessary	2.1	2.4	2.2	1.1
Parenteral medications				
Subcutaneous	.7	.4	.3	.2
Intravenous	.1	0	0	0
Intramuscular	.8	.8	.4	0
Administration of oxygen	.6	.1	3/	0
Aspiration	.3	0	0	0
Other	.8	.5	.4	.4

1/ Based on (1) condition and service weights of 0 to 10 and (2) December 1959 counts of recipients in each class of care having the specified condition or requiring and receiving the specified service without additional charge.

2/ Because of rounding, detail will not necessarily add to totals.

3/ Less than 0.1.

TABLE III-7: MEDIAN COSTS, CLASS I CARE

	1959 PER CAPITA COSTS 1/		ADJUSTMENTS FOR CHANGES SINCE 1959		ESTIMATED 1960 PER CAPITA COSTS 2/	
	PER DAY	PER MONTH 3/	TAX CHANGES	CHANGES IN PRICE OR WAGE LEVEL	PER DAY	PER MONTH 3/
TOTAL	$5.86	$178.29	-	-	$6.07	$184.80
RETURN ON INVESTMENT (MORTGAGE INTEREST PLUS SIX PERCENT ON UNMORTGAGED NET INVESTMENT) 4/	5/.21	5/6.39	0	0	5/.21	5/6.39
ADMINISTRATION AND GENERAL 4/	5/.27	5/8.21	5% INCREASE IN BUSINESS TAXES	0	5/.27	5/8.30
TAXES, DEPRECIATION AND RENT ON LAND, BUILDINGS AND EQUIPMENT 4/	5/.37	5/11.26	0	0	5/.37	5/11.26
FOOD FOR PATIENTS	5/.61	5/18.56	+0.17% INCREASE FOR INCRD. SALES TAX	+0.8%	5/.62	5/18.74
FOOD FOR STAFF AND GUESTS	.04	1.22	"	+0.8%	.04	1.23
UTILITIES (INCLUDING FUEL OIL) 4/	5/.18	5/5.48	"	0	5/.18	5/5.49
OTHER OPERATING COSTS OTHER THAN PERSONNEL 6/	.36	10.95	"	0	.36	10.97
SALARIES AND SALARY ALLOWANCES FOR OTHER THAN NURSING PERSONNEL AND ADMINISTRATOR	7/.56	7/17.04	+0.5% OF WAGES OF PAID PERSONNEL FOR SS TAX INCREASE	+4.0%	.58	17.78
ADMINISTRATIVE SALARY ALLOWANCES	5/.31	5/9.43	0	+4.0%	5/.32	5/9.81
NURSING PERSONNEL:						
RN'S	7/.84	7/25.55	+0.5% OF WAGES OF PAID PERSONNEL (SS)	+5.0%	.89	26.95
LPN'S	7/.37	7/11.26	"	+5.0%	.39	11.86
UNLICENSED PERSONNEL	7/1.56	7/47.46	"	+6.0%	1.66	50.54
OTHER PERSONNEL COSTS	.18	5.48	0	0	.18	5.48

1/ UNLESS OTHERWISE SPECIFIED, BASED ON DAYS CARE AND ADJUSTED FOR UNDERUTILIZATION OF CAPACITY. ADJUSTMENT FOR UNDERUTILIZATION OF CAPACITY CONSISTS OF INCREASING THE DAYS CARE TO 85 PERCENT OF CAPACITY FOR HOMES OPERATING BELOW THIS LEVEL.
2/ 1959 PER CAPITA COSTS PLUS ADJUSTMENTS FOR CHANGES SINCE 1959. 3/ BASED ON 30.42-DAY MONTH. 4/ BASED ON CAPACITY-DAYS.
5/ NO ADJUSTMENT FOR UNDERUTILIZATION OF CAPACITY - NOT RELEVANT. 6/ SUPPLIES, REPLACEMENTS AND MAINTENANCE. MAINTENANCE COMPUTED ON BASIS OF 1957-1959 AVERAGE. 7/ 1959 PER CAPITA COSTS ADJUSTED TO REFLECT DECEMBER 1959 WAGE RATES. SALARY ALLOWANCES FOR UNPAID FAMILY LABOR COMPUTED ON BASIS OF THIRD QUARTILES OF DECEMBER 1959 WAGE RATE DISTRIBUTIONS.

TABLE III-8: MEDIAN COSTS, CLASS II CARE

	1959 PER CAPITA COSTS 1/		ADJUSTMENTS FOR CHANGES SINCE 1959		ESTIMATED 1960 PER CAPITA COSTS 2/	
	PER DAY	PER MONTH 3/	TAX CHANGES	CHANGES IN PRICE OR WAGE LEVEL	PER DAY	PER MONTH 3/
TOTAL	$5.10	$155.14	-	-	$5.27	$160.33
RETURN ON INVESTMENT (MORTGAGE INTEREST PLUS SIX PERCENT ON UNMORTGAGED NET INVESTMENT) 4/	5/.20	5/6.08	0	0	5/.20	5/6.08
ADMINISTRATION AND GENERAL 4/	5/.26	5/7.91	5% INCREASE IN BUSINESS TAXES	0	5/.26	5/8.00
TAXES, DEPRECIATION AND RENT ON LAND, BUILDINGS AND EQUIPMENT 4/	5/.34	5/10.34	0	0	5/.34	5/10.34
FOOD FOR PATIENTS	5/.63	5/19.16	+0.17% INCREASE FOR INCRD. SALES TAX	+0.8%	5/.64	5/19.34
FOOD FOR STAFF AND GUESTS	.04	1.22	"	+0.8%	.04	1.23
UTILITIES (INCLUDING FUEL OIL) 4/	5/.18	5/5.48	"	0	5/.18	5/5.49
OTHER OPERATING COSTS OTHER THAN PERSONNEL 6/	.36	10.95	"	0	.36	10.97
SALARIES AND SALARY ALLOWANCES FOR OTHER THAN NURSING PERSONNEL AND ADMINISTRATOR	7/.57	7/17.34	+0.5% OF WAGES OF PAID PERSONNEL FOR SS TAX INCREASE	+4.0%	.60	18.10
ADMINISTRATIVE SALARY ALLOWANCES	5/.31	5/9.43	0	+4.0%	5/.32	5/9.81
NURSING PERSONNEL:						
RN'S	7/.57	7/17.34	+0.5% OF WAGES OF PAID PERSONNEL (SS TAX)	+5.0%	.60	18.29
LPN'S	7/.31	7/9.43	"	+5.0%	.33	9.94
UNLICENSED PERSONNEL	7/1.15	7/34.98	"	+6.0%	1.22	37.26
OTHER PERSONNEL COSTS	.18	5.48	0	0	.18	5.48

1/ UNLESS OTHERWISE SPECIFIED, BASED ON DAYS CARE AND ADJUSTED FOR UNDERUTILIZATION OF CAPACITY. ADJUSTMENT FOR UNDERULITIZATION OF CAPACITY CONSISTS OF INCREASING THE DAYS CARE TO 85 PERCENT OF CAPACITY FOR HOMES OPERATING BELOW THIS LEVEL.
2/ 1959 PER CAPITA COSTS PLUS ADJUSTMENTS FOR CHANGES SINCE 1959. 3/ BASED ON 30.42-DAY MONTH. 4/ BASED ON CAPACITY-DAYS.
5/ NO ADJUSTMENT FOR UNDERUTILIZATION OF CAPACITY - NOT RELEVANT. 6/ SUPPLIES, REPLACEMENTS AND MAINTENANCE. MAINTENANCE COMPUTED ON BASIS OF 1957-1959 AVERAGE. 7/ 1959 PER CAPITA COSTS ADJUSTED TO REFLECT DECEMBER 1959 WAGE RATES. SALARY ALLOWANCES FOR UNPAID FAMILY LABOR COMPUTED ON BASIS OF THIRD QUARTILES OF DECEMBER 1959 WAGE RATE DISTRIBUTIONS.

TABLE III-9: MEDIAN COSTS, CLASS III CARE

	1959 PER CAPITA COSTS 1/		ADJUSTMENTS FOR CHANGES SINCE 1959		ESTIMATED 1960 PER CAPITA COSTS 2/	
	PER DAY	PER MONTH 3/	TAX CHANGES	CHANGES IN PRICE OR WAGE LEVEL	PER DAY	PER MONTH 3/
TOTAL	$4.52	$137.51	-	-	$4.66	$141.73
RETURN ON INVESTMENT (MORTGAGE INTEREST, PLUS SIX PERCENT ON UNMORTGAGED NET INVESTMENT) 4/	5/.19	5/5.78	0	0	5/.19	5/5.78
ADMINISTRATION AND GENERAL 4/	5/.23	5/7.00	5% INCREASE IN BUSINESS TAXES	0	5/.23	5/7.06
TAXES, DEPRECIATION AND RENT ON LAND, BUILDINGS AND EQUIPMENT 4/	5/.33	5/10.04	0	0	5/.33	5/10.04
FOOD FOR PATIENTS	5/.66	5/20.08	+0.17% INCREASE FOR INCRD. SALES TAX	+0.8%	5/.67	5/20.27
FOOD FOR STAFF AND GUESTS	.04	1.22	"	+0.8%	.04	1.23
UTILITIES (INCLUDING FUEL OIL) 4/	5/.18	5/5.48	"	0	5/.18	5/5.49
OTHER OPERATING COSTS OTHER THAN PERSONNEL 6/	.29	8.82	"	0	.29	8.83
SALARIES AND SALARY ALLOWANCES FOR OTHER THAN NURSING PERSONNEL AND ADMINISTRATOR	7/.68	7/20.69	+0.5% OF WAGES OF PAID PERSONNEL FOR SS TAX INCREASE	+4.0%	.71	21.57
ADMINISTRATIVE SALARY ALLOWANCES	5/.31	5/9.43	0	+4.0%	5/.32	5/9.81
NURSING PERSONNEL:						
RN'S	7/.32	7/9.73	+0.5% OF WAGES OF PAID PERSONNEL (SS)	+5.0%	.34	10.27
LPN'S	7/.29	7/8.82	"	+5.0%	.31	9.30
UNLICENSED PERSONNEL	7/.84	7/25.55	"	+6.0%	.89	27.21
OTHER PERSONNEL COSTS	.16	4.87	0	0	.16	4.87

1/ UNLESS OTHERWISE SPECIFIED, BASED ON DAYS CARE AND ADJUSTED FOR UNDERUTILIZATION OF CAPACITY. ADJUSTMENT FOR UNDERUTILIZATION OF CAPACITY CONSISTS OF INCREASING THE DAYS CARE TO 85 PERCENT OF CAPACITY FOR HOMES OPERATING BELOW THIS LEVEL.
2/ 1959 PER CAPITA COSTS PLUS ADJUSTMENTS FOR CHANGES SINCE 1959. 3/ BASED ON 30.42-DAY MONTH. 4/ BASED ON CAPACITY-DAYS.
5/ NO ADJUSTMENT FOR UNDERUTILIZATION OF CAPACITY - NOT RELEVANT. 6/ SUPPLIES, REPLACEMENTS AND MAINTENANCE. MAINTENANCE COMPUTED ON BASIS OF 1957-1959 AVERAGE. 7/ 1959 PER CAPITA COSTS ADJUSTED TO REFLECT DECEMBER 1959 WAGE RATES. SALARY ALLOWANCES FOR UNPAID FAMILY LABOR COMPUTED ON BASIS OF THIRD QUARTILES OF DECEMBER 1959 WAGE RATE DISTRIBUTIONS.

TABLE III-10: MEDIAN COSTS, CLASS IV CARE

	1959 PER CAPITA COSTS 1/		ADJUSTMENTS FOR CHANGES SINCE 1959		ESTIMATED 1960 PER CAPITA COSTS 2/	
	PER DAY	PER MONTH 3/	TAX CHANGES	CHANGES IN PRICE OR WAGE LEVEL	PER DAY	PER MONTH 3/
TOTAL	$4.03	$122.59	-	-	$4.14	$125.87
RETURN ON INVESTMENT (MORTGAGE INTEREST PLUS SIX PERCENT ON UNMORTGAGED NET INVESTMENT) 4/	5/.19	5/5.78	0	0	5/.19	5/5.78
ADMINISTRATION AND GENERAL 4/	5/.21	5/6.39	5% INCREASE IN BUSINESS TAXES	0	5/.21	5/6.44
TAXES, DEPRECIATION AND RENT ON LAND, BUILDINGS AND EQUIPMENT 4/	5/.31	5/9.43	0	0	5/.31	5/9.43
FOOD FOR PATIENTS	5/.69	5/20.99	+0.17% INCREASE FOR INCRD. SALES TAX	+0.8%	5/.70	5/21.20
FOOD FOR STAFF AND GUESTS	.04	1.22	"	+0.8%	.04	1.23
UTILITIES (INCLUDING FUEL OIL) 4/	5/.17	5/5.17	"	0	5/.17	5/5.18
OTHER OPERATING COSTS OTHER THAN PERSONNEL 6/	.27	8.21	"	0	.27	8.22
SALARIES AND SALARY ALLOWANCES FOR OTHER THAN NURSING PERSONNEL AND ADMINISTRATOR	7/.90	7/27.38	+0.5% OF WAGES OF PAID PERSONNEL FOR SS TAX INCREASE	+4.0%	.94	28.52
ADMINISTRATIVE SALARY ALLOWANCES	5/.31	5/9.43	0	+4.0%	5/.32	5/9.81
NURSING PERSONNEL:						
RN'S	7/.17	7/5.17	+0.5% OF WAGES OF PAID PERSONNEL (SS TAX)	+5.0%	.18	5.45
LPN'S	7/.17	7/5.17	"	+5.0%	.18	5.45
UNLICENSED PERSONNEL	7/.46	7/13.99	"	+6.0%	.49	14.90
OTHER PERSONNEL COSTS	.14	4.26	0	0	.14	4.26

1/ UNLESS OTHERWISE SPECIFIED, BASED ON DAYS CARE AND ADJUSTED FOR UNDERUTILIZATION OF CAPACITY. ADJUSTMENT FOR UNDERUTILIZATION OF CAPACITY CONSISTS OF INCREASING THE DAYS CARE TO 85 PERCENT OF CAPACITY FOR HOMES OPERATING BELOW THIS LEVEL.
2/ 1959 PER CAPITA COSTS PLUS ADJUSTMENTS FOR CHANGES SINCE 1959. 3/ BASED ON 30.42-DAY MONTH. 4/ BASED ON CAPACITY-DAYS.
5/ NO ADJUSTMENT FOR UNDERUTILIZATION OF CAPACITY - NOT RELEVANT. 6/ SUPPLIES, REPLACEMENTS AND MAINTENANCE. MAINTENANCE COMPUTED ON BASIS OF 1957-1959 AVERAGE. 7/ 1959 PER CAPITA COSTS ADJUSTED TO REFLECT DECEMBER 1959 WAGE RATES. SALARY ALLOWANCES FOR UNPAID FAMILY LABOR COMPUTED ON BASIS OF THIRD QUARTILES OF DECEMBER 1959 WAGE RATE DISTRIBUTIONS.

CHARACTERISTICS OF CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

Section I. Identification

A. Case number _____
CO Program Basic No.

B. Name of Recipient _____
Last First Middle

C. Name of nursing home _____

Section II. Characteristics of Recipient

D. Date of birth _____
Month Year

E. Sex and race (circle one)

Male:	Female:
1. White	3. White
2. Nonwhite	4. Nonwhite

F. Major impairment(s). (Circle all applicable codes. Consider only impairments contributing to recipient's need for nursing home care and/or affecting the type of care required)

1. Nonparalytic stroke or late effects thereof
2. Paralytic stroke or late effects thereof
3. Other paralysis or palsy
4. Other heart or circulatory disease
5. Fracture of hip
6. Other fracture
7. Arthritis or rheumatism
8. Diabetes
9. Cancer or other neoplasms
10. (Other) genitourinary disease or impairment
11. (Other) gastrointestinal disease or impairment
12. Asthma or bronchitis
13. Blindness
14. Deafness
15. Debility
16. Senile behavior disorders
17. Other behavior disorders
18. Other (Specify: _____)

G. Mental condition (Circle all applicable codes. For each of codes 2 - 5 circled, enter a corresponding check in column 1 or 2)

	1 Part of the time	2 Most or all of the time
1. Always clear		
Confused:		
2. Mildly confused only		
3. Seriously disoriented but without eccentric behavior		
4. Seriously disoriented with eccentric behavior		
5. Not incontinent but disoriented with respect to toilet facilities		
6. Mentally retarded		

H. Bed status (circle one)

Bedridden:

1. All of the time
2. Most of the time
3. Part of the time

4. Not bedridden

I. Mobility within nursing home (Circle all applicable codes. For each code circled, enter a check in column 1, 2 or 3)

	Part of the time	Most of the time	All of the time
1. Walks alone or with no more help than cane or crutch			
2. Moves himself about with a mechanical aid such as walker or wheelchair			
3. Able to walk or move in wheelchair only with help of attendant			
Unable to walk or be moved about in wheelchair:			
4. Able to turn and/or sit on bedside by self			
5. Helpless, must be turned or lifted			

J. Continence (Enter one check in each column)*

	(1) Bladder	(2) Bowel
1. Always continent		
2. Occasionally incontinent		
3. Dribbling		
4. Frequently incontinent		
5. Always incontinent		

* Incontinence refers to involuntary elimination only. Voluntary elimination but with confusion as to location is not to be considered incontinence (Cross-reference Item G-5)

K. Services needed by recipient and provided by staff of home. (Circle the appropriate code for each service needed by recipient and provided by staff of home without additional charge to the recipient. A code is not to be circled if the recipient is self-dependent in the specified function or if the service, though provided by the home, is in fact unwarranted by the recipient's condition. If -- and only if -- a code is circled, a check is to be entered in each of Sections A and B.)

	Section A: Service needed by recipient:		Section B: Maximum self-help encouraged by staff of home?			
	Occasionally 1	Frequently or routinely 2	Yes 3	No 4	Unknown 5	Not applicable 6
Washing face, hands, teeth and/or dentures:						
1. Supervision only						
2. Some assistance, e.g., help to and from wash basin, collecting and carrying toilet articles						
3. Face, hands, teeth and/or dentures washed by attendant						
Care of finger nails:						
4. Supervision only						
5. Nail care by attendant						
Care of feet and toe nails:						
6. Supervision only						
7. Routine nail care by attendant						
8. Special podiatric care						
Care of hair:						
9. Combing						
10. Washing						
Shaving:						
11. Supervision only						
12. Some assistance, e.g., help to and from wash basin, collecting and carrying toilet articles						
13. Shaved by attendant						
Dressing (clothing, nightwear, appliances):						
14. Supervision only						
15. Help with difficult items only						
16. General help						
17. Completely dressed by attendant						

K. Services needed by recipient and provided by staff of home (Continued)

	Section A		Section B			
	Service needed by recipient:		Maximum self-help encouraged by staff of home?			
	Occasionally 1	Frequently or routinely 2	Yes 3	No 4	Unknown 5	Not applicable 6
Feeding and diet:						
18. Tray in room						
19. Help in cutting food						
20. Fed some food(s) or meals						
21. Fed all meals						
22. Intravenous feeding						
23. Dietary requirements (other than "normal" diet):						
Bathing:						
24. Help in or out of tub or shower only						
25. Back and/or feet washed						
26. General help needed						
27. Shower or chair bath, unable to help						
28. Bed bath						
Toilet:						
29. Help to and from toilet						
30. Commode, no help						
31. Help to and from commode						
32. Bed pan and/or urinal						
33. Take pulse or temperature (specify frequency _____)						
34. Take respiration (specify frequency _____)						
35. Take blood pressure (specify frequency _____)						

K. Services needed by recipient and provided by staff of home (Continued)

	Section A: Service needed by recipient		Section B: Maximum self-help encouraged by staff of home			
	Occasionally 1	Frequently or routinely 2	yes 3	no 4	Unknown 5	Not applicable 6
36. Catheterization (other than retention)						
37. Retention catheterization*						
Dressings or bandages:						
38. Complex and/or extensive (specify number per day _____)						
39. Other (specify number per day: _____)						
Oral medications:						
40. Routine						
41. Critical, observation necessary						
Parenteral medications:						
42. Subcutaneous (specify frequency _____)						
43. Intravenous (specify frequency _____)						
44. Intramuscular (specify frequency _____)						
45. Administration of oxygen (specify frequency _____)						
46. Aspiration (specify frequency _____)						
47. Extra supervision because of confusion						
48. Extra care or supervision because of (other) eccentricities of behavior						
49. Other (specify _____ _____ _____)						
50. None						

* Code 37 is to be circled only in cases in which retention catheters are used because of medical order.

L. Personal care, nursing or recreational services needed by recipient and provided by or within nursing home but at extra charge to recipient (Specify service, frequency of need and charge. Indicate whether charge refers to time period, e.g., per month, or to each occasion service rendered, e.g., per shampoo).

Service	Frequency with which service needed (e.g., daily, weekly, monthly)	Charge

M. Recipient's usual activities. (Circle all appropriate codes)

1. Listens to radio and/or TV
2. Reads newspapers, magazines and/or books
3. Does handiwork or arts and crafts
4. Takes part in games and/or group activities in home
5. Helps with work in home (specify: _____)
6. Goes off the grounds alone or with others (to visit, shop, walk, church, etc.)
7. Receives friends and/or relatives
8. Other (specify: _____)
9. None of above

N. Ability of recipient to purchase clothing and personal incidentals (circle one)

1. Able to manage money and usually able to purchase own clothing and personal incidentals
2. Able to manage money but usually unable to purchase own clothing and personal incidentals (specify person usually making purchases _____)
3. Unable to manage money (specify person(s) managing money and making purchases _____)

O. Class of care (last) certified for recipient (circle one)

1. I
2. II
3. III
4. IV

P. Date of (last) certification _____
Month Year

Q. Class of care recipient currently receiving (Class of care for which nursing home being paid) (Circle one)

1. I
2. II
3. III
4. IV

R. Date recipient last entered this nursing home (Disregard absences of less than 30 days regardless of purpose and absences because of hospitalization regardless of length) _____
Month Year

S. Change in recipient's condition since date of last entry into this nursing home (circle one)

1. Substantial improvement
2. Slight improvement
3. Condition static

Deterioration, recipient not moribund:

4. Slight deterioration
5. Substantial deterioration

6. Deterioration, recipient currently moribund

T. Date recipient last seen by attending physician _____
Month Year

U. Estimated period for which recipient will require nursing home care (Circle one. Code 1 is to be used for all cases in which care is expected to be terminal as well as for cases in which care, though not necessarily terminal, is expected to continue for an indefinite period)

1. Indefinite
2. Less than 3 months
3. 3, less than 6 months
4. 6 months, less than one year
5. One year or more

Comments:

Person completing schedule _____

Date schedule completed _____

SOCIAL CHARACTERISTICS OF CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

Section I. Identification

A. Case number _____
CO Program Basic No.

B. Name of recipient _____
Last First Middle

C. Name of nursing home _____

Section II. Personal Characteristics of Recipient and Spouse

D. Date of birth _____
Month Year

E. Sex and race (circle one):

Male:	Female:
1 White	3 White
2 Nonwhite	4 Nonwhite

F. Marital status (circle one)

1 Never married

2 Widowed

3 Married, spouse living, not estranged

4 Divorced or otherwise estranged

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G. Customary living arrangements of recipient during six months prior to entering this nursing home (circle one)

Note: Consider person to have been in own home (a) if person and/or spouse had equity in the home regardless of the responsibility assumed for household management or (b) if person lived in rented or free quarters with cooking facilities and person and/or spouse had primary responsibility for management of the home.

In own home:

1 Alone

2 With spouse (other persons may or may not have been present)

3 With other related person(s), spouse not present (nonrelated persons may or may not have been present)

4 With nonrelated person(s) only

5 In home of son or daughter

6 In home of other relative

7 In boarding home or home of nonrelated person

8 In nursing home (specify name of home _____)

9 In other institution (specify _____)

10 Other (specify _____

_____)

H. Age of spouse (circle one)

1 Not applicable -- recipient single, widowed or estranged

2 Under 50

3 50, under 65

4 65, under 70

5 70, under 75

6 75, under 80

7 80, under 85

8 85 or over

I. Present living arrangements of spouse (circle one)

Note: See Note, Item G for definition of own home.

1 Not applicable -- recipient single, widowed or estranged

In own home:

2 Alone

3 With related person(s) (nonrelated persons may also be present)

4 With nonrelated person(s) only

5 In home of son or daughter

6 In home of other relative

7 In boarding home or home of nonrelated person

8 In nursing home (specify name of home _____)

9 In other institution (specify _____)

10 Other (specify _____)

Section III. Assistance History

J. Date public assistance last authorized for recipient (Disregard transfers between programs and closings or suspensions of three months or less)

_____
Month Year

K. Date Recipient first known to SDPA _____
Month Year

L. Total number of months for which any assistance received since date recipient first known to the SDPA (circle one)

1 Less than 3 months

2 3, less than 6 months

3 6 months, less than 1 year

4 1 year, less than 2 years

5 2, less than 4 years

6 4, less than 6 years

7 6, less than 8 years

8 8, less than 10 years

9 10 years or more

M. Income (other than public assistance) budgeted to recipient for December 1959. (circle all applicable codes and indicate monthly amounts)

1 None

2 OASDI $_____

3 Military-connected income $_____

4 Contributions from spouse $_____

5 Contributions from children $_____

6 Contributions from parents $_____

7 Contributions from other relatives $_____

8 Rentals $_____

9 Payments on contracts $_____

10 Other property income (specify _____) $_____

11 Other (specify _____) $_____

N. Other resources of recipient (Circle all applicable codes and specify approximate value of resource. If property is owned jointly or in common, specify only value of recipient's share)

1 None

2 Equity in home $_____

3 Equity in other real estate $_____

4 Cash or securities $_____

Life insurance:

5 Face value $_____

6 Cash surrender value $_____

7 Other *(specify _____) $_____

* Exclude items, e.g., personal effects, for which the CO makes no dollar evaluation.

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O. Income of spouse for December 1959 (Circle all applicable codes and indicate monthly amounts. Exclude amounts budgeted to scheduled recipient)

Not applicable:

1 Recipient single, widowed or estranged

2 Not estranged but spouse has disclaimed financial responsibility

Public assistance:

3 OAA $_____

4 AB $_____

5 ADC $_____

6 DA $_____

7 GA $_____

8 OASDI $_____

9 Military-connected income $_____

10 Contributions from children $_____

11 Contributions from other relative(s) $_____

12 Wages or income from self-employment $_____

13 Rentals $_____

14 Payments on contracts $_____

15 Other property income (specify type _____) $_____

16 Other (specify _____) $_____

Section IV. Nursing Home History

P. Chronology of recipient's care in licensed private nursing homes. (The entries on line 1 are to refer to the recipient's first admission to care in a licensed private nursing home. Information on subsequent admissions to nursing home care, including transfers between homes, is to be entered chronologically on the following lines. All relevant information available to the CO is to be reported even though incomplete or approximate. Limitations on the data are to be indicated in the Comments section of this item.)

	I	II. ADMITTED FROM -						III	IV	V. DISCHARGED TO -					
	DATE OF ADMISSION	HOSPITAL	OTHER NURSING HOME	OWN HOME	HOME OF ADULT CHILD	BOARDING HOME	OTHER	CLASS OF CARE AT ADMISSION	DATE OF DISCHARGE	HOSPITAL	OTHER NURSING HOME	OWN HOME	HOME OF ADULT CHILD	BOARDING HOME	OTHER
1.															
2.															
3.															
4.															
5.															
6.															

Comments: _____

* For definition, see Note, Item G.

Section V. Events Contributing to Nursing Home Placement

In Section V enter a brief narrative describing, to the best of the CO's knowledge, the complex of events that resulted in placement in a nursing home, e.g., recipient had stroke 1/58, only partial recovery, cared for at home by spouse until 10/58 when spouse died, cared for in home of daughter until daughter became ill 6/59 when recipient placed in nursing home.

Person completing schedule _____

Date schedule completed _____

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STATE OF WASHINGTON

DEPARTMENT OF PUBLIC ASSISTANCE

CONFIDENTIAL

NURSING HOME COST STUDY
SCHEDULE A
CLASSIFICATION, CAPACITY AND PUBLIC ASSISTANCE PATIENT-DAYS

SCHEDULE A IS TO BE COMPLETED BY THE STATE DEPARTMENT OF PUBLIC ASSISTANCE. A DUPLICATE OF THE INFORMATION WILL BE TRANSMITTED TO THE NURSING HOME.

A. NAME OF HOME _____ B. LICENSE NO. _____

C. ADDRESS OF HOME _____

D. CLASSIFICATION OF HOME AS OF DECEMBER 31, 1959. (MAKE ONE ENTRY IN ITEM D-A. IF CLASSIFICATION WAS CHANGED DURING 1959, ALSO INDICATE PREVIOUS CLASSIFICATION AND DATE OF CHANGE IN ITEM D-B.)

D-A CLASSIFICATION AS OF 12/31/59:

1 I

2 II

3 III

4 IV

D-B PREVIOUS CLASSIFICATION (CHANGED EFFECTIVE _____)
MONTH DAY YEAR

1 I

2 II

3 III

4 IV

E. LICENSED CAPACITY AS OF DECEMBER 31, 1959. (IF LICENSED CAPACITY WAS CHANGED DURING 1959, ALSO INDICATE PREVIOUS CAPACITY AND DATE OF CHANGE.)

PRESENT CAPACITY _____

PREVIOUS CAPACITY _____ CHANGED EFFECTIVE _____
MONTH DAY YEAR

F. DAYS OF CARE PROVIDED TO PUBLIC ASSISTANCE RECIPIENTS DURING 1959. (IN COMPUTING PATIENT-DAYS INCLUDE THE DAY THE PATIENT ENTERED THE HOME BUT EXCLUDE THE DAY THE PATIENT LEFT THE HOME. IF THE PATIENT DIED ON DAY OF ENTRY, ONE DAY OF CARE IS TO BE COUNTED. IN ALL OTHER CASES IN WHICH THE PATIENT ENTERED AND LEFT ON THE SAME DAY, NO DAY'S CARE IS TO BE COUNTED.)

CLASS OF CARE	PATIENT-DAYS		
	TOTAL	JANUARY THROUGH JUNE	JULY THROUGH DECEMBER
I			
II			
III			
IV			
TOTAL			

SOF 489 5/60

STATE OF WASHINGTON

DEPARTMENT OF PUBLIC ASSISTANCE

CONFIDENTIAL

NURSING HOME COST STUDY
SCHEDULE B

SECTION I. IDENTIFICATION OF HOME

A. NAME OF HOME _____

B. ADDRESS OF HOME _____

C. HOME OPERATED BY: (CIRCLE ONE CODE)

1. PROPRIETORSHIP
2. PARTNERSHIP
3. PROFIT CORPORATION
4. NONPROFIT CORPORATION (RELIGIOUS, FRATERNAL OR BENEVOLENT AUSPICES)

D. NAME OF OPERATOR (PROPRIETOR, PARTNERS OR CORPORATION) _____

_____

SECTION II. NURSING HOME PATIENT-DAYS

INCLUDE ALL DAYS CARE PROVIDED TO PRIVATE-PAY AND PUBLIC ASSISTANCE NURSING HOME PATIENTS. EXCLUDE DAYS CARE PROVIDED TO HOSPITAL PATIENTS AND BOARD AND ROOM CASES.

IN COMPUTING DAYS OF CARE INCLUDE THE DAY THE PATIENT ENTERED THE HOME BUT EXCLUDE THE DAY THE PATIENT LEFT THE HOME. IF THE PATIENT DIED ON DAY OF ENTRY, ONE DAY OF CARE IS TO BE COUNTED. IN ALL OTHER CASES IN WHICH THE PATIENT ENTERED AND LEFT ON THE SAME DAY, NO DAY'S CARE IS TO BE COUNTED.

E. DAYS OF CARE PROVIDED TO NURSING HOME PATIENTS DURING CALENDAR YEAR 1959 BY SIX-MONTH PERIODS:

JANUARY THROUGH JUNE _____

JULY THROUGH DECEMBER _____

SECTION III. TANGIBLE FIXED ASSETS AS OF DECEMBER 31, 1959

F. LAND AND BUILDINGS USED AND USEFUL IN NURSING HOME OPERATION INCLUDING EQUIPMENT (SUCH AS HEATING EQUIPMENT) ATTACHED TO AND PART OF BUILDING. (CIRCLE CODE 1 OR MAKE APPROPRIATE ENTRIES IN ITEMS 2 THROUGH 4.)

1. NOT RELEVANT - LAND AND BUILDINGS RENTED OR LEASED.

2. COST OF LAND AND BUILDINGS. (INCLUDE (A) ACQUISITION COST TO PRESENT OWNER, (B) SPECIAL LOCAL IMPROVEMENT ASSESSMENTS LEVIED ON PRESENT OWNER FROM DATE OF PURCHASE THROUGH DECEMBER 31, 1959, AND (C) EXPENDITURES BY PRESENT OWNER FROM DATE OF PURCHASE THROUGH DECEMBER 31, 1959 FOR PERMANENT IMPROVEMENTS OR BETTERMENTS. EXCLUDE GOODWILL AND ALLOWANCES FOR UNPAID FAMILY LABOR.) (SEE ITEM F-3) ..... $ _____

3. ADJUSTMENT (ALLOWANCES) FOR UNPAID LABOR OF OWNER AND/OR FAMILY IN CONNECTION WITH ORIGINAL CONSTRUCTION, PERMANENT IMPROVEMENTS AND/OR BETTERMENTS. (IN COMPUTING ALLOWANCES IT IS RECOMMENDED THAT IF PRACTICABLE, THE GOING RATES BE USED FOR UNSKILLED AND SEMI-SKILLED WORK AND 80 PERCENT OF THE GOING RATES BE USED FOR SKILLED WORK. IF NOT PRACTICABLE, E.G., IF RECORDS DO NOT PERMIT, OR IF SPECIAL CIRCUMSTANCES EXIST (E.G., IF AN INDIVIDUAL IS IN FACT A MEMBER OF THE SKILLED TRADE INVOLVED), COMPUTE THE ALLOWANCES ON ANY REASONABLE BASIS AND INDICATE THE BASIS USED IN THE SPACE PROVIDED.) ..... _____

BASIS OF COMPUTATION: _____

_____

_____

F. (CONTINUED)

4. DEPRECIATION RESERVE (SUM OF (A) TOTAL ACCUMULATED DEPRECIATION FROM DATE OF PURCHASE THROUGH DECEMBER 31, 1959 OF ACQUISITION COST TO PRESENT OWNER OF BUILDINGS AND ATTACHED EQUIPMENT, AND (B) TOTAL ACCUMULATED DEPRECIATION THROUGH DECEMBER 31, 1959 OF EXPENDITURES BY PRESENT OWNER FOR PERMANENT IMPROVEMENTS AND BETTERMENTS, AND (C) TOTAL ACCUMULATED DEPRECIATION THROUGH DECEMBER 31, 1959 OF ADJUSTMENT REPORTED IN ITEM F-3. DEPRECIATION ON THE ADJUSTMENT IS TO BE COMPUTED ON THE SAME BASIS USED IN CLAIMING DEPRECIATION UNDER THE FEDERAL INCOME TAX.) ..... $ _____

G. OTHER DEPRECIABLE TANGIBLE PROPERTY USED AND USEFUL IN NURSING HOME OPERATION (EXCLUDE REAL ESTATE).

IF ALL EQUIPMENT IS LEASED, CIRCLE CODE 1 AND MAKE NO FURTHER ENTRIES. IF SOME BUT NOT ALL EQUIPMENT IS LEASED, EXCLUDE LEASED EQUIPMENT FROM THE ENTRIES IN ITEMS G-2 AND G-3.

ALTHOUGH A THREEFOLD BREAKDOWN OF OTHER DEPRECIABLE TANGIBLE PROPERTY IS REQUESTED, IT IS RECOGNIZED THAT SUCH A BREAKDOWN MAY NOT BE PRACTICABLE FOR ALL HOMES, REGARDLESS OF THE METHODS OF BOOKKEEPING, ENTRIES ARE TO BE MADE IN ITEM G-2. TO THE EXTENT THAT THE METHODS OF BOOKKEEPING PERMIT. ONE OR MORE ENTRIES ARE ALSO TO BE MADE IN ITEM G-3.

1. NOT RELEVANT -- ALL EQUIPMENT RENTED OR LEASED

2. TOTAL:

A. ACTUAL COST TO PRESENT OWNER ..... _____

B. TOTAL ACCUMULATED DEPRECIATION THROUGH DECEMBER 31, 1959 ..... _____

3. BREAKDOWN:

A. NURSING, MEDICAL OR THERAPEUTIC EQUIPMENT:

(1) ACTUAL COST TO PRESENT OWNER ..... _____

(2) TOTAL ACCUMULATED DEPRECIATION THROUGH 12/31/59 ..... _____

B. CULINARY EQUIPMENT:

(1) ACTUAL COST TO PRESENT OWNER ..... _____

(2) TOTAL ACCUMULATED DEPRECIATION THROUGH 12/31/59 ..... _____

C. OTHER EQUIPMENT:

(1) ACTUAL COST TO PRESENT OWNER ..... _____

(2) TOTAL ACCUMULATED DEPRECIATION THROUGH 12/31/59 ..... _____

SECTION IV. OPERATING COSTS (OTHER THAN SALARIES, WAGES AND OTHER PERSONNEL COSTS) FOR YEAR ENDED DECEMBER 31, 1959

FOR EACH ITEM IN SECTION IV, COSTS REFER TO NET EXPENDITURES, I.E., ANY REVENUE OBTAINED FROM (EXTRA) CHARGES FOR THAT ITEM IS TO BE DEDUCTED FROM GROSS COSTS. EXAMPLES OF SUCH REVENUE ARE CHARGES TO STAFF OR GUESTS FOR MEALS, REIMBURSEMENT OF TELEPHONE CHARGES BY PATIENTS OR FAMILIES AND PAYMENT BY PATIENTS OR FAMILIES FOR PERSONAL ITEMS OR MEDICINE CHEST SUPPLIES. THE VALUES OF DONATED ITEMS ARE NOT TO BE REPORTED AS COSTS IN SECTION IV.

FOR EACH ITEM, THE TOTAL ENTRY IS THE SUM OF THE SEPARATE COST ITEMS.

IF FOR ANY ITEM THE NATURE OF THE OPERATION OR THE METHODS OF BOOKKEEPING ARE SUCH THAT SOME COSTS CANNOT BE ITEMIZED AS REQUESTED, USE A BREAKDOWN AS CLOSELY COMPARABLE AS PRACTICABLE AND INDICATE THE NATURE OF THE DIFFERENCE IN THE MARGIN OR ON AN ATTACHED SHEET.

H. ADMINISTRATION AND GENERAL EXPENSES FOR YEAR ENDED DECEMBER 31, 1959.

1. STATIONERY, OFFICE SUPPLIES, POSTAGE, TELEPHONE, TELEGRAPH, ADVERTISING, PUBLIC RELATIONS ..... $_____

2. BUSINESS TAXES (EXCLUDE REAL ESTATE, PERSONAL PROPERTY AND PAYROLL TAXES AND FEDERAL INCOME TAX.) ..... _____

3. PURCHASE OF ACCOUNTING, AUDITING AND LEGAL SERVICES FROM OUTSIDE FIRMS OR SELF-EMPLOYED INDIVIDUALS ..... _____

4. INSURANCE:

A. GENERAL LIABILITY AND MALPRACTICE ..... _____

B. BUSINESS INTERRUPTION ..... _____

C. FIRE AND BOILER ..... _____

D. OTHER (EXCLUDE PAYMENTS ON INDUSTRIAL, SICKNESS, HOSPITALIZATION OR LIFE INSURANCE FOR EMPLOYEES.) ..... _____

5. OTHER (INCLUDE BUSINESS INTEREST OTHER THAN INTEREST ON MORTGAGES AND CONTRACTS. EXCLUDE BAD DEBTS AND ALLOWANCES THEREFOR. ENTER TOTAL AND SPECIFY ITEMS INCLUDED.) ..... _____

TOTAL, ADMINISTRATION AND GENERAL ..... _____

I. TAXES, DEPRECIATION EXPENSE AND RENT ON LAND AND BUILDINGS USED AND USEFUL IN NURSING HOME OPERATION FOR YEAR ENDED DECEMBER 31, 1959.

1. REAL ESTATE AND PERSONAL PROPERTY TAXES. (EXCLUDE SPECIAL ASSESSMENTS FOR PROPERTY IMPROVEMENT.) ..... _____

2. DEPRECIATION EXPENSE ..... _____

3. RENT FOR LAND AND/OR BUILDINGS NOT OWNED ..... _____

TOTAL, LAND AND BUILDINGS ..... _____

J. DEPRECIATION EXPENSE AND RENT FOR (DEPRECIABLE) TANGIBLE PROPERTY (OTHER THAN THAT INCLUDED IN ITEM I) USED AND USEFUL IN NURSING HOME OPERATION FOR YEAR ENDED DECEMBER 31, 1959.

REGARDLESS OF THE METHODS OF BOOKKEEPING, ENTRIES ARE TO BE MADE IN ITEM J-1. TO THE EXTENT THAT THE METHODS OF BOOKKEEPING PERMIT, ONE OR MORE ENTRIES ARE ALSO TO BE MADE IN ITEM J-2.

1. TOTAL:

A. DEPRECIATION EXPENSE ..... _____

B. EQUIPMENT RENTALS ..... _____

2. BREAKDOWN:

A. NURSING, MEDICAL OR THERAPEUTIC EQUIPMENT:

(1) DEPRECIATION EXPENSE ..... _____

(2) EQUIPMENT RENTALS ..... _____

B. CULINARY EQUIPMENT:

(1) DEPRECIATION EXPENSE ..... _____

(2) EQUIPMENT RENTALS ..... _____

C. OTHER EQUIPMENT:

(1) DEPRECIATION EXPENSE ..... _____

(2) EQUIPMENT RENTALS ..... _____

K. PLANT OPERATION AND MAINTENANCE COSTS FOR YEAR ENDED DECEMBER 31, 1959.

1. UTILITIES, TOTAL. (ENTER THE SUM OF FUEL OTHER THAN ELECTRICITY, ELECTRICITY, WATER, GARBAGE AND SEWERAGE. IF THE METHODS OF BOOKKEEPING PERMIT, ALSO MAKE ENTRIES IN ITEMS K-1-a THROUGH K-1-c.) ..... $_____

   a. FUEL OTHER THAN ELECTRICITY ..... _____

   b. ELECTRICITY ..... _____

   c. WATER, GARBAGE AND SEWERAGE ..... _____

2. SUM OF (a) PURCHASED SERVICES FROM OUTSIDE FIRMS OR SELF-EMPLOYED INDIVIDUALS FOR MAINTENANCE AND REPAIR OF BUILDING AND EQUIPMENT, (b) MAINTENANCE AND REPAIR SUPPLIES AND (c) ADJUSTMENT (ALLOWANCES) FOR UNPAID LABOR OF OWNER AND/OR FAMILY ON MAINTENANCE AND REPAIR OF BUILDING AND EQUIPMENT. (EXCLUDE SERVICES AND SUPPLIES FOR IMPROVEMENTS, ENLARGEMENTS OR MAJOR REPLACEMENTS. ALLOWANCES FOR UNPAID LABOR ARE TO BE COMPUTED ON THE SAME BASES AS IN ITEM F-3.) ..... _____

NOTE: SINCE CONSIDERABLE YEAR-TO-YEAR FLUCTUATION MAY OCCUR IN THE COSTS OF MAINTENANCE AND REPAIR, COMPARABLE INFORMATION IS ALSO REQUESTED FOR 1957 AND 1958. IF THE FACILITY WAS UNDER A DIFFERENT OPERATION IN ONE OR BOTH OF THESE YEARS, NO ENTRY IS TO BE MADE FOR THE YEAR(S) INVOLVED. IF THE FACILITY WAS UNDER THE SAME OPERATOR IN 1957 AND 1958 BUT THE METHODS OF BOOKKEEPING ARE SUCH THAT IT IS NOT PRACTICABLE TO REPORT THE REQUESTED INFORMATION, ENTER "NOT AVAILABLE".

   a. 1958 .....$ _____

   b. 1957 ..... _____

3. PURCHASED SERVICES FROM OUTSIDE FIRMS OR SELF-EMPLOYED INDIVIDUALS FOR MAINTENANCE OF GROUNDS ..... _____

TOTAL, PLANT OPERATION AND MAINTENANCE ..... _____

L. DIETARY COSTS FOR YEAR ENDED DECEMBER 31, 1959

1. FOOD. (IF NO FOOD OR NEGLIGIBLE AMOUNT FOR PATIENT USE WAS HOME-PRODUCED, ENTER ZERO IN ITEM L-1-b. IF THE ENTRY IS OTHER THAN ZERO, INDICATE THE METHOD OF ESTIMATING THE COST OF HOME-PRODUCED FOOD IN ITEM AA, PAGE 68.)

   a. PURCHASED FOOD ..... _____

   b. COST OF HOME-PRODUCED FOOD ..... _____

2. OTHER COSTS (EXCLUSIVE OF PERSONNEL) OF SERVING MEALS, I.E., REPLACEMENTS (OF DISHES, UTENSILS, ETC) AND KITCHEN SUPPLIES. (INDICATE WHETHER THE ENTRY IN THIS ITEM ALSO INCLUDES LAUNDRY AND CLEANING SUPPLIES:

   [ ] OTHER SUPPLIES INCLUDED

   [ ] OTHER SUPPLIES EXCLUDED) _____

TOTAL, DIETARY ..... _____

3. NUMBER OF FREE MEALS SERVED TO OWNERS, STAFF AND/OR GUESTS DURING CALENDAR YEAR 1959. (IF EXACT DATA ARE NOT READILY AVAILABLE, ENTER APPROXIMATE NUMBER AND WRITE "ESTIMATE" IN MARGIN.)

   a. TO OWNERS AND/OR FAMILIES _____

   b. TO STAFF _____

   c. TO GUESTS _____

M. HOUSEKEEPING, LINENS AND LAUNDRY COSTS FOR YEAR ENDED DECEMBER 31, 1959

1. REPLACEMENTS OF LINEN, BEDDING, EXPENDABLE EQUIPMENT, ETC ..... $ _____

2. SUPPLIES OTHER THAN REPORTED IN ITEM L-2 ..... _____

3. PURCHASE OF LAUNDRY SERVICE, LINEN SERVICE AND/OR CLEANING SERVICE FROM OUTSIDE FIRMS OR SELF-EMPLOYED INDIVIDUALS. (NOTE INSTRUCTIONS AT BEGINNING OF SECTION IV RE DEDUCTING REVENUE FROM GROSS COSTS.) ..... _____

TOTAL, HOUSEKEEPING, LINENS AND LAUNDRY ..... _____

N. COSTS OF NURSING, PERSONAL CARE AND RECREATION EQUIPMENT AND SUPPLIES FOR YEAR ENDED DECEMBER 31, 1959

1. REPLACEMENTS (EXCLUDE EQUIPMENT ACCOUNTED FOR IN ITEM I) ..... _____

2. SUPPLIES (OTHER THAN REPORTED IN ITEMS L AND M) ..... _____

TOTAL, NURSING, PERSONAL CARE AND RECREATION ..... _____

SECTION V. SALARIES, WAGES AND OTHER PERSONNEL COSTS FOR YEAR ENDED DECEMBER 31, 1959

O. TOTAL WAGES PAID TO NURSING PERSONNEL, JANUARY THROUGH JUNE AND JULY THROUGH DECEMBER 1959.

INFORMATION IS REQUESTED FOR A FOURFOLD BREAKDOWN OF NURSING PERSONNEL. IF A FOURFOLD BREAKDOWN IS NOT PRACTICABLE, WAGES MAY BE REPORTED FOR A TWOFOLD BREAKDOWN, VIZ., LICENSED AND UNLICENSED PERSONNEL. IT IS HOPED THAT WHENEVER FEASIBLE THE FOURFOLD BREAKDOWN WILL BE USED.

SINCE THE MINIMUM WAGE LAW MAY HAVE ALTERED THE LEVEL AND STRUCTURE OF WAGE RATES, WAGES ARE TO BE REPORTED BY SIX-MONTH PERIODS.

INCLUDE PAYROLL DEDUCTIONS. EXCLUDE (1) COMPENSATION OTHER THAN CASH, (2) INDUSTRIAL, SICKNESS, HOSPITALIZATION OR LIFE INSURANCE AND (3) PAYROLL TAXES (I.E., EMPLOYER'S SHARE OF F.I.C.A., WORKMEN'S COMPENSATION, MEDICAL AID AND UNEMPLOYMENT INSURANCE).

EXCLUDE UNPAID LABOR OF PROPRIETOR, PARTNER(S) AND/OR FAMILIES.

ALSO EXCLUDE "SPECIAL" EMPLOYEES, I.E., PERSONS ON TERMINAL LEAVE FROM A STATE SCHOOL FOR THE MENTALLY RETARDED AND EMPLOYED UNDER SPECIAL TERMS AND CONDITIONS ONLY.

INCLUDE SALARY ALLOWANCES FOR MEMBERS OF RELIGIOUS ORDERS IF SUCH ALLOWANCES ARE CARRIED AS COSTS IN THE HOME'S BOOKS. NO (OTHER) SALARY ALLOWANCES FOR DONATED SERVICES ARE TO BE REPORTED.

ENTER INFORMATION ON SHIFT DIFFERENTIALS IN THE SPACE PROVIDED.

	TOTAL MONEY WAGES
A. JANUARY THROUGH JUNE 1959	
1. LICENSED PERSONNEL, TOTAL	$
(A) REGISTERED NURSES	
(B) LICENSED PRACTICAL NURSES	
2. UNLICENSED PERSONNEL, TOTAL	
(A) AIDES	
(B) ORDERLIES	

O. (CONTINUED)

	TOTAL MONEY WAGES
B. JULY THROUGH DECEMBER 1959	
1. LICENSED PERSONNEL, TOTAL	$
(A) REGISTERED NURSES	
(B) LICENSED PRACTICAL NURSES	
2. UNLICENSED PERSONNEL, TOTAL	
(A) AIDES	
(B) ORDERLIES	

C. SHIFT DIFFERENTIALS IN HOURLY RATES. (CIRCLE ONE CODE. IF CODE 2 IS CIRCLED, INDICATE THE AMOUNT OF THE SHIFT DIFFERENTIALS IN RATES IN THE SPACE PROVIDED.)

1. NO SHIFT DIFFERENTIALS

2. SHIFT DIFFERENTIALS IN HOURLY RATES. (INDICATE AMOUNT OF DIFFERENTIAL IN HOURLY RATES OVER DAY SHIFT)

	EVENING OR PM	NIGHT
RN		
LPN		
AIDE		
ORDERLY		

P. WAGES AND HOURS FOR NURSING PERSONNEL, APRIL AND DECEMBER 1959

INFORMATION ON HOURS AS WELL AS WAGES IS BEING REQUESTED FOR TWO MONTHS ONLY, VIZ., APRIL AND DECEMBER. THE INFORMATION IS TO REFER TO WAGES PAID FOR HOURS WORKED IN APRIL AND DECEMBER, NOT TO WAGES PAID IN APRIL AND DECEMBER FOR HOURS WORKED IN OTHER MONTHS.

INCLUSIONS, EXCLUSIONS AND THE DEFINITION OF WAGES ARE THE SAME AS FOR ITEM M. COLUMN (2) REFERS TO HOURS THE CASH COMPENSATION FOR WHICH IS REPORTED IN COLUMN (1). INCLUDE PAID VACATION AND SICK LEAVE IN THE COUNT OF HOURS.

	(1) TOTAL MONEY WAGES	(2) TOTAL HOURS
A. APRIL 1959		
1. LICENSED PERSONNEL, TOTAL	$	
(A) REGISTERED NURSES		
(B) LICENSED PRACTICAL NURSES		
2. UNLICENSED PERSONNEL, TOTAL		
(A) AIDES		
(B) ORDERLIES		
B. DECEMBER 1959		
1. LICENSED PERSONNEL, TOTAL		
(A) REGISTERED NURSES		
(B) LICENSED PRACTICAL NURSES		
2. UNLICENSED PERSONNEL, TOTAL		
(A) AIDES		
(B) ORDERLIES		

Q. WAGES, OTHER PERSONNEL, JANUARY THROUGH JUNE AND JULY THROUGH DECEMBER 1959

INFORMATION IS REQUESTED FOR A FOURFOLD BREAKDOWN OF OTHER PERSONNEL. IF A FOURFOLD BREAKDOWN IS NOT PRACTICABLE, WAGES MAY BE REPORTED FOR A TWOFOLD BREAKDOWN, VIZ., ADMINISTRATOR OR MANAGER AND OTHER. IT IS HOPED THAT WHENEVER FEASIBLE THE FOURFOLD BREAKDOWN WILL BE USED.

DEFINITIONS, INCLUSIONS AND EXCLUSIONS PARALLEL THOSE FOR ITEM O.

IF AN EMPLOYEE'S FUNCTIONS ARE DIVIDED BETWEEN OCCUPATIONAL GROUPS, HIS OR HER WAGES ARE TO BE ALLOCATED ACCORDING TO THE (APPROXIMATE) PERCENTAGE DISTRIBUTION OF THE EMPLOYEE'S TIME.

	TOTAL MONEY WAGES
JANUARY THROUGH JUNE 1959	
1. ADMINISTRATOR OR MANAGER	$
2. OTHER, TOTAL	
A. OTHER ADMINISTRATIVE OR CLERICAL	
B. KITCHEN, LAUNDRY AND LINEN SERVICE, HOUSEKEEPING	
C. PLANT OPERATION AND MAINTENANCE, GROUNDS	
JULY THROUGH DECEMBER 1959	
1. ADMINISTRATOR OR MANAGER	
2. OTHER, TOTAL	
A. OTHER ADMINISTRATIVE OR CLERICAL	
B. KITCHEN, LAUNDRY AND LINEN SERVICE, HOUSEKEEPING	
C. PLANT OPERATION AND MAINTENANCE, GROUNDS	

R. WAGES AND HOURS, OTHER PERSONNEL, APRIL AND DECEMBER 1959

SEE INSTRUCTIONS FOR ITEM P.

	(1) TOTAL MONEY WAGES	(2) TOTAL HOURS
APRIL 1959		
1. ADMINISTRATOR OR MANAGER	$	
2. OTHER, TOTAL		
A. OTHER ADMINISTRATIVE OR CLERICAL		
B. KITCHEN, LAUNDRY AND LINEN SERVICE, HOUSEKEEPING		
C. PLANT OPERATION AND MAINTENANCE, GROUNDS		

R. (CONTINUED)

DECEMBER 1959	(1) TOTAL MONEY WAGES	(2) TOTAL HOURS
1. ADMINISTRATOR OR MANAGER	$	
2. OTHER, TOTAL		
A. OTHER ADMINISTRATIVE OR CLERICAL		
B. KITCHEN, LAUNDRY AND LINEN SERVICE, HOUSEKEEPING		
C. PLANT OPERATION AND MAINTENANCE, GROUNDS		

S. SPECIAL EMPLOYEES

ITEM S REFERS ONLY TO PERSONS ON TERMINAL LEAVE FROM A STATE SCHOOL FOR THE MENTALLY RETARDED AND EMPLOYED UNDER SPECIAL TERMS AND CONDITIONS. IF NO SUCH EMPLOYEES WERE ON STAFF DURING 1959, ENTER NA (NOT APPLICABLE) IN ITEM S-1.

1. TOTAL CASH WAGES PAID DURING 1959. (INCLUDE PAYROLL DEDUCTIONS. EXCLUDE EMPLOYER'S PAYROLL TAXES.) ..... $ _____

2. NUMBER OF PERSON-MONTHS REPRESENTED BY CASH WAGES IN ITEM S-1. (MULTIPLY EACH EMPLOYEE BY THE NUMBER OF MONTHS ON STAFF DURING 1959 AND ENTER THE SUM OF THESE PRODUCTS.) ..... _____

3. COMPENSATION OTHER THAN CASH. (CIRCLE ALL APPLICABLE CODES)

   A. BOARD AND ROOM

   B. LAUNDRY

   C. OTHER (SPECIFY: _____)

T. TOTAL PAYROLL TAXES, YEAR ENDED DECEMBER 31, 1959. (ENTER GRAND TOTAL OF EMPLOYER'S SHARE OF SOCIAL SECURITY (F.I.C.A.), UNEMPLOYMENT COMPENSATION, INDUSTRIAL INSURANCE (LABOR AND INDUSTRIES OR PRIVATE) AND MEDICAL AID.) ..... _____

U. OTHER PERSONNEL COSTS, CALENDAR YEAR 1959. (EXCLUDE COSTS REPORTED IN PREVIOUS ITEMS, VIZ., MONEY WAGES, PAYROLL TAXES, FREE MEALS AND COMPENSATION TO SPECIAL EMPLOYEES.) ..... _____

1. SICKNESS, HOSPITALIZATION AND LIFE INSURANCE PAYMENTS FOR EMPLOYEES ..... _____

2. OTHER (SPECIFY: _____)

_____

_____

_____) _____

V. UNPAID NURSING SERVICES PROVIDED BY PROPRIETOR, PARTNER(S) AND/OR FAMILIES, JANUARY THROUGH JUNE AND JULY THROUGH DECEMBER 1959.

ENTER APPROXIMATE TOTAL HOURS BY 6-MONTH PERIODS.

IF NO UNPAID FAMILY NURSING SERVICES WERE PROVIDED, ENTER "NA" IN THE MARGIN.

JANUARY THROUGH JUNE 1959	PROPRIETOR OR PARTNER A		PARTNER B		OTHER UNPAID FAMILY LABOR
	SELF (1)	SPOUSE (2)	SELF (3)	SPOUSE (4)	(5)
1. REGISTERED NURSE					
2. LICENSED PRACTICAL NURSE					
3. AIDE					
4. ORDERLY					

V. (CONTINUED)

JULY THROUGH DECEMBER 1959	PROPRIETOR OR PARTNER A SELF (1)	PROPRIETOR OR PARTNER A SPOUSE (2)	PARTNER B SELF (3)	PARTNER B SPOUSE (4)	OTHER UNPAID FAMILY LABOR (5)
1. REGISTERED NURSE					
2. LICENSED PRACTICAL NURSE					
3. AIDE					
4. ORDERLY					

W. OTHER UNPAID SERVICES PROVIDED BY PROPRIETOR, PARTNER(S) AND/OR FAMILIES, JANUARY THROUGH JUNE AND JULY THROUGH DECEMBER 1959.

FOR ADMINISTRATOR OR MANAGER, ENTER APPROXIMATE FULL-TIME EQUIVALENT EMPLOYEE COUNT, E.G., IF PROPRIETOR WORKED FULL-TIME AS ADMINISTRATOR OR MANAGER, ENTER "1" IN ROW 1, COLUMN 1; IF HE WORKED APPROXIMATELY HALF-TIME AS ADMINISTRATOR, ENTER "1/2" ETC.

FOR OTHER SERVICES, ENTER APPROXIMATE TOTAL HOURS BY SIX-MONTH PERIODS. IF PREFERRED, APPROXIMATE FULL-TIME EQUIVALENT EMPLOYEE COUNT MAY BE ENTERED IN LIEU OF HOURS.

EXCLUDE TIME FOR WHICH COST ALLOWANCES HAVE BEEN ENTERED IN ITEMS F AND K.

IF NO UNPAID FAMILY SERVICES WERE PROVIDED, ENTER "NA" IN THE MARGIN.

JANUARY THROUGH JUNE 1959	PROPRIETOR OR PARTNER A SELF (1)	PROPRIETOR OR PARTNER A SPOUSE (2)	PARTNER B SELF (3)	PARTNER B SPOUSE (4)	OTHER UNPAID FAMILY LABOR (5)
1. ADMINISTRATOR OR MANAGER					
2. OTHER, TOTAL					
A. KITCHEN, LAUNDRY AND LINEN SERVICE, HOUSEKEEPING					
B. PLANT OPERATION AND MAINTENANCE, GROUNDS					
JULY THROUGH DECEMBER 1959					
1. ADMINISTRATOR OR MANAGER					
2. OTHER, TOTAL					
A. KITCHEN, LAUNDRY AND LINEN SERVICE, HOUSEKEEPING					
B. PLANT OPERATION AND MAINTENANCE, GROUNDS					

X. COSTS (OTHER THAN FOOD) INCLUDED IN THIS SCHEDULE THAT APPLY TO THE PERSONAL USE OF PROPRIETORS, PARTNERS AND OTHER FAMILY MEMBERS. (CIRCLE ALL APPLICABLE CODES AND ENTER NUMBER OF FAMILY MEMBERS, INCLUDING PROPRIETOR, RECEIVING SUCH MAINTENANCE ITEMS.)

	PERSONS RECEIVING
0. NOT RELEVANT - NO MAINTENANCE ITEMS WITHDRAWN	
1. LODGING (SPECIFY NUMBER OF ROOMS)	
2. LAUNDRY	
3. OTHER (SPECIFY: _____ _____ _____)	

SECTION VI. MISCELLANEOUS

Y. BASIS ON WHICH OPERATING COSTS REPORTED (CIRCLE ONE CODE).

1. CASH

2. ACCRUAL

Z. DAYS OF CARE PROVIDED DURING 1959 TO PATIENTS OR CLIENTS OTHER THAN NURSING HOME PATIENTS. (IF REPORTED COSTS INCLUDE COSTS OF CARE FOR OTHER THAN NURSING HOME PATIENTS, E.G., AN OCCASIONAL BOARD AND ROOM CASE, ENTER THE DAYS OF CARE FOR SUCH PERSONS. DAYS OF CARE ARE DEFINED AS FOR ITEM E. IF NO CARE OTHER THAN NURSING HOME CARE WAS PROVIDED, ENTER ZERO.)

JANUARY THROUGH JUNE _____

JULY THROUGH DECEMBER _____

AA. METHOD OF ESTIMATING COST OF HOME-PRODUCED FOOD. (CIRCLE CODE 1 OR INDICATE METHOD IN ITEM 2.)

1. NOT RELEVANT, NO COSTS REPORTED IN ITEM L-1-B.

2. METHOD OF ESTIMATING COST: _____

_____

_____

BB. OUTSTANDING MORTGAGES AND/OR CONTRACTS ON FIXED ASSETS AS OF DECEMBER 31, 1959:

1. LAND AND BUILDINGS (INCLUDING EQUIPMENT ATTACHED TO AND PART OF BUILDING) $ _____

2. OTHER DEPRECIABLE TANGIBLE PROPERTY $ _____

CC. INTEREST EXPENSE ON OUTSTANDING MORTGAGES AND/OR CONTRACTS ON FIXED ASSETS FOR YEAR ENDED DECEMBER 31, 1959.

1. LAND AND BUILDINGS (INCLUDING EQUIPMENT ATTACHED TO AND FORMING PART OF BUILDING) $_____

2. OTHER DEPRECIABLE TANGIBLE PROPERTY $ _____

• • •

ACKNOWLEDGEMENT OF NURSING HOME OPERATOR

I, THE UNDERSIGNED OPERATOR OF THE _____ NURSING HOME DO HEREBY AFFIRM THAT I HAVE READ THE ABOVE REPORT AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION REPORTED IS TRUE AND CORRECT AND IN KEEPING WITH THE INSTRUCTIONS FOR ITS PREPARATION.

DATED _____ SIGNED _____

ACKNOWLEDGEMENT OF PUBLIC ACCOUNTANT

I, THE UNDERSIGNED, DO HEREBY AFFIRM THAT I HAVE PREPARED THE ANSWERS TO THE ABOVE REPORT ACCORDING TO THE INSTRUCTIONS AND THAT THE ANSWERS GIVEN, WHEREVER APPLICABLE, ARE IN RECONCILEMENT WITH THE FEDERAL INCOME TAX RETURN FILED BY THE NURSING HOME OPERATOR FOR THE SAME PERIOD.

DATED _____ SIGNED _____

LICENSE NUMBER _____

SOF 489-B 5/60

STATE OF WASHINGTON

DEPARTMENT OF PUBLIC ASSISTANCE

CONFIDENTIAL

NURSING HOME COST STUDY

Schedule C

SINCE POLICIES VARY AMONG HOMES, THE PURPOSE OF THIS SUPPLEMENTARY SCHEDULE IS TO OBTAIN INFORMATION NEEDED IN INTERPRETING DIFFERENCES IN OPERATING COSTS.

A. POLICIES WITH RESPECT TO SUPPLYING CERTAIN ITEMS AND SERVICES TO PUBLIC ASSISTANCE NURSING HOME PATIENTS DURING 1959. (ENTER ONE CHECK IN EACH ROW. IF THE COSTS FOR AN ITEM DO NOT APPEAR IN THE FIRM'S BOOKS AS OPERATING COSTS, THE ITEM IS TO BE CONSIDERED "NOT SUPPLIED".)

	NOT SUPPLIED (1)	SUPPLIED	
		AT EXTRA CHARGE (2)	WITHOUT EXTRA CHARGE (3)
a. CLOTHING			
1. HOSPITAL GOWNS			
2. OTHER			
b. PERSONAL CARE ITEMS			
1. TOILET SOAP			
2. TOILET TISSUE			
3. CLEANSING TISSUES			
4. TOOTHBRUSH			
5. DENTIFRICES			
6. COMB, BOBBY PINS, ETC.			
7. RAZOR BLADES			
8. SHAVING SOAP			
9. SHAVING BRUSH			
10. MENDING SUPPLIES FOR PATIENT'S OWN CLOTHING			
c. PERSONAL CARE SERVICES			
1. HAIR CUT			
2. SHAMPOO			
3. SHAVE			
4. CARE OF FINGERNAILS			
5. CARE OF TOENAILS			
6. MENDING OF PATIENT'S OWN CLOTHING			
7. SHOPPING SERVICE			
8. TRANSPORTATION TO PHYSICIAN			

SOF 489-C 5/60

A. (CONTINUED)

	NOT SUPPLIED (1)	SUPPLIED AT EXTRA CHARGE (2)	SUPPLIED WITHOUT EXTRA CHARGE (3)
D. MEDICINE CHEST ITEMS			
1. ASPIRIN AND ASPIRIN COMPOUNDS			
2. LAXATIVES			
3. RUBBING LOTION, RUBBING ALCOHOL			
4. DISINFECTANTS AND BANDAGES FOR MINOR CUTS AND ABRASIONS			
5. CLINITEST TABLETS			
6. OTHER (SPECIFY: _____ _____ _____)			
E. LAUNDRY OF -			
1. HOSPITAL GOWNS			
2. NIGHTGOWNS, PAJAMAS			
3. ROBES			
4. DRESSES, BLOUSES			
5. SHIRTS			
6. UNDERCLOTHES			
7. HANKIES			
8. SOX, STOCKINGS			
F. RECREATIONAL ITEMS AND SERVICES			
1. TRANSPORTATION TO CHURCH, SHOPPING, ETC.			
2. USE OF TV			
3. USE OF RADIO			
4. USE OF GAMES			
5. USE OF MAGAZINES			
6. USE OF NEWSPAPERS			
7. OTHER (SPECIFY: _____ _____ _____)			

SOF 489-C 5/60

A. (CONTINUED)

	NOT SUPPLIED (1)	SUPPLIED AT EXTRA CHARGE (2)	SUPPLIED WITHOUT EXTRA CHARGE (3)
g. OTHER RELATED ITEMS AND SERVICES NOT SPECIFIED IN A THROUGH F			

B. DISTINCTION IN ACCOMMODATIONS BETWEEN PRIVATE-PAY AND PUBLIC ASSISTANCE NURSING HOME PATIENTS (CIRCLE ONE CODE).

1. NONE
2. OCCASIONAL (SPECIFY: _____)
3. CUSTOMARY (SPECIFY: _____)

C. DISTINCTION IN SERVICES BETWEEN PRIVATE-PAY AND PUBLIC ASSISTANCE NURSING HOME PATIENTS (CIRCLE ONE CODE).

1. NONE
2. OCCASIONAL (SPECIFY: _____)
3. CUSTOMARY (SPECIFY: _____)

D. YEAR FACILITY FIRST ESTABLISHED AS NURSING HOME. (DISREGARD CHANGES IN OPERATORS.)

_____

E. HISTORY OF FACILITY (CIRCLE ONE):

1. ENTIRE FACILITY INITIALLY CONSTRUCTED AS NURSING HOME
2. PART OF FACILITY INITIALLY CONSTRUCTED AS NURSING HOME, PART CONVERTED FROM OTHER USE
3. ENTIRE FACILITY CONVERTED FROM OTHER USE.

ACKNOWLEDGEMENT OF NURSING HOME OPERATOR

I, THE UNDERSIGNED OPERATOR OF THE _____ NURSING HOME DO HEREBY AFFIRM THAT I HAVE READ THE ABOVE REPORT AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION REPORTED IS TRUE AND CORRECT AND IN KEEPING WITH THE INSTRUCTIONS FOR ITS PREPARATION.

DATED_____

SIGNED _____

RELATIVE WEIGHTS ASSIGNED TO CHARACTERISTICS AND SERVICES FOR ALLOCATING COSTS AMONG CLASSES OF NURSING HOME CARE

	9	1	2	3	4	5	6	7	8	9	10
A. Mental condition											
1 Always clear	X										
Confused:											
2 Mildly confused only				X							
3 Seriously disoriented but without eccentric behavior								X			
4 Seriously disoriented with eccentric behavior											X
5 Not incontinent but disoriented with respect to toilet facilities											X
6 Mentally retarded									X		
B. Mobility within nursing home											
1 Walks alone or with no more help than cane or crutch			X								
2 Moves himself about with a mechanical aid such as walker or wheelchair						X					
3 Able to walk or move in wheelchair only with help of attendant										X	
Unable to walk or be moved about in wheelchair:											
4 Able to turn and/or sit on bedside by self									X		
5 Helpless, must be turned or lifted											X

	0	1	2	3	4	5	6	7	8	9	10
C. Continence, bladder											
1 Always continent	X										
2 Occasionally incontinent			X								
3 Dribbling						X					
4 Frequently incontinent									X		
5 Always incontinent											X
Continence, bowel											
1 Always continent	X										
2 Occasionally incontinent			X								
3 Dribbling						X					
4 Frequently incontinent									X		
5 Always incontinent											X
D. Services needed by recipient and provided by staff of home											
Washing face, hands, teeth and/or dentures:											
1 Supervision only		X									
2 Some assistance, e.g., help to and from wash basin, collecting and carrying toilet articles				X							
3 Face, hands, teeth and/or dentures washed by attendant								X			
Care of fingernails:											
4 Supervision only		X									
5 Nail care by attendant					X						
Care of feet and toenails:											
6 Supervision only				X							
7 Routine nail care by attendant								X			
8 Special podiatric care											X
Care of hair:											
9 Combing						X					
10 Washing						X					
Shaving:											
11 Supervision only		X									
12 Some assistance, e.g., help to and from wash basin, collecting and carrying toilet articles					X						
13 Shaved by attendant							X				

	0	1	2	3	4	5	6	7	8	9	10
D. Services needed by recipient and provided by staff of home (Cont'd)											
Dressing (clothing, nightwear, appliances):											
14 Supervision only			X								
15 Help with difficult items only							X				
16 General help							X				
17 Completely dressed by attendant											X
Feeding and diet:											
18 Tray in room			X								
19 Help in cutting food				X							
20 Fed some food(s) or meals							X				
21 Fed all meals											X
22 Intravenous feeding											X
23 Dietary requirements (other than "normal" diet):	Included elsewhere										
Bathing:											
24 Help in or out of tub or shower only			X								
25 Back and/or feet washed				X							
26 General help needed							X				
27 Shower or chair bath, unable to help											X
28 Bed bath								X			
Toilet:											
29 Help to and from toilet						X					
30 Commode, no help				X							
31 Help to and from commode							X				
32 Bed pan and/or urinal						X					
33 Take pulse or temperature	Included elsewhere										
34 Take respiration											
35 Take blood pressure				X							
36 Catheterization (other than retention)											X
37 Retention catheterization											X
Dressings or bandages:											
38 Complex and/or extensive											X
39 Other						X					
Oral medications:											
40 Routine			X								
41 Critical, observation necessary							X				

	0	1	2	3	4	5	6	7	8	9	10
D. Services needed by recipient and provided by staff of home (Cont'd)											
Parenteral medications:											
42 Subcutaneous							X				
43 Intravenous											X
44 Intramuscular									X		
45 Administration of oxygen									X		
46 Aspiration										X	
47 Extra supervision because of confusion	)										
48 Extra care or supervision because of (other) eccentricities of behavior	) Included elsewhere										
Other						X					
E. Recipient currently moribund											X

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959
TABLE B-1: MARITAL STATUS BY SEX 1/

Marital status	Sex of recipient: Both sexes — Number of cases	Both sexes — Percent of total 2/	Male — Number of cases	Male — Percent of total 2/	Female — Number of cases	Female — Percent of total 2/
Total	8,471	100.0	3,249	100.0	5,222	100.0
Married, spouse living, not estranged	829	9.8	515	15.9	314	6.0
Widowed, single or estranged, total	7,642	90.2	2,734	84.1	4,908	94.0
Widowed	4,706	55.6	3/ 851	26.2	3,855	73.8
Never married	1,681	19.8	3/ 1,278	39.3	403	7.7
Divorced or otherwise estranged	1,255	14.8	605	18.6	650	12.4

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases.
2/ Because of rounding, detail does not necessarily add to totals.
3/ Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

TABLE B-2: CUSTOMARY LIVING ARRANGEMENTS DURING SIX MONTHS PRIOR TO ENTERING PRESENT NURSING HOME, BY SEX [1]

Customary living arrangement	Sex of recipient					
	Both sexes		Male		Female	
	Number of cases	Percent of total [2]	Number of cases	Percent of total [2]	Number of cases	Percent of total [2]
Total	8,471	100.0	3,249	100.0	5,222	100.0
In own home, total	3,675	43.4	1,457	44.8	2,218	42.5
Alone	2,577	30.4	1,031	31.7	1,546	29.6
With spouse	650	7.7	314	9.7	336	6.4
With other related persons (spouse not present)	269	3.2	112	3.4	157	3.0
With nonrelated persons only	179	2.1	0	0	179	3.4
In home of relative, total	1,569	18.5	426	13.1	1,143	21.9
Son or daughter	1,031	12.2	[3] 135	4.2	896	17.2
Other relative	538	6.4	291	9.0	247	4.7
In boarding home or home of nonrelated person	717	8.5	403	12.4	314	6.0
In other nursing home	1,591	18.8	[3] 492	15.1	[3] 1,099	21.0
In other institution	762	9.0	314	9.7	448	8.6
Other	157	1.9	157	4.8	0	0

[1] Based on expanded sample of OAA, AB, DA and Continuing GA cases.
[2] Because of rounding, detail does not necessarily add to totals.
[3] Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

TABLE B-3: AGE OF SPOUSE BY SEX OF RECIPIENT 1/

Age of spouse	Sex of recipient: Both sexes — Number of cases	Both sexes — Percent of total 2/	Male — Number of cases	Male — Percent of total 2/	Female — Number of cases	Female — Percent of total 2/
Total	829	100.0	515	100.0	314	100.0
Under 65, total	112	13.5	112	21.7	0	0
Under 50	0	0	0	0	0	0
50, under 65	112	13.5	112	21.7	0	0
65, under 75, total	269	32.4	179	34.8	90	28.7
65, under 70	157	18.9	112	21.7	45	14.3
70, under 75	112	13.5	67	13.0	45	14.3
75 or over, total	448	54.0	224	43.5	224	71.3
75, under 80	202	24.4	157	30.5	45	14.3
80, under 85	3/ 156	18.8	67	13.0	3/ 89	28.3
85 or over	90	10.9	0	0	90	28.7

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Tabulation confined to cases with spouse living and not estranged.

2/ Because of rounding, detail does not necessarily add to totals.

3/ Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959
TABLE B-4: PRESENT LIVING ARRANGEMENTS OF SPOUSE BY SEX OF RECIPIENT 1/

Living arrangements of spouse	Sex of recipient					
	Both sexes		Male		Female	
	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/
Total	829	100.0	515	100.0	314	100.0
In own home, total	403	48.6	291	56.5	112	35.7
Alone	381	46.0	269	52.2	112	35.7
With related persons	22	2.7	22	4.3	0	0
With nonrelated persons only	0	0	0	0	0	0
In home of relative	0	0	0	0	0	0
In boarding home or home of nonrelated person	0	0	0	0	0	0
In nursing home	3/ 382	46.1	3/ 180	35.0	202	64.3
In other institution	22	2.7	22	4.3	0	0
Other	22	2.7	22	4.3	0	0

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Tabulation confined to cases with spouse living and not estranged.
2/ Because of rounding, detail does not necessarily add to totals.
3/ Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

TABLE B-5: TIME LAPSE BETWEEN DATE PUBLIC ASSISTANCE LAST AUTHORIZED AND DECEMBER 1959 BY SEX 1/

Time lapse between last authorization and December 1959	Sex					
	Both sexes		Male		Female	
	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/
Total	8,404	100.0	3,205	100.0	5,199	100.0
Less than one year, total	1,524	18.1	852	26.6	672	12.9
Less than three months	291	3.5	134	4.2	157	3.0
3, less than 6 months	538	6.4	247	7.7	291	5.6
6, less than 9 months	314	3.7	3/ 292	9.1	22	.4
9 months, less than one year	381	4.5	179	5.6	202	3.9
One year, less than 5 years, total	2,398	28.5	784	24.5	1,614	31.0
One year, less than 2 years	829	9.9	269	8.4	560	10.8
2, less than 3 years	583	6.9	314	9.8	269	5.2
3, less than 4 years	538	6.4	112	3.5	426	8.2
4, less than 5 years	448	5.3	3/ 89	2.8	359	6.9
5 years or more, total	4,482	53.3	1,569	49.0	2,913	56.0
5, less than 10 years	1,479	17.6	493	15.4	986	19.0
10 years or more	3,003	35.7	1,076	33.6	1,927	37.1

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Tabulation excludes cases for which date of last authorization was not reported.

2/ Because of rounding, detail does not necessarily add to totals.

3/ Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

TABLE B-6: TIME LAPSE BETWEEN DATE RECIPIENT FIRST ENTERED A NURSING HOME AND DATE PUBLIC ASSISTANCE LAST AUTHORIZED BY SEX 1/

Time lapse	Sex: Both sexes — Number of cases	Both sexes — Percent of total 2/	Male — Number of cases	Male — Percent of total 2/	Female — Number of cases	Female — Percent of total 2/
Total	8,404	100.0	3,205	100.0	5,199	100.0
Entered a nursing home prior to last authorization of assistance, total	3,406	40.5	1,435	44.8	1,971	37.9
Time lapse between first entering a nursing home and last authorization:						
One year or more	1,210	14.4	583	18.2	627	12.1
Less than one year, total	2,196	26.1	852	26.6	1,344	25.9
6 months, less than 1 year	224	2.7	112	3.5	112	2.2
3, less than 6 months	336	4.0	157	4.9	179	3.4
Less than 3 months	1,636	19.5	583	18.2	1,053	20.3
Assistance last authorized prior to first entering a nursing home, total	4,998	59.5	1,770	55.2	3,228	62.1
Time lapse between last authorization and first entering a nursing home:						
Less than one year, total	696	8.3	247	7.7	449	8.6
Less than 3 months	157	1.9	45	1.4	112	2.2
3, less than 6 months	135	1.6	45	1.4	90	1.7
6 months, less than 1 year	404	4.8	157	4.9	247	4.8
One year or more	4,302	51.2	3/ 1,523	47.5	2,779	53.5

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Excludes cases for which the information was not reported.

2/ Because of rounding, detail does not necessarily add to totals.

3/ Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959
TABLE B-7: TIME LAPSE BETWEEN DATE RECIPIENT FIRST ENTERED A NURSING HOME AND DECEMBER 1959 BY SEX 1/

Time lapse	Sex: Both sexes — Number of cases	Both sexes — Percent of total 2/	Male — Number of cases	Male — Percent of total 2/	Female — Number of cases	Female — Percent of total 2/
Total	8,449	100.0	3,227	100.0	5,222	100.0
Less than one year, total	1,928	22.8	829	25.7	1,099	21.0
Less than 3 months	426	5.0	179	5.5	247	4.7
3, less than 6 months	695	8.2	269	8.3	426	8.2
6, less than 9 months	381	4.5	157	4.9	224	4.3
9 months, less than one year	426	5.0	224	6.9	202	3.9
One year, less than 5 years, total	4,459	52.8	1,569	48.6	2,890	55.3
One year, less than two years	1,344	15.9	605	18.7	3/ 739	14.2
2, less than 3 years	1,076	12.7	359	11.1	717	13.7
3, less than 4 years	1,053	12.5	314	9.7	3/ 739	14.2
4, less than 5 years	986	11.7	291	9.0	695	13.3
Five years or more, total	2,062	24.4	829	25.7	1,233	23.6
5, less than 10 years	1,614	19.1	650	20.1	964	18.5
10 years or more	448	5.3	179	5.5	269	5.2

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Excludes cases for which the information was not reported.
2/ Because of rounding, detail may not necessarily add to totals.
3/ Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

TABLE B-8: SOURCES OF INCOME BY SEX 1/

SOURCE OF INCOME	SEX: BOTH SEXES — NUMBER OF CASES	BOTH SEXES — PERCENT OF TOTAL	BOTH SEXES — AVG. INCOME PER CASE WITH SPECIFIED SOURCE OF INCOME	SEX: MALE — NUMBER OF CASES	MALE — PERCENT OF TOTAL	MALE — AVG. INCOME PER CASE WITH SPECIFIED SOURCE OF INCOME	SEX: FEMALE — NUMBER OF CASES	FEMALE — PERCENT OF TOTAL	FEMALE — AVG. INCOME PER CASE WITH SPECIFIED SOURCE OF INCOME
TOTAL	8,471	100.0	-	3,249	100.0	-	5,222	100.0	-
NO INCOME	5,625	66.4	-	1,815	55.9	-	3,810	73.0	-
INCOME, ALL SOURCES	2/ 2,846	33.6	$54	2/ 1,434	44.1	$60	2/ 1,412	27.0	$47
OASDI	2,398	28.3	57	1,210	37.2	62	1,188	22.7	51
MILITARY-CONNECTED INCOME	224	2.6	72	90	2.8	86	134	2.6	62
CONTRIBUTIONS FROM SPOUSE	45	.5	32	45	1.4	32	0	0	0
CONTRIBUTIONS FROM CHILDREN	67	.8	16	0	0	0	67	1.3	16
CONTRIBUTIONS FROM OTHER RELATIVES	22	.3	8	0	0	0	22	.4	8
PAYMENTS ON CONTRACTS	22	.3	10	22	.7	10	0	0	0
OTHER	515	6.1	44	291	9.0	51	224	4.3	35

1/ BASED ON EXPANDED SAMPLE OF OAA, AB, DA AND CONTINUING GA CASES.

2/ NET COUNT OF CASES WITH INCOME. SINCE SOME RECIPIENTS HAD MORE THAN ONE SOURCE OF INCOME THE CASE COUNT BY SOURCE EXCEEDS THE NET COUNT.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959
TABLE B-9: AMOUNT AND TYPES OF RESOURCES BY SEX 1/

RESOURCE(S)	SEX: BOTH SEXES — NUMBER OF CASES	BOTH SEXES — PERCENT OF TOTAL	BOTH SEXES — AVG. AMOUNT OF RESOURCE PER CASE WITH SPECIFIED TYPE OF RESOURCE	MALE — NUMBER OF CASES	MALE — PERCENT OF TOTAL	MALE — AVG. AMOUNT OF RESOURCE PER CASE WITH SPECIFIED TYPE OF RESOURCE	FEMALE — NUMBER OF CASES	FEMALE — PERCENT OF TOTAL	FEMALE — AVG. AMOUNT OF RESOURCE PER CASE WITH SPECIFIED TYPE OF RESOURCE
TOTAL	8,471	100.0	3/	3,249	100.0	3/	5,222	100.0	3/
NO RESOURCE	3,989	47.1	-	1,905	58.6	-	2,084	39.9	-
RESOURCES, ALL TYPES	2/4,482	52.9	3/	2/1,344	41.4	3/	2/3,138	60.1	3/
EQUITY IN HOME	695	8.2	$2,483	359	11.0	$2,500	336	6.4	$2,464
EQUITY IN OTHER REAL ESTATE	45	.5	2,750	45	1.4	2,750	0	0	-
CASH OR SECURITIES	2,578	30.4	120	740	22.8	133	1,838	35.2	115
LIFE INSURANCE	941	11.1	4/	269	8.3	4/	672	12.9	4/
BURIAL INSURANCE	448	5.3	3/	134	4.1	3/	314	6.0	3/
CEMETERY PLOT	1,793	21.2	3/	471	14.5	3/	1,322	25.3	3/
OTHER	134	1.6	366	22	.7	91	112	2.1	421

1/ BASED ON EXPANDED SAMPLE OF OAA, AB, DA AND CONTINUING GA CASES.
2/ NET COUNT OF CASES WITH RESOURCES. SINCE SOME CASES HAD MORE THAN ONE TYPE OF RESOURCE, CASE COUNT BY TYPE EXCEEDS NET COUNT.
3/ NOT AVAILABLE.
4/ THE AVERAGE FACE VALUE OF LIFE INSURANCE WAS $573 FOR MALES TO $364 FOR FEMALES. THE AVERAGE CASH SURRENDER VALUE WAS $307 FOR MALES AND $271 FOR FEMALES.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959
TABLE B-10: AMOUNT AND SOURCE OF INCOME OF SPOUSE BY SEX OF RECIPIENT 1/

SOURCE(S) OF INCOME OF SPOUSE	SEX OF RECIPIENT: BOTH SEXES — NUMBER OF CASES	BOTH SEXES — PERCENT OF TOTAL	BOTH SEXES — AVG. INCOME PER SPOUSE WITH SPECIFIED SOURCE OF INCOME	MALE — NUMBER OF CASES	MALE — PERCENT OF TOTAL	MALE — AVG. INCOME PER SPOUSE WITH SPECIFIED SOURCE OF INCOME	FEMALE — NUMBER OF CASES	FEMALE — PERCENT OF TOTAL	FEMALE — AVG. INCOME PER SPOUSE WITH SPECIFIED SOURCE OF INCOME
TOTAL	2/762	100.0	$108	2/448	100.0	$109	2/314	100.0	$106
PUBLIC ASSISTANCE	694	91.1	79	426	95.1	77	268	85.4	82
OLD AGE ASSISTANCE	538	70.6	79	314	70.1	73	224	71.3	87
AID TO BLIND	22	2.9	120	22	4.9	120	0	0	-
AID TO DEP. CHILDREN	67	8.8	74	45	10.0	82	22	7.0	58
GENERAL ASSISTANCE	67	8.8	74	45	10.0	82	22	7.0	58
OASDI	381	50.0	48	247	55.1	40	134	42.7	62
MILITARY-CONNECTED INCOME	22	2.9	66	0	0	-	22	7.0	66
CONTRIBUTIONS FROM RELATIVES	22	2.9	36	0	0	-	22	7.0	36
WAGES OR INCOME FROM SELF-EMPLOYMENT	22	2.9	80	22	4.9	80	0	0	-
RENTALS	22	2.9	50	22	4.9	50	0	0	-
OTHER PROPERTY INCOME	22	2.9	102	22	4.9	102	0	0	-
OTHER	135	17.7	10	90	20.1	10	45	14.3	11

1/ BASED ON EXPANDED SAMPLE OF OAA, AB, DA AND CONTINUING GA CASES. TABULATION EXCLUDES CASES IN WHICH RECIPIENT WAS SINGLE, WIDOWED, ESTRANGED OR SPOUSE HAD DISCLAIMED FINANCIAL RESPONSIBILITY.
2/ NET COUNT. SINCE SOME SPOUSES HAD MORE THAN ONE SOURCE OF INCOME, COUNT BY SOURCE EXCEEDS NET COUNT+

SOCIAL CHARACTERISTICS OF CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959
TABLE B-11: CARE BY RELATIVES PRIOR TO ENTERING SHELTERED CARE BY SEX OF RECIPIENT 1/

Care by relatives	Sex of recipient: Both sexes, Number of cases	Both sexes, Percent of total 2/	Male, Number of cases	Male, Percent of total 2/	Female, Number of cases	Female, Percent of total 2/
Total	8,471	100.0	3,249	100.0	5,222	100.0
Cared for by relatives, total 3/	3,765	44.2	1,075	32.4	2,690	51.5
Spouse	897	10.6	426	13.1	471	9.0
Child(ren)	2,219	26.2	269	8.3	1,950	37.3
Parent(s)	224	2.6	157	4.8	67	1.3
Sibling(s)	560	6.6	269	8.3	291	5.6
Other relative(s)	404	4.8	202	6.2	202	3.9
No relatives	493	5.8	224	6.9	269	5.2
Unwilling to be cared for by relatives	179	2.1	45	1.4	134	2.6
Not relevant, transferred from mental hospital	516	6.1	247	7.6	269	5.2
Information on care by relatives not available or not reported	3,518	41.8	4/ 1,658	51.7	1,860	35.6

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Sheltered care is defined as care in a boarding home, nursing home not subject to state licensing or licensed nursing home.
2/ Because of rounding, detail does not necessarily add to total.
3/ Net count. Since some recipients received care from more than one relative either consecutively or simultaneously, case count by relative providing care exceeds net count.
4/ Forced to balance total.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959
TABLE B-12: REASONS FOR REMOVAL OF RECIPIENT FROM RELATIVES' CARE BY SEX OF RECIPIENT 1/

Reason for removal	Sex of recipient					
	Both sexes		Male		Female	
	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/
Total 3/	3,765	100.0	1,075	100.0	2,690	100.0
Deterioration of physical and/or mental condition of recipient	2,667	72.6	740	68.8	1,927	74.1
Illness (including aging) of relative or other member of household	1,053	28.7	336	31.2	717	27.6
Death of relative or other member of household	425	11.6	134	12.4	291	11.2
Employment of relative(s)	246	6.7	22	2.0	224	8.6
Child care responsibilities of relatives	90	2.4	0	0	90	3.5
Other	762	20.7	202	18.8	560	21.5
Reason for removal not reported	90	-	0	-	90	-

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases. Tabulation includes only cases known to have been cared for by relatives.
2/ Excludes cases for which reason for removal not reported.
3/ Net count. Since in some cases there were several reasons for removal, case count by reason exceeds net count.

SOCIAL CHARACTERISTICS OF PUBLIC ASSISTANCE CASES IN LICENSED PRIVATE NURSING HOMES, DECEMBER 1959

TABLE B-13: TYPE OF PHYSICAL AND/OR MENTAL CHANGE IN CONDITION OF RECIPIENT IMMEDIATELY PRECEDING INITIAL NURSING HOME PLACEMENT 1/

Type of change	Sex					
	Both sexes		Male		Female	
	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/	Number of cases	Percent of total 2/
Total	8,471	100.0	3,249	100.0	5,222	100.0
Sudden change or medical emergency	3,384	42.5	1,367	43.9	2,017	41.7
Gradual deterioration only	4,572	57.5	1,748	56.1	2,824	58.3
Not reported	515	-	134	-	381	-

1/ Based on expanded sample of OAA, AB, DA and Continuing GA cases.
2/ Detail may not add to total due to rounding.

Exhibit C - ANALYSIS OF INCREASE IN NURSING HOME CASELOAD, OLD AGE ASSISTANCE, 1953-1958

State of Washington
Department of Public Assistance
Research and Statistics Unit
January 1961

LIST OF TABLES

PART I. INTRODUCTION 1/

Increase in nursing home patients, both private-pay and public assistance

From July 1953 to July 1958 the estimated number of patients in licensed private nursing homes in the State of Washington increased by 3,900 or 51 percent. (Table 1) Classifying the patients by source of funds from which nursing home care is paid, it is estimated that the number of Old Age Assistance patients increased by 50 percent during this five-year period as compared with increases of 25 percent for other public assistance patients and 61 percent for private-pay patients. Old Age Assistance recipients represented 60 percent of all nursing home patients in both 1953 and 1958.

TABLE 1: ESTIMATED NUMBER OF PATIENTS IN LICENSED PRIVATE NURSING HOMES, STATE OF WASHINGTON, 1953-1958 2/

	All patients	Public assistance recipients 3/			Private-pay patients
		Total	Old Age Assistance 4/	Other 4/	
Number of patients					
July 1953	7,733	5,547	4,651	896	2,186
July 1954	8,705	6,092	5,139	953	2,613
July 1955	9,276	6,589	5,616	973	2,687
July 1956	9,887	7,019	6,025	994	2,868
July 1957	10,747	7,578	6,512	1,066	3,169
July 1958	11,646	8,118	6,996	1,122	3,528
Percent distribution by source of nursing home payment 5/					
July 1953	100.0	71.7	60.1	11.6	28.3
July 1954	100.0	70.0	59.0	10.9	30.0
July 1955	100.0	71.0	60.5	10.5	29.0
July 1956	100.0	71.0	60.9	10.1	29.0
July 1957	100.0	70.5	60.6	9.9	29.5
July 1958	100.0	69.7	60.1	9.6	30.2

TABLE 1: ESTIMATED NUMBER OF PATIENTS IN LICENSED PRIVATE NURSING HOMES, STATE OF WASHINGTON, 1953-1958 2/ (CONTINUED)

	All patients	Public assistance recipients 3/ Total	Old Age Assistance 4/	Other 4/	Private-pay patients
Patient count as percent of July 1953					
July 1953	100.0	100.0	100.0	100.0	100.0
July 1954	112.6	109.8	110.5	106.4	119.5
July 1955	120.0	118.8	120.7	108.6	122.9
July 1956	127.9	126.5	129.5	110.9	131.2
July 1957	139.0	136.6	140.0	119.0	145.0
July 1958	150.6	146.3	150.4	125.2	161.4

1/ Under the change in policy effective July 1, 1957, approximately 310 nursing home patients were transferred from the Medical Indigent program to OAA. To avoid a consequent distortion in the trend in utilization of nursing homes by OAA recipients, the 1953-1956 counts of Old Age Assistance cases and of Old Age Assistance cases in licensed private nursing homes have been adjusted on the assumption that the policy in effect since July 1, 1957 was in fact effective throughout the 1953-1958 period. Unadjusted caseload figures are given in Table 1, footnote 4.

2/ Data refer to total patients served during the month.

3/ Includes Medical Indigents.

4/ Both Old Age Assistance caseload and Other assistance caseload have been adjusted on the assumption that the July 1, 1957 change in policy was in effect throughout the 1953-1958 period. The unadjusted estimates are:

	Public assistance recipients		
	Total	OAA	Other
July 1953	5,547	4,567	980
July 1954	6,092	5,010	1,082
July 1955	6,589	5,462	1,127
July 1956	7,019	5,776	1,243

5/ Because of rounding, detail does not necessarily add to totals.

Increase in percentage of OAA cases in nursing homes

The general character of the upward trend in the number of nursing home patients suggests the operation of common social, medical and economic forces affecting both the financially independent and the dependent aged. Particular interest, however, attaches to the increase in the number of Old Age Assistance patients since it occurred during a period when total OAA caseload was falling. From July 1953 to July 1958 the total number of OAA cases dropped by 9,400 or 15 percent. The combination of decreasing total caseload and increasing nursing home caseload has resulted in a steady and substantial increase in the percentage of OAA cases in licensed private nursing homes. By 1958, 13 out of every 100 OAA recipients were receiving nursing home care as compared with 7 of every 100 in 1953. (Table 2) The purpose of this analysis is to evaluate, on the basis of such evidence as is available, the reasons for the increasing number and proportion of OAA cases in licensed private nursing homes.

TABLE 2: ESTIMATED NUMBER OF OAA NURSING HOME CASES PER 100 OAA RECIPIENTS, 1953-1958

	Total OAA cases 1/	OAA cases in licensed private nursing homes 1/	Number of OAA nursing home cases per 100 OAA recipients
July 1953	64,245	4,651	7.2
July 1954	61,912	5,139	8.3
July 1955	58,798	5,616	9.6
July 1956	56,593	6,025	10.6
July 1957	55,739	6,512	11.7
July 1958	54,824	6,996	12.8

1/ Both total OAA caseload and OAA cases in licensed private nursing homes have been adjusted on the assumption that the July 1, 1957 change in policy with respect to Medical Indigents was in effect throughout the 1953-1958 period.

PART II. CHARACTERISTICS OF AGED POPULATION

Increase in total aged; relatively greater increases in females and in the very old

From 1950 to 1958 the aged population in the State of Washington increased by approximately 48,000 or 23 percent. (Table 3) The relative increase was greater for females than for males and for the older than for the "younger" aged. While in 1950 there were 104 males 65 or over for every 100 females, by 1958 there were 103 females for every 100 males. Over the same period the ratio of persons 75 or over to persons 65 through 74 increased from 44 to 51 per 100. By sex and specific age-group the relative increase over the 8 years ranged from 3 percent for males aged 65 through 69 to 51 percent for females in the age groups 75 through 79 and 85 or over.

Changes in Washington similar to national pattern

Although the ratio of aged males to females is higher in the State of Washington than in the nation as a whole, the age distribution of the total population 65 and over was markedly similar to the national pattern in both 1950 and 1958. (Table 4) Moreover the most noteworthy nationwide changes in the aged population over this period, viz., the relatively small increase in the number of men 65 through 69 and the disproportionately large increase in the number of women 75 or over, were even more marked in the State of Washington.

Increasing incidence of disability with age

The increasing number and proportion of aged persons has occasioned a complex of social and economic problems. Both within the total population and within the population 65 or over, the incidence of disability increases with advancing age. It has been estimated that almost half the aged population have chronic diseases or impairments 1/ and that approximately 16 percent suffer from long-term disability as compared with 3 percent of the age group 14 through 64. 2/

1/ U.S. Dept. of Health, Education and Welfare, Social Security Administration, Division of Research and Statistics, Health Costs of the Aged, Report #20, May 1956.

2/ "Estimated Prevalence of Long-Term Disability, 1954" Social Security Bulletin, June 1955. The long-term disabled were defined as persons who because of physical or mental disease or impairment had for more than 6 months been unable to work or to follow other normal activities, e.g., keeping house. Since a permanently disabled person whose incapacity had existed for less than 6 months was excluded by definition, the 16 percent cited in the narrative must be regarded as a minimum estimate.

TABLE 3: ESTIMATED AGE-SEX DISTRIBUTION OF POPULATION 65 YEARS OR OVER, STATE OF WASHINGTON, 1950 AND 1958 1/

	1958						1950						PERCENT INCREASE 1950-1958		
	NUMBER			PERCENT OF TOTAL 2/			NUMBER			PERCENT OF TOTAL 2/					
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
TOTAL, 65 YEARS OR OVER	260,000	128,000	132,000	100.0	49.2	50.8	211,700	108,100	103,600	100.0	51.1	48.9	22.8	18.4	27.4
65, LESS THAN 70	94,000	47,000	47,000	36.2	18.1	18.1	87,200	45,500	41,700	41.2	21.5	19.7	7.8	3.3	12.7
70, LESS THAN 75	78,000	39,000	39,000	30.0	15.0	15.0	59,400	30,400	29,000	28.1	14.4	13.7	31.3	28.3	34.5
75, LESS THAN 80	52,000	25,000	27,000	20.0	9.6	10.4	35,900	18,000	17,900	17.0	8.5	8.5	44.8	38.9	50.8
80, LESS THAN 85	22,000	11,000	11,000	8.5	4.2	4.2	19,300	9,600	9,700	9.1	4.5	4.6	14.0	14.6	13.4
85 OR OVER	14,000	6,000	8,000	5.4	2.3	3.1	9,900	4,600	5,300	4.7	2.2	2.5	41.4	30.4	50.9

1/ SOURCES:
1950 - U. S. DEPARTMENT OF COMMERCE, BUREAU OF CENSUS, 1950 CENSUS OF POPULATION
1958 - WASHINGTON STATE DEPARTMENT OF HEALTH

2/ BECAUSE OF ROUNDING DETAIL DOES NOT NECESSARILY ADD TO TOTALS.

TABLE 4: ESTIMATED AGE-SEX DISTRIBUTION OF POPULATION 65 YEARS OR OVER, CONTINENTAL UNITED STATES, 1950 AND 1958 1/

	1958						1950						PERCENT INCREASE 1950-1958		
	NUMBER			PERCENT OF TOTAL 2/			NUMBER			PERCENT OF TOTAL 2/					
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
TOTAL, 65 YEARS OR OVER	15,041,000	6,854,000	8,187,000	100.0	45.6	54.4	12,194,700	5,767,400	6,427,300	100.0	47.3	52.7	23.3	18.8	27.4
65, LESS THAN 70	5,642,000	2,669,000	2,972,000	37.5	17.7	19.8	4,928,100	2,395,000	2,533,100	40.4	19.8	20.8	14.5	11.4	17.3
70, LESS THAN 75	4,228,000	1,948,000	2,280,000	28.1	13.0	15.2	3,411,900	1,628,800	1,783,100	28.0	13.4	14.6	23.9	19.6	27.9
75, LESS THAN 80	2,881,000	1,265,000	1,617,000	19.2	8.4	10.8	2,128,400	992,500	1,135,900	17.5	8.1	9.3	35.4	27.5	42.4
80, LESS THAN 85	1,449,000	621,000	828,000	9.6	4.1	5.5	1,149,400	514,300	635,100	9.4	4.2	5.2	26.1	20.7	30.4
85 OR OVER	841,000	351,000	490,000	5.6	2.3	3.3	576,900	236,800	340,100	4.7	1.9	2.8	45.8	48.2	44.1

1/ SOURCE: U. S. DEPARTMENT OF COMMERCE, BUREAU OF THE CENSUS, CURRENT POPULATION REPORTS, SERIES P-25, #193.
2/ BECAUSE OF ROUNDING DETAIL DOES NOT NECESSARILY ADD TO TOTALS.

Higher incidence of multiple impairments and more severe disability among the "older" aged

The incidence of multiple impairments is higher and the extent of disability more severe among the "older" than among the "younger" aged. Of persons receiving Old Age Assistance in the State of Washington in May 1953, 8 percent of those aged 80 or over and 4 percent of those aged 75 through 79 were bedridden because of chronic illness or infirmity as compared with 2 percent of the age groups 65 through 69 and 70 through 74. (Table 5) Recipients who, although not bedridden, required considerable care from others because of their physical and/or mental condition represented 7 percent of the age group 65 through 69 but 29 percent of the group 80 or over. Sixteen percent of the recipients aged 75 through 79 and 38 percent of those 80 or over were unable to care for themselves in the activities of daily living (eating, dressing, moving about the home) as compared with 8 percent of the recipients 65 through 69 and 10 percent of those aged 70 through 74.

TABLE 5: PHYSICAL AND MENTAL CONDITION OF OLD AGE ASSISTANCE RECIPIENTS BY AGE GROUP, STATE OF WASHINGTON, MAY 1953

Age of recipient	All recipients 2/	Physical and mental condition 1/				
		Bedridden	Not bedridden but requiring considerable care from others			Able to care for self
			Total	Due primarily to physical condition	Due primarily to mental condition	
Total	100.0	3.9	14.5	12.2	2.3	81.6
65, less than 70	100.0	1.6	6.8	6.8	0	91.6
70, less than 75	100.0	1.6	8.2	6.8	1.4	90.2
75, less than 80	100.0	3.6	12.5	10.9	1.5	83.9
80 or over	100.0	8.5	29.3	23.6	5.7	62.2

1/ A recipient was considered bedridden only if confined to bed because of chronic illness or infirmity. A recipient was considered as able to care for self if able to eat, dress and move about his home without assistance and not requiring care because of mental condition, i.e., if able to care for self insofar as activities of daily living were concerned.

2/ Because of rounding, detail does not necessarily add to totals.

A 1954 nursing home study by the U. S. Public Health Service indicates that on a national basis the incidence of nursing home care among persons over 65 increased sharply with age group and that for each of these age groups, the nursing home rate was higher for females than for males. 1/ Although physical disability was found to be severe for nursing home patients regardless of age, incontinence and mental confusion were more extensive among the "older" aged. While 32 percent of the patients aged 65 through 74 were incontinent and 50 percent were confused at least part of the time, nearly 40 percent of the patients 85 or over were incontinent and 65 percent were confused. A diagnosis of senility was reported for 41 percent of the patients 85 or over as compared with 15 percent of those aged 65 through 74.

1/ U. S. Department of Health, Education and Welfare, Public Health Service, Nursing Homes, Their Patients and Their Care. Public Health Monograph No. 46, March 1957.

The larger proportion of aged women than of aged men in nursing homes is associated with the higher incidence of widowhood among women.

TABLE 6: ESTIMATED DISTRIBUTION OF POPULATION 65 YEARS OR OVER BY TOTAL MONEY INCOME, STATE OF WASHINGTON, 1953 AND 1958 1/

MONEY INCOME	1953 NUMBER TOTAL	1953 NUMBER MALE	1953 NUMBER FEMALE	1953 PERCENT TOTAL	1953 PERCENT MALE	1953 PERCENT FEMALE	1958 NUMBER TOTAL	1958 NUMBER MALE	1958 NUMBER FEMALE	1958 PERCENT 2/ TOTAL	1958 PERCENT 2/ MALE	1958 PERCENT 2/ FEMALE
TOTAL	231,000	116,400	114,600	100.0	100.0	100.0	260,000	128,000	132,000	100.0	100.0	100.0
LESS THAN $1,000	146,500	53,900	92,600	63.4	46.3	80.8	145,200	46,500	98,700	55.8	36.3	74.8
LESS THAN 500	70,800	19,200	51,600	30.6	16.5	45.0	51,200	8,200	43,000	19.7	6.4	32.6
500, LESS THAN 1,000	75,700	34,700	41,000	32.8	29.8	35.8	94,000	38,300	55,700	36.2	29.9	42.2
$1,000, LESS THAN 2,000	39,700	26,500	13,200	17.2	22.8	11.5	55,100	35,000	20,100	21.2	27.3	15.2
1,000, LESS THAN 1,500	26,000	17,200	8,800	11.3	14.8	7.7	35,700	22,200	13,500	13.7	17.3	10.2
1,500, LESS THAN 2,000	13,700	9,300	4,400	5.9	8.0	3.8	19,400	12,800	6,600	7.5	10.0	5.0
$2,000 OR MORE	44,800	36,000	8,800	19.4	30.9	7.7	59,700	46,500	13,200	23.0	36.3	10.0
2,000, LESS THAN 3,000	16,600	12,500	4,100	7.2	10.7	3.6	20,400	14,200	6,200	7.8	11.1	4.7
3,000, LESS THAN 5,000	17,900	15,000	2,900	7.7	12.9	2.5	23,800	19,500	4,200	9.2	15.3	3.2
5,000 OR MORE	10,300	8,500	1,800	4.5	7.3	1.6	15,500	12,700	2,800	6.0	9.9	2.1

1/ ESTIMATES BASED ON ASSUMPTION THAT CHANGES IN INCOME DISTRIBUTION FOR THE AGED IN THE STATE OF WASHINGTON HAVE BEEN SIMILAR TO THE NATIONAL CHANGES.

2/ BECAUSE OF ROUNDING, DETAIL DOES NOT NECESSARILY ADD TO TOTALS.

Problems of disability complicated by high incidence of widowhood

The problems of illness and disability among the aged are complicated by the high incidence of widowhood, particularly among women in the older age-groups. The presence of a spouse, particularly a younger spouse, can mean care at home for the ill or disabled person as well as the possibility of supplementary earned income for meeting medical expenses. On a nationwide basis 15 percent of the males aged 65 through 74 and 38 percent of those 75 or over were widowed as of March 1958. 1/ The percentages widowed were markedly higher for females both because of their greater longevity and because men typically marry women younger than themselves. Forty-six percent of the females 65 through 74 and 72 percent of those 75 or over were widowed. Grouping the single, separated or divorced with the widowed aged gives a closer count of those without a marriage partner to aid in time of illness. A startling 81 percent of all females aged 75 or over and 48 percent of all males in this age group had no spouse or the spouse was not present. The percentages for the "younger" aged were lower but still substantial. Twenty-six percent of the males 65 through 74 and 57 percent of the females were without the presence of a spouse.

Available data on Old Age Assistance recipients in the State of Washington indicate a similar pattern. Of the cases receiving OAA in May 1953, 63 percent of the males and 79 percent of the females had no spouse or the spouse was not present. Recipients without a spouse ranged from 66 percent of those aged 65 through 69 to 81 percent of those 80 or over.

High percentage of single and widowed aged living alone or with nonrelatives

Although a significant percentage of the non-institutional aged without a spouse live with adult children, nationwide some 40 percent of the females and 50 percent of the males live alone or with nonrelatives. 2/ Among non-institutional assistance recipients the percentages are even higher. It is estimated that in the State of Washington in May 1953, some 70 percent of the OAA recipients without a spouse and not in hospitals, nursing homes or other institutions were living alone or with nonrelatives. 3/ Individuals in such living arrangements are not only more likely to need some form of institutional care in the event of acute or chronic illness than are persons living with relatives but their need would typically be more immediate. Even among the aged living with children need for sheltered care may be relatively frequent since adult children, because of family and job responsibilities of their own, are in general less able and willing then a spouse to furnish nursing care and/or economic support in the event of disability.

1/ U. S. Department of Commerce, Bureau of the Census. "Marital Status and Family Status", Current Population Reports, Series P-20, #87.

2/ Steiner, Peter O. and Dorfman, Robert The Economic Status of the Aged. University of California Press, 1957.

3/ Since the percentage of OAA recipients living alone or with nonrelatives was higher in the State of Washington than nationwide, it is possible that the relatively high percentage of recipients in such living arrangements is associated with the absence of a relative responsibility law in this state.

Low income of the aged, particularly the "older" aged

Finally the heavy incidence of illness and disability among the aged occurs during that period of adult life when the individual typically is least able financially to assume the costs of medical care. Despite the substantial improvement in the income of persons 65 or over during the past decade, the aged, particularly the "older" aged, remain a low-income group. Nationwide, of the persons 65 or over and not in institutions in 1957, 66 percent of the males and 93 percent of the females had money income of less than $2,000 a year. 1/ More than a third of all aged males and approximately 80 percent of the females had annual money incomes of less than $1,000. The overall statistical exaggerate the economic well-being of the "older" aged since earnings of the employed and typically "younger" and healthier aged are included. In 1957 about one-fifth of the men 65 or over and 4 percent of the women were employed on a full-time basis with median incomes of $3,430 and $2,010 respectively. Median incomes of the other aged were $1,420 for males and $740 for females. From another standpoint, considering only the aged living alone or with nonrelatives and thus without access to the potential medical resources (e.g., nursing care, supervision, assistance in daily activities) implied by the presence of relatives in the household, median 1956 money income ranged from $2,080 for couples to $960 and $880 respectively for men and women without a spouse.

Recent data on income by age are not available for the State of Washington. However, assuming that the changes in income distribution for aged males and females respectively have been similar to the national changes, it is estimated that 56 percent of the aged persons in the State had incomes of less than $1,000 in 1958 as compared with 63 percent in 1953. (Table 6) Particularly in view of the increase in the aged population, the number rather than the percentage of aged persons with low incomes is more relevant for the purposes of this analysis. It is estimated that 145,000 aged persons in the State had incomes of less than $1,000 in 1958 as compared with 146,000 in 1953. The estimated number of females in this income-group actually increased from 93,000 in 1953 to 99,000 in 1958. An estimated total of 200,000 aged had incomes of less than $2,000 in 1958, an increase of 14,000 or 8 percent over the five-year period.

Large percentage of aged with no liquid assets of insurance

The economic position of the aged is not appreciably improved when liquid assets and insurance holdings are considered. As of 1951 the relative number of aged with no liquid assets ranged from 42 percent of couples with husband aged 65 or over to 62 percent of the males and 67 percent of the females with no spouse present. 2/ Among the aged couples, 44 percent of the husbands carried no life insurance and another 32 percent carried less than $1,200. Medical and hospitalization insurance is also a limited resource for the aged partly because of the unwillingness of many companies to issue or continue policies for older persons and partly because the limited incomes of many aged preclude purchase of coverage. In 1952, only 26 percent of the aged population not in nursing homes or other institutions had hospitalization insurance. Coverage by

1/ "Money Income of Aged Persons: A 10-year Review, 1948 to 1958", Social Security Bulletin, June 1959.

2/ Steiner, Peter O. and Dorfman, Robert, op. cit More recent data on asset holdings of OASI beneficiaries are available and are cited on Page 13. Since, as compared with the total aged population, the "younger" males and "older" females are underrepresented among OASI beneficiaries, the 1951 material though dated, is considered more suitable than beneficiary data in a discussion of the total aged population.

age group ranged from 36 percent of those 65 through 69 to 15 percent of those 75 or over. 1/ A 1957 survey of OASI beneficiaries indicates that 43 percent had some form of hospitalization insurance with coverage ranging from 50 percent of those 65 through 69 to 26 percent of those 80 or over. 2/ Not only is coverage for currently insurable medical risks severely limited but a relatively large part of the medical budgets of the aged consists of expenses not currently insurable, e.g., nursing home care. In view of the limited financial and medical resources of many of the aged, the possibilities of credit for medical emergencies or chronic care must also be regarded as limited.

PART III. CHANGES IN TOTAL OLD AGE ASSISTANCE CASELOAD, 1953-1958

Decrease in number and percentage of aged receiving OAA

Despite the growth in aged population during the five-year period covered by this Study, the number of Old Age Assistance recipients in the State of Washington fell from 64,245 in July 1953 to 54,824 in July 1958. Approximately 21 out of every 100 aged persons in the State were receiving OAA in mid-1958 as compared with 28 out of every 100 in mid-1953. Had the 1953 recipient rate by age-group continued, some 74,000 aged persons in the State would have been receiving OAA in 1958. Thus while the absolute number of OAA cases dropped by 9,400 over the five years, because of the growth in aged population the decrease in potential caseload attributable to the decline in the recipient rate is approximately 19,000. 3/

Increase in number of aged receiving OASI and increase in average benefits

The decrease in the number and proportion of aged persons receiving OAA has been primarily due to the increase in the number of aged persons receiving Old-Age and Survivors Insurance and to the increase in the level of OASI benefits. Although some of the caseload decrease is also due to the growth in other public retirement programs (Railroad retirement, Government employees' retirement, Veterans' compensation and pension) and the increased prevalence of private pension plans, these other retirement programs are

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1/ U.S. Department of Health, Education and Welfare, Social Security Administration, Division of Research and Statistics, Health Costs of the Aged, Report No. 20, May 1956.

2/ "Aged Beneficiaries of Old-Age and Survivors Insurance: Highlights on Health Insurance and Hospitalization Utilization, 1957 Survey", Social Security Bulletin December 1958.

The difference in coverage indicated by the 1952 report on total aged population and the 1957 report on OASI beneficiaries represent in part a growth in v luntary health insurance over the period but also reflect differences between the characteristics of OASI beneficiaries and the remainder of the aged population.

3/ Had the recipient rate not declined, the 7,000 nursing home cases receiving OAA as of July 1958 would have represented 9 percent rather than 13 percent of the total OAA caseload.

quantitatively small relative to OASI. 1/ Since there has been a long-run decrease in the percentage of men 65 or over in the labor force and, of those employed, an increase in the percentage working less than full-time, earnings from employment have probably had a negligible effect on the OAA caseload decrease. 2/

The number of aged persons in the State of Washington receiving OASI benefits increased from about 80,000 at the beginning of 1953 to more than 150,000 at the beginning of 1958. Even with the growth in the aged population, the number of aged OASI beneficiaries per 100 pessons 65 or over increased from 35 in 1953 to 59 in 1958. Over the same period, the average monthly benefit increased from $44.20 to $58.33. This increase in the number of aged beneficiaries and in their average benefit represents an increase in total (OASI) funds available to the aged in the State of about $6 million per month.

An exclusive focus on the over-all growth in the OASI program obscures four factors crucial to the interpretation of the changing character of the Old Age Assistance caseload:

(1) The "older" aged are less likely to be eligible for OASI benefits than are the "younger" aged.

(2) Those "older" aged who are eligible for OASI benefits receive, on the average, lower benefits than do the "younger" aged.

(3) An aged widow entitled to OASI benefits by virtue of her deceased husband's employment record receives, on the average, lower benefits than do persons whose benefits are based on their own past earnings.

(4) Many of the aged persons receiving OASI benefits have no other retirement income and negligible liquid assets for medical or other emergencies.

"Older" aged less likely to be eligible for OASI

The "older" aged are less likely to be eligible for OASI benefits because of the limited coverage of the insurance system prior to the 1950 amendments. Many were already out of the labor force at the time coverage was expanded and are ineligible because their past employment was exclusively or primarily in noncovered industries. Many of the older women, never themselves employed, were widowed prior to the establishment of OASI or prior to the expansion of coverage. Assuming the age distribution of aged OASI beneficiaries in the State of Washington is similar to that in the nation as a whole, the estimated number of persons receiving OASI benefits in the State in 1958 ranges from 66 of every 100 aged 70 through 74 to 21 of every 100 aged 85 or over. (Table 7)

1/ It is estimated that nationwide approximately 58 percent of the population 65 or over received OASI benefits in 1958 as compared with 16 percent receiving pensions under other public retirement programs and 8 percent receiving benefits under private pension plans. Since about a third of the persons receiving benefits under other public retirement programs and probably even more of those receiving private pensions also receive OASI benefits, the dominance of OASDI as a source of retirement income is apparent. See "Money Income of Aged Persons: A 10-Year Review, 1948 to 1958", Social Security Bulletin, June 1959.

2/ Nationally, 47 percent of the men aged 65 or over had work experience in 1957 as compared with 49 percent in 1950. Of those working, 32 percent worked at part-time jobs in 1957 as compared with 24 percent in 1950. Although there has been some increase in the percentage of older women in the labor force, as of 1957 only 15 percent had any work experience in the course of the year. See U. S. Department of Commerce, Bureau of the Census, Current Population Reports, Labor Force, "Work Experience of the Population in 1957", Series P-50, #86.

TABLE 7: ESTIMATED NUMBER OF AGED OASI BENEFICIARIES PER 100 AGED PERSONS AND ESTIMATED AVERAGE OASI BENEFITS BY AGE GROUP, STATE OF WASHINGTON, DECEMBER 31, 1957

Age in years	Estimated OASI beneficiaries per 100 population	Estimated average monthly OASI benefit			
		Old-age	Aged wife's or husband's	Widow's or widower's	Parent's
Total, 65 or over	59	$66.65	$35.56	$49.61	$50.79
65, less than 70	63	70.60	37.10	52.84	50.28
70, less than 75	66	66.65	35.21	49.76	49.82
75, less than 80	55	62.83	33.28	47.24	50.13
80, less than 85	50	58.55	31.67	45.52	52.06
85 or over	21	56.97	30.65	44.51	52.72

The "older" aged eligible for OASI receive lower average benefits

Primarily because the earnings on which their benefits are based were relatively low, those "older" aged eligible for OASI benefits receive, on the average, smaller OASI benefits than do the "younger" aged. Not only were wage rates lower during the period of their participation in the labor force but unemployment was more widespread and prolonged. It is estimated that at the end of 1957 approximately 72 percent of the aged OASI beneficiaries in the State received old-age (OASI) benefits proper while 18 percent received aged wife's or husband's benefits and 10 percent received widow's or widower's benefits. Only a negligible number received survivor's benefits as aged parents. With the exception of the latter quantitatively unimportant group, estimated average benefits dropped consistently with age for each type of beneficiary. For those receiving old-age benefits, the estimated average benefit dropped from $70.60 for the age-group 65 through 69 to $56.97 for the age-group 85 or over. For aged wives or husbands and widows or widowers, the comparable ranges were from $37.10 to $30.65 and $52.84 to $44.51 respectively.

Sharp decrease in OASI income on death of husband

Since probably no more than one percent of the aged beneficiaries in the State who receive wife's or husband's or widow's or widower's benefits are male, the problems of these groups can be considered, for all practical purposes, to be those of aged females. Since the OASI benefit paid on behalf of an aged wife is one-half that of her husband's benefit while that paid to an aged widow is three-fourths of her deceased husband's, the OASI income available to the "economic unit" is halved on the death of the husband. Even assuming sufficient liquid assets and insurance to meet the costs of the husband's terminal illness and burial, any such drastic reduction in income involves substantial budgetary readjustments -- particularly since the majority of widow beneficiaries receive OASI benefits substantially below the maximum. As of December 31, 1957 with a maximum widow's benefit of $81.40 per month, 89 percent of the widow beneficiaries in the State of Washington received less than $70 and 51 percent received less than $50.

Many OASI beneficiaries have no other income and negligible liquid assets

Finally, many OASI beneficiaries are exclusively or primarily dependent on OASI for money income and in addition, have neglible liquid assets. Nationwide in 1957, 12 percent of the beneficiary couples, 18 percent of the single retired workers and 25 percent of the aged widows had no money income other than OASI. 1/ Excluding income from temporary sources (e.g., earnings, unemployment compensation) and supplementary income (e.g., public assistance), 30 percent of the couples, 44 percent of the single retired workers and 43 percent of the aged widow beneficiaries had no "retirement income" other than OASI. 2/ The median annual "retirement income" (other than OASI) was $176 for aged couples, $28 for single retired workers and $30 for aged widow beneficiaries. Some 24 percent of the beneficiary couples, 44 percent of the single retired workers and 40 percent of the aged widow beneficiaries had no liquid assets 3/ and 30 percent of the couples and half the single retired workers and widows had no life insurance. The median amount of liquid assets was $1,578 for couples, $219 for single retired workers and $457 for aged widows. Excluding those aged beneficiaries without liquid assets, the median amount was $2,983 for couples, $1,950 for single retired workers and $2,600 for aged widows. For those with life insurance the median face value was $1,810, $950 and $740 for beneficiary couples, retired workers and aged widows respectively.

OASI has changed the character of the OAA program

Through its differential effects on the aged population, Old-Age and Survivors' Insurance has gradually altered the character of the Old Age Assistance caseload. Old Age Assistance has become increasingly the resource of those aged who receive no OASI benefits or relatively low benefits and of those whose OASI benefits, though not necessarily low, are inadequate because of special needs, notably for chronic medical care. Since in general both groups are correlated to an important extent with age and sex, the OAA caseload has become increasingly one of the "older" aged, particularly of older females.

OAA caseload older with increasing percentage of females

In mid-1958, 34 percent of the OAA cases in the State of Washington were 80 years or over as compared with 26 percent in 1953. (Table 8) While the number of cases under 80 years of age decreased by 24 percent over this 5-year period, the number aged 80 years or over increased by 12 percent. At the extremes, the number of male recipients aged 65 through 69 decreased by 53 percent while the number of female recipients aged 85 or over increased by 24 percent.

1/ "Income of OASI Beneficiaries: Highlights from Preliminary Data, 1957 Survey", Social Security Bulletin, August 1958.

2/ "Retirement income" is defined as income that beneficiaries could reasonably expect to continue in the future at approximately the same amounts as in 1957. "Retirement income" includes OASI, employer and union pensions, veteran's pensions, annuities, rents, interest and dividends.

3/ "Assets and Net Worth of OASI Beneficiaries: Highlights from Preliminary Data, 1957 Survey", Social Security Bulletin, January 1959.
Liquid assets are defined as reserve money at home, bank checking and savings accounts, postal savings, shares in savings and loan associations and credit unions, mortgages and other money on loan and all types of stocks and bonds.

TABLE 8: ESTIMATED AGE AND SEX DISTRIBUTION OF OLD AGE ASSISTANCE CASELOAD, STATE OF WASHINGTON, JULY 1953 AND JULY 1958

	1958						1953 1/						PERCENT CHANGE 1953-1958		
	NUMBER OF CASES			PERCENT OF TOTAL			NUMBER OF CASES			PERCENT OF TOTAL					
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
ALL AGES	54,824	21,052	33,772	100.0	38.4	61.6	64,245	27,818	36,427	100.0	43.3	56.7	-14.7	-24.3	- 7.3
65, LESS THAN 70	7,840	2,467	5,373	14.3	4.5	9.8	12,656	5,204	7,452	19.7	8.1	11.6	-38.1	-52.6	-27.9
70, LESS THAN 75	13,487	5,099	8,388	24.6	9.3	15.3	18,438	8,223	10,215	28.7	12.8	15.9	-26.9	-38.0	-17.9
75, LESS THAN 80	14,911	5,975	8,936	27.2	10.9	16.3	16,576	7,003	9,573	25.8	10.9	14.9	-10.1	-14.7	- 6.7
80, LESS THAN 85	10,965	4,441	6,524	20.0	8.1	11.9	10,343	4,818	5,525	16.1	7.5	8.6	+ 6.0	- 7.8	+18.1
85 OR OVER	7,621	3,070	4,551	13.9	5.6	8.3	6,232	2,570	3,662	9.7	4.0	5.7	+22.3	+19.5	+24.3

1/ THE 1953 CASELOAD HAS BEEN ADJUSTED ON THE ASSUMPTION THAT THE JULY 1, 1957 CHANGE IN POLICY WITH RESPECT TO MEDICAL INDIGENTS WAS IN EFFECT THROUGHOUT THE 1953-1958 PERIOD.

OAA caseload atypical of total aged population

Recipient rates by age and sex indicate the extent to which the OAA caseload is atypical of the total aged population. It is estimated that 21 out of every 100 persons aged 65 or over were receiving OAA in the State of Washington in mid-1958. (Table 9) By age-group the rate accelerated from 8 of every 100 aged 65 through 69 to 54 of every 100 aged 85 or over. For each age-group, a higher percentage of females than of males were receiving OAA. At the extremes, 5 of every 100 males aged 65 through 69 were OAA recipients as compared with nearly 60 out of every 100 females 80 years or over.

TABLE 9: ESTIMATED NUMBER OF OLD AGE ASSISTANCE RECIPIENTS PER 100 AGED PERSONS BY AGE GROUP AND SEX, STATE OF WASHINGTON, JULY 1958

	Total	Male	Female
Total	21.1	16.4	25.6
65, less than 70	8.3	5.2	11.4
70, less than 75	17.3	13.1	21.5
75, less than 80	28.7	23.9	33.1
80, less than 85	49.8	40.4	59.3
85 or over	54.4	51.2	56.9

PART IV. EFFECT OF INCREASING AGE OF OLD AGE ASSISTANCE RECIPIENTS ON NUMBER OF NURSING HOME CASES

Increasing average age would tend to increase percentage of cases in nursing homes

Because of the association of advancing age with disability and widowhood, the increasing average age of the OAA caseload would, in the absence of offsetting factors, result in an increasing percentage of cases in licensed private nursing homes. Although over the five-year period covered by this Study there was, for each age-group of OAA recipients, an upward trend in the utilization of nursing homes; for any one year a definite correlation exists between age and utilization rate. (Table 10) In 1953, for example, the number of nursing home cases per 100 OAA recipients ranged from 4 in the age-group 65 through 69 to 22 in the age-group 85 or over. In 1958 the range was from 6 of every 100 recipients aged 65 through 69 to 29 of every 100 aged 85 or over.

TABLE 10: ESTIMATED NUMBER OF OAA NURSING HOME CASES PER 100 OAA RECIPIENTS BY AGE GROUP, 1953-1958 1/

	Age in years					
	All ages	65, less than 70	70, less than 75	75, less than 80	80, less than 85	85 or over
July 1953	7.2	3.7	3.9	5.9	10.5	22.0
July 1954	8.3	4.1	4.7	6.9	11.8	23.4
July 1955	9.6	4.5	5.6	7.8	13.0	25.1
July 1956	10.6	4.8	6.2	8.7	14.0	26.3
July 1957	11.7	5.2	6.9	9.5	15.1	27.5
July 1958	12.8	5.5	7.5	10.2	16.3	29.4

1/ Estimates adjusted on the assumption that the July 1, 1957 change in policy with respect to Medical Indigents was in effect throughout the 1953-1958 period.

"Excess" nursing home caseload defined

The difference between the actual number of nursing home cases and the number that would have been in nursing homes had the 1953 nursing home rate per 100 recipients continued is the "discrepancy" in nursing home caseload that this report is designed to explain. Basically this "discrepancy" is the number of nursing home cases in excess of those attributable to changes in total OAA caseload and increases from zero in the base year 195e to 3,000 in 1958. (Table 11) Had the 1953 rate been maintained, OAA nursing home caseload would have fallen from 4,700 in 1953 to 3,900 in 1958 rather than in fact increasing to 7,000.

TABLE 11: ESTIMATED NUMBER OF OLD AGE ASSISTANCE NURSING HOME CASES IN EXCESS OF THOSE ATTRIBUTABLE TO CHANGES IN TOTAL OAA CASELOAD, 1953-1958 1/

	OAA cases in licensed private nursing homes	OAA nursing home caseload if 1953 rate per 100 recipients had continued	"Excess" OAA nursing home caseload 2/
July 1953	4,651	4,651	0
July 1954	5,139	4,458	681
July 1955	5,616	4,233	1,383
July 1956	6,025	4,075	1,950
July 1957	6,512	4,013	2,499
July 1958	6,996	3,947	3,049

1/ Estimates adjusted on the assumption that the July 1, 1957 change in policy with respect to Medical Indigents was in effect throughout the 1953-1958 period.

2/ Number of nursing home cases less number of nursing home cases if 1953 rate per 100 recipients had continued.

The difference between the number of nursing home cases based on the over-all 1953 rate and the number of cases that would have been in nursing homes had 1953 utilization rates by age-group continued can be regarded as the part of the total "discrepancy" attributable to the increasing average age of the OAA caseload. It is the difference between the theoretical number of nursing home cases had a constant percentage relationship to total caseload been maintained and the theoretical number of nursing home cases based on a constant percentage relationship to caseload by age-group.

20 percent of "excess" nursing home caseload due to increasing average age

Had 1953 recipient rates by age-group continued, the number of OAA cases in licensed private nursing homes would have remained practically constant over the five-year period, i.e., the decrease in total OAA caseload would have been substantially offset by the increased concentration of caseload in the older age-group. (Table 12) Although the number of nursing home cases that can be attributed to increasing average age ranges from 126 in 1954 to 577 in 1958, the percentage of the total "discrepancy" or "excess" thus explained is relatively stable. In general, about 20 percent of the total "discrepancy" is due to the fact that recipients are, on the average, older and some 80 percent is due to increased utilization of nursing home within age groups. 1/

PART V. TRANSFER OF NON-PSYCHOTIC PATIENTS FROM MENTAL HOSPITALS

15 percent of "excess" nursing home caseload due to transfers from mental hospitals

In the fall of 1954 the State Departments of Health, Institutions and Public Assistance began a cooperative program of transferring selected patients from state mental hospitals to nursing homes. The patients were those primarily senile (excluding those with senile psychosis) and considered suitable in behavior for nursing home placement. It is estimated that as of July 1958 some 450 OAA cases in private nursing homes had been so released from mental hospitals. Thus approximately 15 percent of the "excess" nursing home caseload in 1958 is attributable to the program of transfers from mental hospitals.

PART VI. EFFECT OF INCREASING MEDICAL CARE COSTS ON THE NUMBER OF OAA NURSING HOME CASES

Increase in price index for medical care

From August 1953 to August 1958 the Consumer's Price Index for the City of Seattle increased by 8 percent and the component Medical Care Index by 18 percent. Exclusive focus on this five-year period, however, understates the cumulative effect of rising prices on aged persons with fixed and/or low incomes and modest savings. By mid-1958 the Index for the City of Seattle had risen to 126 percent of its 1947-1949 average and the Medical Care Index to 148 percent. A monthly annuity of $100 established in 1948 was equivalent in terms of general purchasing power to only $79 a decade later. Savings of $500 accumulated by 1947-1949 for medical emergencies were, in terms of the Medical Care Price Index, worth but $338 by 1958.

1/ Only two breakdowns of the 1953 nursing home data are available: (1) by age and (2) by sex. A breakdown by age by sex is not available and nursing home utilization rates had altered too markedly over the period to warrant extrapolation. Examination of the available data indicates, however, that the increasing proportion of older aged in the OAA caseload is so highly correlated with the increasing proportion of females that the additional amount of the "excess" nursing home load (over and above that explained by increasing age) that can be attributed to changes in the sex ratio is negligible.

TABLE 12: ESTIMATED PROPORTION OF "EXCESS" OAA NURSING HOME CASELOAD ATTRIBUTABLE TO INCREASING AVERAGE AGE OF THE TOTAL OAA CASELOAD AND PROPORTION ATTRIBUTABLE TO INCREASING UTILIZATION BY AGE GROUP 1/

	OAA NURSING HOME CASELOAD IF -		"EXCESS" NURSING HOME CASELOAD			PERCENT DISTRIBUTION OF "EXCESS" NURSING HOME CASELOAD		
	1953 RATE PER 100 RECIPIENTS HAD CONTINUED	1953 RATES PER 100 RECIPIENTS BY AGE GROUP HAD CONTINUED	TOTAL	ATTRIBUTABLE TO INCREASING AVERAGE AGE OF TOTAL OAA CASELOAD 2/	ATTRIBUTABLE TO INCREASING UTILIZATION BY AGE GROUP	TOTAL	ATTRIBUTABLE TO INCREASING AVERAGE AGE OF TOTAL OAA CASELOAD	ATTRIBUTABLE TO INCREASING UTILIZATION BY AGE GROUP
JULY 1953	4,651	4,651	0	-	-	-	-	-
JULY 1954	4,458	4,584	681	126	555	100.0	18.5	81.5
JULY 1955	4,233	4,509	1,383	276	1,107	100.0	20.0	80.0
JULY 1956	4,075	4,478	1,950	403	1,547	100.0	20.7	79.3
JULY 1957	4,013	4,513	2,499	500	1,999	100.0	20.0	80.0
JULY 1958	3,947	4,524	3,049	577	2,472	100.0	18.9	81.1

1/ FOR DEFINITION OF "EXCESS" NURSING HOME CASELOAD, SEE TABLE 11, FOOTNOTE 2.
2/ OAA NURSING HOME CASELOAD IF 1953 RATES BY AGE GROUP HAD CONTINUED LESS NURSING HOME CASELOAD IF 1953 OVER-ALL RATE HAD CONTINUED.

Larger increase in medical expenses of the aged then in Price Index

More important, the increase in medical expenses incurred by aged persons has outdistanced the increase in the Medical Care Price Index. It is estimated that from 1947 to 1957 while the index of medical care costs increased nationwide by 38 percent, the median medical care expenses incurred by aged OASI beneficiaries increased by 90 percent for couples and 114 percent for nonmarried beneficiaries. 1/ Over the same period beneficiary couples with annual medical costs of $300 or more increased from 15 percent of all beneficiary couples to 31 percent and those with costs of $500 or more from 6 percent to 16 percent. Fourteen percent of the nonmarried aged beneficiaries had medical costs of $300 or more in 1957 and 8 percent had costs of at least $500.

Probable reasons for rapid increase in medical expenses of the aged

Although information is not available to assess the relative importance of the various factors, the sharp increase in the medical expenses of the aged relative to increases in the cost of medical care is probably associated with (1) the increasing average age of the population 65 or over, (2) differential increases in the prices of items dominant in the medical budgets of the aged, viz., drugs and hospitalization and (3) increases in the quality and availability of medical care for older persons. 2/ Nevertheless, irrespective of the reasons for the divergence between medical expenses and the over-all cost of medical care, the former is the more valid measure of the real economic burden of illness and disability. Even for the relatively short period covered by this study it is likely that the average medical expenses of the elderly in the State increased by at least 25 to 30 percent as compared with the 18 percent increase indicated by the Medical Care Price Index.

Distinction between recurrent and nonrecurrent medical expenses

Measurement of the impact of rising medical expenses is further complicated by the nonhomogeneity of the population 65 or over with respect to income and disability. Annual medical expenses of $400 have different meanings for an aged person with $3,000 income and $5,000 savings and one with $1,000 income and $200 savings. Similarly, one-time medical expenses of $400 per year have different economic implications than recurrent medical expenses of $400 annually. Data are not adequate to estimate the proportion of the aged with high and recurrent medical costs but given the

1/ "Medical Care Costs of Aged OASI Beneficiaries: Highlights from Preliminary Data, 1957 Survey", Social Security Bulletin, April 1959; "Medical Care Expenditures of Beneficiaries in Three Cities", Social Security Bulletin, November 1951. Technically the data are not strictly comparable because (1) the early sample was regional and the later sample national, (2) considerable changes in the characteristics of the OASI beneficiary group occurred over the decade and (3) the definitions of median medical expenses are not identical. However, it is likely that the margin of error is not large and that any bias present is a downward one, i.e., that the cited percentages do not overstate and may understate the actual increase in medical costs.

2/ It is relevant that the quality of medical care is usually beyond the patients' control. An aged patient for whom more effective, if more expensive, medication and treatment are available is seldom given the alternative of cheaper but outmoded therapy.

association of age and such chronic impairments as heart disease, hemiplegia and senility it is likely that many incur heavy expenses on a continuing basis. The available information does indicate, however, that there is no definite or consistent relationship between the money income of the aged and their expenditures for medical care. 1/ Since liquid assets, medical insurance and the possibilities of credit are positively correlated with income, it is probable that while the higher-income aged may be in a relatively strong position to assume medical bills, many, if not most, of those with low incomes are unable to meet substantial medical costs independently. Although the low-income aged with high but nonrecurrent medical expenses may be able to manage without OAA, e.g., through help from relatives or use of the Medical Indigent program, it is likely that those with such heavy recurrent costs as are involved in nursing home care must, for the most part, eventually resort to continuing public assistance.

Medical expenses of the aged apparently not related to income

Finally, it is difficult to relate depletion of assets to increasing medical expenses in that assets can be and are used by the elderly not only for medical and other emergencies but also for current living. Although the data are fragmentary, it appears that use of accumulated resources is a well-established part of the economic pattern of the aged. It is estimated that in 1951 persons 65 or over were, nationwide, dissaving at the rate of $1 billion per year. 2/ Assets were used during 1957 by more than 40 percent of the OASI beneficiary groups with high medical costs. 3/ Nearly a third of the couples and a fourth of the nonmarried beneficiaries with high medical costs used at least $500 of assets in the course of the year. A decade earlier when both prices and incomes werelower, about half the OASI beneficiary couples with medical expenses of $200 or more used assets and it was estimated that at such a dissavings rate, half of the couples with medical costs of $200 or more would, in one year or less, be left with no assets or no assets other than real estate. 4/ With the price level increases of recent years, dissaving by the aged, at least for substantial or emergency expenditures, has probably increased. Certainly depletion of savings has become an increasingly important reason for the opening of Old Age Assistance cases. In the State of Washington the number of OAA cases opened because of depletion of savings increased by 43 percent between 1953 and 1958 with the rate per 1,000 open cases rising from 34 to 57. Whether the increasing consumption of assets is for current living or medical costs cannot be determined or estimated.

Use of assets by the aged

1/ "Medical Care Costs of Aged OASI Beneficiaries: Highlights from Preliminary data, 1957 Survey", Social Security Bulletin, April 1959; Steiner, Peter O. and Dorfman, Robert, The Economic Status of the Aged, University of California Press, 1957; "Medical Care Expenditures of Beneficiaries in Three Cities", Social Security Bulletin, November 1951.

2/ Steiner, Peter O. and Dorfman, Robert, op. cit.

3/ Social Security Bulletin, April 1959. High medical costs were defined as $800 or more for couples and $500 or more for nonmarried beneficiaries.

4/ Social Security Bulletin, November 1951.

Because of the paucity of the data, the complexity of the interrelationships and the broad range of assumptions involved, any estimate of the effect of increasing medical costs on the number of Old Age Assistance nursing home cases must be regarded as tentative. As noted earlier, 1/ it is estimated that as of 1956, some 145,000 aged in the State had incomes of less than $1,000 and an additional 55,000 had incomes of $1,000 but less than $2,000. 1/ The former group and perhaps the latter can in general be considered economically vulnerable with respect to such heavy medical costs as are associated with prolonged hospitalization or long-term nursing home care.

Increase in number of low-income aged with high medical costs

If it were assumed that the increase in the proportion of aged persons with relatively high medical expenses has been similar in the State of Washington to the estimated national increase, probably some 24,000 aged in the State with income of less than $1,000 had medical costs of $300 or more in 1958 as compared with an estimated 14,000 in 1953. Since, depending on class of care, minimum nursing home costs range from about $100 to $200 a month, these persons with income of less than $1,000 a year or $84 per month can be expected to require public assistance in the event of nursing home care. Thus the estimated five-year increase of almost 10,000 in the number of low-income aged with relatively heavy medical expenses represents a corresponding increase in "potential" OAA nursing home caseload. In reality, probably some 12 percent of the increase or about 1,200 cases can be allocated to nursing home care. 2/ Extending the concept of low-income aged to include those with incomes of $1,000 but less than $2,000 would account for an additional 600 cases. Since accelerated depletion of assets is subsumed in the present estimate, between 1,200 and 1,800 of the "excess" OAA nursing home caseload or between 40 and 60 percent can be attributed to increased medical costs.

40-60 percent of "excess" nursing home caseload due to increased medical costs

PART VII. EFFECT OF SOCIAL FACTORS ON INCREASED NUMBER OF NURSING HOME CASES

The residual "excess" OAA nursing home caseload, i.e., the 5-25 percent not explicable by increases in age and medical expenses can be ascribed to the increased availability of nursing home care, the increased acceptance of nursing home care by the aged, their families and the community and to those "negative" social pressures that often make difficult or impossible the care of the aged in the home of children or other relatives.

1/ See Table 6, page 7.

2/ Judging by information available only for aged OASI beneficiaries, it appears that nationwide between 10 and 15 percent of the aged with medical costs of $300 or more require long-term institutional care. See "Medical Care Costs of OASI Beneficiaries: Highlights from Preliminary Data, 1957 Survey" Social Security Bulletin, April 1959.

Increased availability of nursing home care

The estimated number of licensed private nursing home beds in the State of Washington increased from 7,700 in July 1953 to 11,600 in July 1958, an increase of 3,900 or 51 percent. 1/ The extent to which the increased availability of beds is itself a response to increased need is an academic question but it is incontrovertible that the more than 11,000 persons in nursing homes as of mid-1958 could not have been cared for in the 7,000 - odd beds available in mid-1953. Nursing home placement is hardly a moot question if nursing home beds are not available.

Increased acceptance of nursing home care

Both the increased availability of care and the higher standards of comfort and pleasantness in modern nursing homes as compared with their predecessors have contributed to increasing acceptance of nursing home care by the aged, their families and the community. An elderly person is probably less reluctant to enter sheltered care if he has already had friends or relatives comfortably cared for in nursing homes than if he considers his experience to be an isolated one. Similarly, relatives are probably more willing to accept nursing home placement or willing to accept placement at an earlier stage of an illness if nursing home care of the elderly is fairly common and does not occasion social opprobrium.

"Negative" pressures making care of the elderly at home difficult

The "negative" social pressures that often make difficult or impossible the care of the aged in the home of children or other relatives are well known. Changes in housing styles and characteristics have often made the three-generation household or the home care of chronic illness impractical or undesirable because of lack of space and privacy. Secondly, the increasing employment of married women means that often no one is available in the home to give the nursing care required. In the spring of 1958, 30 percent of married women with at least one child under 18 were employed as compared with 20 percent a decade earlier. 2/ Of married women with no child under 18, 31 percent were employed in 1948 and 36 percent in 1958. Finally, the high rate of mobility since World War II among families with head of working age would operate against home care of the aged since movement of an elderly person who is ill or infirm may be impractical or impossible. Some 39 percent of the families with head under age 35 and 15 percent of those with head at least 35 but under 55 move in the course of a year. 3/ Regardless of the net social desirability of recent housing changes, high labor force mobility and the employment of women, these factors have undoubtedly accentuated the problems of the elderly in our society. 4/

1/ The discrepancies between the estimated number of beds and the estimated patient count in Table 1 are apparent only. The patient count refers to total served during the month whereas the estimated count of beds refers to a point in time.

2/ "Facts about Families", Social Security Bulletin, May 1959.

3/ Ibid.

4/ A concise statement of the development of the nursing home in response not only to medical needs but to other environmental and social factors is given in Nursing Homes, Their Patients and Their Care (U. S. Public Health Service, Public Health Monograph No. 46, 1957).

PART VIII. SUMMARY

From 1953 to 1958 the estimated number of Old Age Assistance nursing home patients increased by 50 percent while the total number of OAA cases dropped by 15 percent. The increasing number and proportion of OAA cases in licensed private nursing homes can only be explained in terms of the changing size and characteristics of the aged population in the State. The decrease in OAA caseload is primarily due to the increased number of aged beneficiaries of Old-Age and Survivors Insurance and to the increased level of benefits. However, the differential effects of the expansion of OASI on the aged population has altered the character of the OAA program. OAA is becoming increasingly the resource of persons with special needs, notably for chronic medical care and thus increasingly a program of the "older" aged. Since the incidence of chronic impairments increases with age, the increasing average age of the recipients has had an upward effect on nursing home caseload. It is estimated that 20 percent of the "discrepancy" between the changes in total OAA caseload and OAA nursing home caseload is due to the increasing average age of recipients, 15 percent to transfers of senile patients from mental hospitals and between 40 percent and 60 percent to increased costs of medical care. The residual "discrepancy" is due to social factors. The limitations of the available data make any such estimates tentative and narrower limits cannot be presently ascribed. Because of the interrelationships and interaction among the various medical, social and economic factors it may well be that even with additional information precise assignment of causality will be an insoluble problem.

HEALTH CARE FOR THE AGED IN THE STATE OF WASHINGTON

Odin W. Anderson, Ph.D.,
Research Director, Health Information Foundation
William T. Reich, Ph.D.

This report was prepared with the assistance of Paul Meyer, Graduate Student, Institute of Public Affairs, University of Washington.

INTRODUCTION

The present medical care program for old age assistance recipients in the State of Washington is the result of long experience with various methods of providing such care. The present program is of interest both because of the comprehensive care it provides and the unusual administrative mechanisms it employs. Among its unusual features are these:

- The state contracts with a voluntary health insurance agency for physicians' care of its assistance recipients. This care is actually provided through a number of local, physician-sponsored medical care plans that give recipients free choice of physician.
- The state contracts with a prepaid dental care agency for dental services for assistance recipients, allowing them essentially free choice of dentist.
- The program supports very extensive use of nursing home facilities by its old age assistance recipients. About one out of six of these is a nursing-home patient.
- It provides recipients with virtually all needed health services — including physicians' home and office calls, prescribed drugs, appliances, and dental care and dentures.

This study, while not intended as an analysis in depth, presents the essential features of the Washington program—its development, provisions, utilization, and costs—for those in other areas who are concerned with providing health care for the aged and for other groups.

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LATE IN 1940 THE VOTERS of the State of Washington approved a referendum (Initiative 141) establishing a full, statewide medical care program for old-age assistance recipients. Initiative 141 assigned administrative and fiscal responsibility for this program to the state Department of Social Security, although the actual administration of the program was to be borne by county welfare offices. The desired scope of the medical care program was only suggested by the initiative: ". . . the department shall provide for those eligible for medical, dental, surgical, optical, hospital and nursing care by a doctor of recipient's own choosing, and shall also provide artificial limbs, eyes, hearing aids and other needed appliances."

From 1941, when the statewide program went into effect, until 1947 the Department of Social Security assumed ultimate responsibility for the program. In 1947 control of all assistance programs, including medical care, was returned by the state legislature to the counties.

In 1949 a second referendum, Initiative 172, returned full responsibility for public assistance once again to the state. Initiative 172 set the scope of the medical care program in some detail, although it did not specify how care was to be provided, except for assuring free choice of physician for the assistance recipient: "In addition to Senior Citizen grants, each recipient who is in need of medical and dental and other care to restore his health shall receive:

> "(a) Medical and dental care by a practitioner of any of the healing arts licensed by the State of Washington of recipient's own choice.
>
> "(b) Nursing care in applicant's home and hospital care as prescribed by applicant's doctor, and ambulance service.

> "(c) Medicines, drugs, optical supplies, glasses, medical and pharmaceutical supplies, artificial limbs, hearing aids and other appliances prescribed as necessary."

The medical care program was first administered by the Department of Social Security, then by the Department of Health. In 1955 the program was transferred again to the Department of Social Security, at which time its name was changed to the Department of Public Assistance.

As this summary indicates, the early history of the statewide medical care program was neither uninterrupted nor stable. Nevertheless, both state and counties accumulated valuable experience in different methods of providing health care. Most of the health programs now in use were first attempted or tested in these earlier years.*

In 1955, when the medical care program for old age assistance recipients (as well as for others receiving state assistance) was returned to the Department of Public Assistance, the state initiated the present organization for providing care. It carried over the Division of Medical Care established in 1953 when the program was in the Department of Health headed by a physician assistant director who, after the transfer, then became responsible to the director of public assistance. At the same time the state carried over a twelve-member "Welfare Medical Care Committee" created to advise the assistant director. The assistant director was authorized to define the medical services to which recipients of public assistance would be entitled, within this framework:

> *The division of medical care shall provide for necessary physicians' services and hospital care, considering the recommendations of the welfare medical care committee, and may provide such allied services as dental services, nursing home care, ambulance services, drugs, medical supplies, nursing services in the home, and other appliances, considering recommendations of the welfare medical care committee, who shall take into consideration the appropriations available.*
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> *(Chapter 273, 1955 Sessions Laws)*

*The problems, issues, and experience of the state's medical program prior to 1948 were discussed in two earlier studies by Dr. Anderson: *Administration of Medical Care; Problems and Issues*, Bureau of Public Health Economics Research Series No. 2, School of Public Health, University of Michigan (Ann Arbor, 1947) and *Prepayment of Physicians' Services for Recipients of Public Assistance in the State of Washington; Problems and Issues*, Bureau of Public Health Economics Research Series No. 4, School of Public Health, University of Michigan (Ann Arbor, 1949).

One of the most important developments to follow was an agreement in 1956 with the Washington State Dental Service Corporation for that dental prepayment agency to administer the state's public assistance dental care program. From October, 1956, to mid-1958 several different dental programs were operated experimentally in different parts of Washington. Then, in June, 1958, Washington became the first state to have a statewide prepaid dental contract for assistance recipients. It had earlier been the first state to contract for physicians' services with a prepayment plan.

Other developments in the medical care program since 1955 included the first cost analysis of Washington nursing home operation, permitting payment rates based on actual cost averages, improved liaison and control between the division of medical care and physicians' furnishing services to its assistance recipients, revision of the list of drugs which could be prescribed routinely, and improved hospital reimbursement methods to allow for the mounting costs of hospital care.

As noted later, problem areas remain in the Washington program for old age assistance recipients, some of which will undoubtedly prove difficult to solve. But the developments of the past five years have consistently been directed toward meeting the problems of a medical care program — chiefly those of climbing costs and use of services — without curtailing services believed necessary to the recipients. The broad, flexible program that has resulted deserves study.

THE PRESENT MEDICAL CARE PROGRAM

OAA Recipients About one out of five—48,000 of the estimated 260,000 — aged people in the State of Washington receives old age assistance (OAA). Almost 65 per cent of OAA recipients are women. While the growth of Federal Old Age, Survivors, and Disability Insurance rolls (OASDI) has lowered the number of people receiving state assistance, it has also changed the character of the state old age assistance caseload. The OAA caseload has become increasingly one of the *older* aged, particularly of older women. Almost 40 per cent of OAA cases are 80 years of age or more; the average age of OAA recipients is between 75 and 80.

Eligibility for Assistance In Washington, people in need are eligible for old age assistance if they are 65 or over and have resided in the state for five of the past nine years and a full year before applying for assistance. To be eligible for assistance, applicants are limited in resources to $200 in savings and a maximum of $500 in cash and life insurance cash value.

The state sets no minimum or maximum assistance grants, paying recipients "reasonable allowances for shelter, fuel, food, clothing, household maintenance and operation, personal maintenance, and necessary incidentals." These allowances are determined from annual cost of living studies. Under "average conditions," the minimum grant is $75 per month—less any income the recipient may have. The average grant, including vendor payments, is now $90 per month.

Physicians' Services In most of the state, physicians' services are provided OAA recipients by physician members of the state's county medical bureaus—Washington's unique, physician-sponsored independent prepayment plans. The Department of Public Assistance contracts for these services through the Washington Physicians Service, an association of the independent county plans. Washington Physicians Service, paid a flat $3.31 monthly payment per assistance recipient, distributes this payment (less a small administrative charge) to the various county medical bureaus according to the number of OAA recipients in each bureau area. Coverage of assistance recipients under this contract begins one month after they join the assistance rolls. During the first month, care is provided under a direct fee-for-service arrangement.

An exception to the contract arrangement with Washington Physicians Service exists in urban King County (Seattle), the state's largest county, which contains about a fourth of the state's OAA recipients. Most medical care for indigents in King County is provided in the county hospital, which is entirely supported by state funds. Limited physicians' care is provided on a fee-for-service basis by physicians in private practice. The following description of the program for providing physicians' services covers only the counties now in the program under the contract between Washington Physicians Service and the State Department of Public Assistance.

Under the terms of this agreement, physicians of the county bureaus in all counties of the state except King County furnish old age assistance

recipients all "needed" medical care, including surgery, home and office visits, visits in a hospital or nursing home, diagnostic X-rays and laboratory tests, and specialist services. Medical services excluded are principally those covered in direct payment by the Department to hospitals (X-ray and radiation therapy, physical therapy, diagnostic X-rays and laboratory procedures for hospitalized recipients, and the administration of anesthesia) and treatment of tuberculosis and mental illnesses beyond diagnosis.

Each county bureau sets its own fee schedule for remunerating its physician members for their services to OAA recipients. All the bureaus pay their participating physicians on a fee-for-service basis for surgery and special services. About half of the bureaus pay a "case average rate" or capitation fee for office, home, and nursing home visits, while the remaining bureaus pay a fee-for-service for these calls.

Since the total amount received by each bureau for the care its physicians provide is determined by the number of assistance recipients in the bureau area rather than by the services given, the amount often does not permit full payment of the fee set in the fee schedule established for welfare recipient care by the bureau. Where this is the case, the physicians receive only a part of the stipulated fee—the percentage determined by how much the use of services exceeds that which could be met by full payment of the fee schedule. The extent to which services are given may, for example, allow payment of only 75 to 80 per cent of the stipulated fee. At present the reported prorated fees paid to physicians in the various counties range between 65 and 100 per cent of the local fee schedules.

The need for prorating payment when the use of physicians' services exceeds the amount available for payment is believed to provide a strong incentive for local physicians to monitor the program in their bureau area. Local physicians are assumed to help control the cost of the program by influencing their colleagues to reduce non-essential office calls and medical and surgical work so that each service provided can be paid for at close to the established fee schedule. Since physicians also determine hospital and nursing home admissions, as well as drug prescriptions and the use of other medical services, this indirect control is thought to hold other medical utilization to a minimum.

A second and more important control of medical services is provided by 35 *screening physicians*—well-known practicing physicians in

each bureau who are employed by the Department of Public Assistance to review the requests of attending physicians for surgery, hospitalization, or diagnostic workups, and to approve only those essential in the treatment of a chronic, emergent, or acute condition. Screening physicians are paid on a part-time or full-time basis, depending on the amount of the physician's time spent in screening work.

The local screening physicians are regarded as vital to the success of the entire medical care program, particularly because, as already noted, physicians' decisions affect many costs in the program besides those of their own services. The screening physician in each bureau applies controls at a level most readily acceptable to local physicians. His presence avoids delays in questions about allowed treatment, and avoids direct communications with the state department which physicians often consider burdensome.

Hospital Care Complete general hospital care in ward and/or private accommodations is provided OAA recipients either in county hospitals, as in King County and three other counties, or in any voluntary hospital in the remainder of the state. The Department of Public Assistance pays each voluntary hospital a specific per diem rate based on its reimbursable costs during the preceding year up to a limit set by the department, on the basis of three groupings by size. The county hospitals are paid the full cost of their operation.

Except for the priviso that hospitalization of OAA recipients must be "necessary," no formal limits are set by the department on admissions or length of stay. In practice, however, both hospital admissions and length of stay are reviewed by the screening physicians.

Nursing Home Care The Department of Public Assistance contracts directly with individual private nursing homes for care to OAA recipients.* Almost all homes in the state — 320 of 334 licensed homes comprising almost 14,000 beds — accept OAA patients. Nursing homes are paid rates which depend on the classification of each patient according to the amount of nursing care he requires. Patients are classified by assistance department screening physicians or classification nurses into one of four groups. Most screening is now done by the full-time classification nurses, with the aim of screening all patients at

*A small proportion – less than 10 per cent – of OAA recipients receiving nursing home care are in hospitals which have nursing home beds or in retirement homes.

intervals determined by the individual patient's condition. Patients classified in "Group I" are bedfast and helpless, or either bedfast or semi-ambulatory but requiring maximum care because of their physical condition or mental confusion. For each OAA patient receiving Group I care, the home receives $6.38 per day. Patients in Group II are confined to bed or are semi-ambulatory but require moderately complex nursing care. For each Group II patient the home receives $5.27 per day. Patients in Group III, for whom the home receives $4.66 per day, require bedrest or are semi-ambulatory or ambulatory with some minor additional problem requiring nursing care. Patients in Group IV ($4.14 per day) are ambulatory or semi-ambulatory and require some degree of supervision.

The homes themselves are also classified into four groups according to the amount and complexity of nursing care they are equipped to provide. They can be paid only for the classification of patient care they can provide in terms of the number of registered and licensed practical nurses they employ. For example, a home which lacks the required staffing for Group I classification is classified as a Group II home provided stipulated licensed personnel for a Group II home are employed. It can be paid only the rates for Group II, III, and IV patients, even though it may provide care for some patients who ordinarily would be classified in Group I. All the homes agree to accept the compensation rate set by the department as payment in full for OAA patients. Where patients have some income of their own, the department determines what part of the allowed per diem payment is to be made directly by the patient.

Nursing home payments do not include physicians' services, but cover all nursing care, supervision of needed medications and treatment, and attendance to patients' personal care, as well as promotion of their self-help, providing them with a satisfactory environment, and safeguarding their personal possessions. Not covered are the cost of such personal services as haircuts, laundry, long-distance telephone calls, cigarettes, toilet articles, personal clothing, and the like, which are paid for by the patient.

Drugs The medical care program covers the cost of all "essential" drugs prescribed for OAA recipients by their physicians. Household drugs which can be purchased without a prescription are not provided in the program. Druggists are paid directly by the state for prescriptions

they fill, at prices agreed to by the state pharmaceutical association. These prices are somewhat lower than normal prescription prices. Drugs prescribed in the hospital are included in hospital payments. Drugs which may be prescribed without special authorization by the local screening physician are listed in a limited "formulary." Drugs not in the formulary and all single prescriptions costing more than $10 require prior authorization by the screening physician.

Dental Services The Department of Public Assistance contracts with the Washington Dental Service Corporation, one of the few dental care prepayment plans in the country, to provide dental services for OAA recipients and all others receiving public assistance.* In most of the state care is provided on a free-choice, fee-for-service basis by dentists who have signed contracts with both the Department of Public Assistance and the Dental Service Corporation. Any licensed dentist in the state may participate, and over 60 per cent do. Participating dentists are paid according to a fee schedule established by the department. In Pierce County, which includes the city of Tacoma and contains about 10 per cent of the state's OAA recipients, care is provided in a closed-panel dental clinic associated with the Pierce County Hospital, under the administration of the Washington Dental Service Corporation.

The program does not try to provide comprehensive dental care. However, it does include the extraction of teeth, filling of decayed teeth (if such treatment may prevent a future need for dentures), construction of full dentures (when maximum use and benefit can be expected), the repair of broken dentures, and X-rays.

As in the medical care program, screening dentists are used to review requested dental care when the Chief of Dental Services directs. Extraction of teeth (or palliative treatment) for the relief of pain, and repair of broken dentures may be performed by participating dentists without prior authorization. All other care requires prior authorization by Washington Dental Service Corporation. Questions about the treatment requested are referred by Washington Dental Service Corporation to the community's screening dentist, who is paid $3 for each case he screens.

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*The dental program – including its development and experience – is fully described in "The Dental Service Corporation in a Public Assistance Program: a Report from Washington State," (Public Health Service Publication No. 680), Washington, D. C., 1959.

Other Health Goods and Services The Washington Medical Care Program for OAA recipients also covers the cost of ambulance service to and from health facilities, glasses (the cost of eye examinations is included in physicians' services), limited visiting nursing services, and hearing aids and other appliances, which are generally purchased by the Department of Public Assistance and loaned to assistance recipients.

UTILIZATION AND COSTS

Despite the steady decline in the number of OAA recipients over recent years, the cost of the Washington medical care program has continued to rise. The increased use of services by recipients, related to their increased age, changes in the state program, and the increased cost of health goods and services have more than offset the lowered caseload.

Several special studies made in the past few years provide valuable data on the use of specific services by OAA recipients: The study of the role of the dental service corporation mentioned earlier gives data on the type of dental care used by OAA and other assistance recipients. Two very recent studies of nursing homes made by the department provide a wealth of data about the patient composition and the health care needs of patients in the state's private nursing homes. And an earlier study of drug utilization (discussed later) gave the department data that enabled it to reduce the cost of its drug program. With the exception of care in voluntary hospitals, basic data in other areas of use and cost do not yet exist although they might be valuable for control of costs and projections of utilization. Studies of utilization of services in the various counties would also reveal how closely the specifications for care set by the state are followed — whether or not OAA recipients in different parts of the state receive essentially the same quality and quantity of care.

Physicians' Services Data have not been compiled on the use of various kinds of physicians' services by OAA recipients, nor on the per capita or total cost of different physicians' services. As Table I shows, the per capita cost of physicians' services has risen from about $32 in fiscal 1957 to $40 in fiscal 1960, but what this represents in

Table I

Medical Care Cost per OAA Recipient by Type of Care

Type of Care	1956-1957*	%	1957-1958	%	1958-1959	%	1959-1960	%
Physicians' services	$ 31.80	11.0	$ 38.16	11.9	$ 38.16	11.4	$ 39.72	11.1
Hospital care	71.08	24.6	73.47	22.9	72.83	21.8	84.65	23.6
Nursing Home care	154.78	53.6	187.77	58.5	203.02	60.7	210.55	58.7
Drugs	26.36	9.1	17.36	5.4	16.59	5.0	17.41	4.9
Dental services	2.96	1.0	3.46	1.1	3.78	1.1	6.23	1.7
Appliances, etc.	1.68	.6	.82	.3	.28	.1	.24	.1
Total	$288.69	100.0	$321.04	100.0	$334.66	100.0	$358.80	100.0

*From July 1 to June 30.

terms of either use or increased physicians' fees is not known. It is certain, however, that the cost of physicians' services is understated throughout because physicians' services provided in the county hospitals — particularly in King County Hospital — are included in *hospital* costs rather than as the cost of physicians' services. However, what part of the approximately $5 million paid to county hospitals for care of OAA patients represents physicians' care it not known.

Hospital Care More data exist concerning hospitalization of OAA recipients — at least for hospitalization in voluntary hospitals. While the admission and readmission rates are not known, the average length of stay of OAA patients in voluntary hospitals was 7.4 days in fiscal 1960, a little longer in the county hospitals. This is at most one-half as long as the average length of stay for the same age-group in the general population. The average cost per day in voluntary hospitals was $30.71, for an average cost per admission of $227.

As noted above, the per capita cost of hospital care includes physicians' care in county hospitals, so that the actual cost is something less than the $85 given for 1960 — possibly between $75 and $80.

Nursing Home Care Nursing home payments now account for close to 60 per cent of the total cost of the Washington medical care program for OAA recipients. Recent analyses of the increasing nursing home caseload and of nursing home costs and the characteristics of nursing home patients provide excellent data on use and cost of this type of care.*

From July, 1953, to July, 1960, the number of OAA recipients in nursing homes increased 56 per cent — from under 4,700 to 7,300 — while the total OAA caseload declined from 64,000 to 48,000. One out of 14 recipients was a nursing home patient in 1953; one out of six was a nursing-home patient in mid-1960.

While the increased use of nursing homes by OAA recipients cannot be attributed to any single factor, research by the Department of Public Assistance indicates that some five or six causes apparently account for most of the increase.

*"Analysis of Increase in Nursing Home Caseload, Old Age Assistance, 1953-1958" January, 1961, and "Nursing Home Cost Study," February, 1961. Both studies were prepared and issued by the Research and Statistical Unit of the Department of Public Assistance.

The first of these, it found, is the increasing average age of OAA recipients, with the result that a higher proportion of them require institutional care. The increased average age stems from the general aging of the population (credited to increased longevity) and from the loss of the "younger" aged from the OAA group as Federal OASDI benefits have broadened (the "older" aged — in particular, older women—are less often covered by OASDI, and when they are, the amount they receive is generally lower). At present, over 60 per cent of OAA nursing home patients are women; well over half of OAA nursing home patients are at least 80 years old.

Increased medical care costs have also helped increase the OAA nursing home load, the department study found. Aged people who were financially independent while well, entered public assistance rolls after their financial assets were depleted by payments for serious illness requiring long-term hospital or nursing-home care. Additionally, many aged who could otherwise still be self-supporting cannot pay for nursing home care costing between $120 and $200 per month without public assistance. Extended illness and the resultant depletion of their resources have meant that a higher proportion of nursing-home patients are now OAA recipients.

A third cause of the increased nursing-home load cited in the department's study was a state decision in 1954 to transfer a number of senile patients from the state mental hospitals to nursing homes. An estimated 500 of these patients were transferred between 1955 and 1958.

Other probable causes of the increased nursing-home load are discussed in the department study. The available number of nursing home beds in Washington has more than kept pace with the increased use. The number of beds rose from 7,700 in mid-1953 to over 13,000 in mid-1960. In most other sections of the country the absence of adequate nursing home facilities restricts referrals to them. In Washington, on the other hand, new home construction has resulted in some surplus of beds. Slightly over 1,000 nursing home beds are vacant, with most homes operating at about 93 per cent occupancy.

The construction of new attractive nursing home facilities and the increasingly vigorous standards for them set by the state and their own association have undoubtedly also increased the acceptability of nursing homes by the aged, their families, and their physicians.

The Department of Public Assistance study has estimated the effects of each of the major causes of the "discrepancy" between the nursing-home caseload that might have been projected from the decreasing OAA caseload and the actual increase in nursing-home caseload. It estimates that 20 per cent of this "discrepancy" is due to the increasing average age of recipients, 15 per cent to the transfer of senile aged from the state mental hospitals, between 40 and 60 per cent to the increased costs of medical care, and the balance — 5 to 25 per cent — to the greater acceptability of the homes and other social factors.

Obviously, the use of nursing homes in Washington differs from that in other parts of the country. It would be a mistake, however, to think that the large proportion of OAA recipients in nursing homes indicates that the homes are being used as boarding homes for the aged. Most nursing-home patients require substantial care. Of all public assistance recipients in nursing homes, 2,500 are Group I patients, 2,000 are Group II patients, 3,000 are Group III patients, and fewer than 600 are in the minimal-care Group IV. The department's most recent study of the characteristics of assistance recipients in nursing homes reveals these striking facts:

- Thirty per cent were bedridden most or all of the time; another 10 per cent were bedridden part of the time.
- While 48 per cent were able to walk alone or with no more help than cane or crutch, 37 per cent were unable, at least part of the time, to walk or be moved in a wheelchair.
- Only 26 per cent were always clear mentally. Thirty-seven per cent were seriously disoriented at least part of the time.
- Only 9 per cent had but one impairment requiring care. Twenty-seven per cent had two impairments requiring care, 25 per cent had three, and 39 per cent had four or more conditions that required care.
- Including cases in which care was expected to be terminal, 96 per cent were expected to remain in nursing home care for an indefinite period. Only 2 per cent were expected to need care for less than a year.

The increased cost of nursing home care is due principally to the higher number of OAA recipients in nursing homes, not to any substantial increase in payments per patient to the homes. Nursing homes have received only two special increases between 1953 and the end of 1960 — both requiring additional services. In 1957 the homes were given an increase of 40¢ per patient per diem if they agreed to provide cost data for the department's study of nursing home costs. In 1960 they received an increase of 7¢ per diem if they agreed to provide routine household drugs to patients. As a result of the recently completed cost study, a new contract, with increased rates (particularly for Group III and Group IV patients) has been instituted — the first payment system for nursing homes in Washington and perhaps in the nation based on actual per diem costs.

Drugs In 1955 the Department of Public Assistance compiled a full list of drugs which could be prescribed for OAA recipients without prior authorization. Over the two years following, drug expenditures rose sharply. An intensive study by the department of drug costs revealed that a major part of the rise was occasioned by widespread prescription of tranquilizers and anti-hypertensives (costing an estimated $½ million per year in all welfare programs). The study also showed great divergencies in prescribing practices. For example, in two comparable nursing homes in the same city the cost per month for drugs differed by $28 per patient. In 1957 the department curtailed its drug expenditures by limiting the list of drugs which could be prescribed without special approval to only the most "essential" and frequently used drugs. As Table I shows, the per capita cost of drugs has been about $10 a year lower in the past three years than it was before 1957. A revised, somewhat liberalized drug formulary was recently placed in effect (October, 1960) but it is not expected to increase drug costs appreciably.

The present $17 per year "drug cost" per person does not include drugs furnished hospitalized patients. These are included in hospital costs. In addition, nursing homes furnish their OAA patients with common household preparations (aspirin, rubbing alcohol, milk of magnesia, body lotions, etc.) without charge, for an amount included in their per diem payment. Additionally, an unknown amount is expended by OAA recipients themselves for medications not included in the program.

Dental Services The most recent data concerning the use of dental services by OAA recipients were those compiled between October, 1956, and September, 1957, for the Department of Health, Education, and Welfare pamphlet mentioned earlier. During that period, only about 6 per cent of OAA recipients applied for dental care (a substantially higher proportion of men than women). About two-thirds of the applicants for care required full dentures, and most of the remaining third required some other prosthetic services (relining, repair of broken plates, etc.). The average expenditure for each recipient receiving dental service was $54.59.

The sharp rise in the cost of dental services in 1959-1960 (from $3.78 to $6.23 per person) in part reflects the effects of an increased fee schedule adopted July 1, 1959. At that time the maximum charge for full upper or lower dentures (to cite the most common service performed for OAA patients) rose from $75 to $90.

Comparison with Other Programs Because utilization of physicians' services and some hospital care cannot be stated for the Washington program, overall comparison with the utilization of other groups is difficult. What data exist indicate that Washington OAA recipients make unusually full use of nursing-home care and probably less total use of hospital care than do comparable groups of aged in other parts of the country as indicated by the extremely low length of stay of Washington OAA recipients. A comparison of the number of nursing home beds and general hospital beds to population in Washington state, the entire country, and a few selected states shows that Washington has three times the number of nursing home beds of the country at large and much higher than any state.* It is also comparatively well-supplied with general hospital beds. The combination makes for a generous use of facilities compared with other areas. These differences apparently reflect different regional patterns of medical care, not merely differences in the particular assistance programs.

Some cost comparisons can be made with nationwide expenditures for medical care and with the expenditures of other assistance pro-

*The article by Leslie M. Abbe, "Hospitals and nursing homes in the United States, 1959," *Public Health Reports* 74: 1089-1097, Dec. 1959 provides data on nursing homes by state. As of Jan. 1959 Washington was reported to have *4.34* nursing beds per 1000 population compared with the United States *1.43*, California *1.54*, New York *1.02*, and Colorado *2.43*. For general hospital beds derived from the American Hospital Association *Guide for 1960* the number of general hospital beds per 1000 in Washington is *3.34*, United States *3.62*, California *3.22*, New York *4.35*, and Colorado *4.00*.

grams. In 1958 the nationwide per capita expenditure for insured people 65 and over, was $214, not including expenditures for nursing homes.* The comparable per capita cost of the Washington program in 1958-1959 was $132. Interestingly, the per capita cost of health care for the aged in Colorado, recently studied by HIF, was almost identical in 1959 ($133), although the Colorado program provides no dental care, no prescribed drugs outside of hospital or nursing home, and only limited out-of-hospital physicians' services. When expenditures for nursing homes are included, the cost of the Washington program far exceeds that of Colorado (a per capita total of $335 in 1958-1959, compared with $222 in Colorado).

PROBLEM AREAS IN THE PROGRAM

As might be expected, the major problems in the Washington program, both in the present and recent past, have arisen as direct results of its continued rising costs. Even before the cost of the program for the aged reached its present near-$20 million annual figure, the program administrators and the state legislators were concerned over the burden placed on the general population by the growing costs.

In the past several years, particular attention has been focused on three parts of the medical care program: nursing homes, the county hospitals, and drugs. The list of drugs was revised and special authorization was required for expensive prescriptions and those not part of the formulary. This revised list is assumed to enable the prescribing of life saving drugs and those of clearly demonstrated therapeutic value.

The special attention focused on nursing home costs resulted in the full cost study already discussed. Nursing home payments are now to be made on the basis of median costs for each of the different classifications of patient care. The new payments represent the first time that nursing-home payments have been related to known costs. Despite this, of course, the total cost of nursing home care for old-age assistance recipients (well over $10 million per year) continues to be a source of concern. It has been suggested by some of those concerned with nursing-home care in Washington that this state, in its more

*Data from the nationwide family survey by Health Information Foundation and National Opinion Research Center to be published.

extensive use of these facilities, has simply progressed further along a road which all state or other medical care programs for the aged will have to follow. They suggest that nursing home care, which already accounts for over 60 per cent of the cost of the entire Washington OAA medical care program, will continue to increase in importance and that the "problem" of nursing home costs should focus merely on assuring that payments reflect actual costs and the most efficient and beneficial organization of this medical service.

The third area which has received particular attention—the county hospitals — has not resulted in any program changes. The problem in the relationship between the county hospitals and the program — in particular, between the King County hospital and the program — has been created by the fact that the county hospitals are entirely dependent for support on the state welfare programs and that their rising costs have required them repeatedly to return to the state for deficiency appropriations.

Besides those created by rising costs, the largest number of administrative problems for the medical care program have stemmed from questions rising between the different suppliers of health care services and the plan administration. These are inevitable, but in the case of the Washington program, they have been generally minor and readily resolved. The disallowed treatment that has been requested by a physician for his patient has probably been the major source of this category of problem. Since treatment or hospitalization has often already been given the assistance patient, the rejection of the request means that the service is not reimbursable (and is generally not collectible from the patient).

OBSERVATIONS AND IMPLICATIONS

Since 1941 a comprehensive health program has been in operation in the State of Washington under the power given by a state referendum. The mandate has been general, but for 20 years the state has felt that nothing less than a comprehensive program was intended. Further, no source of tax funds was ever earmarked, and no statutory ceiling was ever set on expenditures. In general, expenditures have been allowed to reach their own level in accordance with what appear to be the medical needs of the age-group of 65 years of

age and over, the group with which this report is specifically concerned. Certainly, no state in the union has supported a more complete program or been more generous in providing funds. Obviously, the program has a firm place among the services provided by the state, and it would probably be impolitic to change its essential character.

A very interesting feature of the health program is the mixture of methods by which the state fulfills the intent of the law authorizing it. About 15 per cent of the expenditure is delegated to medical and dental prepayment agencies under the control of the medical and dental professional associations on a negotiated premium. This is the explicit delegation of financial control but, naturally, the physicians' influence pervades the entire program, outside of dental care. Physicians' services were first provided on a cost-plus basis, but after several years of experience with expenditure levels, the medical bureau felt able to negotiate the premium. Hospital care and nursing home care payments are made directly to individual hospitals and nursing homes on a per diem or average per diem basis. The unit price of drugs was negotiated with the professional pharmaceutical association. Appliances are purchased directly from the vendors, hearing aids on a bid basis.

The health program for recipients of old-age assistance in the state of Washington is thus geared to the current structure of the health establishment. In this arrangement much responsibility has been delegated to the medical profession. In addition to guaranteeing physicians' services, the medical profession provides an administrative mechanism. The state is thereby freed of all direct administration and supervision. The existence of the medical bureaus for many years has made this possible. The prepayment agencies serve as buffers between the state agency and physicians and permit administration to be decentralized to the county levels. County welfare departments have been able to divest themselves of complicated day-to-day administration which many welfare administrators felt would greatly overshadow other welfare activities for which they were responsible.

In this kind of a setting the health program for the aged has developed to its present status. A review of its history shows that in principle the program has remained the same, but two things deserve attention. First, the screening physicians provided by the medical bureaus in coordination with the medical director on the state level

have been set up in an increasingly elaborate framework. It is unlikely this would have been acceptable unless the physician's part of the program was integrated in the county medical bureaus.

Second, the development of the nursing home program in a relatively spontaneous manner shows other states contemplating a similar program what to expect. Undeniably, the nursing home portion accounts for a tremendous proportion of the total cost. There are no data but it does not appear that the nursing home program has appreciably reduced the cost of hospital care despite the short hospital stay. There is a great deal of concern in the state with the nursing home program and there is talk of the need to establish home care programs to reduce the cost of nursing home care. Ironically, nursing home care was regarded as a means to take the pressure off the hospitals.

The recipients of old-age assistance appear to be receiving a great deal of care, although the paucity of utilization data precludes comparisons with other programs. The state could well require more detail on the use of physicians' services from the county medical bureaus, so that it would have more information on what it was buying. Likewise, the county medical bureaus should know more about what they are providing. A scarcity of information necessary for administrative evaluation has been chronic in the state of Washington, but it apparently indicates that there is a good deal of trust between the state government and the medical profession. Certainly, there is general satisfaction with the program. Periodically, there is public concern with the rising costs resulting in legislative and administrative soul searching, but ultimately the funds are appropriated with admonitions to use the money as efficiently as possible within the mandate the state has accepted for the care of its indigent aged. So far, it can be said the state has been generous. Other states contemplating a similar program must not have any illusions about the cost of comprehensive services for the aged. ■

AMA's Positive 10-Point Program For 1961

(Submitted by Dr. Peter T. Brooks)

I. COSTS OF MEDICAL CARE

The American Medical Association's Commission on the Cost of Medical Care is studying every aspect of medical care costs. When the study is completed, the commission will report its findings and make appropriate recommendations to the public as well as to the profession.

II. VOLUNTARY HEALTH INSURANCE AND PREPAYMENT

The AMA is conducting a series of conferences with the National Association of Blue Shield Plans, the Blue Cross Association, the American Hospital Association, and the health insurance industry to accelerate the progress already achieved and to insure effective cooperation between the prepayment plans, the health insurance companies, and the medical profession. Special attention will be given to coverage of the aged through plans and policies that fit their needs and pocketbooks.

III. HELP TO THE NEEDY AND NEAR-NEEDY AGED

The AMA is working diligently to insure early implementation by the States of the Kerr-Mills medical aid for the aged law which enables the individual States to guarantee to every aged American who needs help the health care he requires.

IV. HEALTH OF THE AGED

The AMA dedicates its efforts to promote positive health objectives for older people through (1) flexible retirement policies; (2) improved nutrition; (3) a changed mental attitude from dependency to self-reliance; (4) home care programs and new nursing homes designed for the elderly, and (5) the utilization of modern diagnostic and therapeutic techniques to advance the prevention of chronic illnesses.

V. MENTAL HEALTH

Mental disease is still the Nation's No. 1 health problem. More than 50 percent of all the Nation's hospital beds are filled with mentally ill patients. The AMA will hold the first National Congress on Mental Health to bring together all the Nation's talent and resources in a gigantic effort to help solve this enormous problem.

VI. PHYSICIAN SUPPLY

The AMA is launching a $200,000-a-year student honors program, including scholarships and loans, to attract more qualified students to medical careers. About 250 outstanding college students will be named AMA honor scholars each year, with approximately 50 of these receiving scholarships of $1,000 a year for 4 years, payable when they enter medical school. In addition, the AMA has created a central security fund to guarantee loans made to medical students. The AMA will step up its medical recruitment program, a concerted effort to attract students into medical careers to assure a sufficient number of well-trained physicians for the future. It will urge expansion of existing medical schools and the creation of new medical schools.

VII. CONTINUING EDUCATION AND RESEARCH

The AMA's postgraduate educational programs are being markedly stepped up in 1961. New mechanisms of communications are being reviewed and joint projects with other medical organizations will be initiated.

In 1961 through the American Medical Research Foundation the AMA will play a more active role in encouraging basic and long-range research in the medical sciences. The AMRF is now sponsoring a research project designed to provide detailed information on the births of 100,000 babies in 100 hospitals and a study of over a million births a year is planned.

VIII. INTERNATIONAL HEALTH

The health of all peoples is interrelated. A new program of international health has been initiated by the AMA. Projects to assist medical missionaries are underway and other programs are planned in cooperation with Federal agencies, the World Medical Association and the World Health Organization.

IX. PRESERVATION OF THE FREEDOM OF PATIENTS AND PHYSICIANS

The AMA will continue its efforts to make sure that every person has access to good medical care, no matter where he lives, and that care is available without regard to his ability to pay. The medical profession believes it is the basic right of every American to choose the physician in whom he has the greatest confidence, just as it is his right to choose his line of work and the church he attends. The AMA will oppose vigorously all efforts to socialize medicine, piecemeal or across the board, seeking always to preserve the freedom of the health professions which have given this Nation the greatest medical care system in the world.

X. HEALTH AND SAFETY EDUCATION

The AMA will expand its educational program in health and safety with more emphasis on healthful living practices and physical fitness of our youth. It will continue its programs urging the installation of lifesaving seat belts in all automobiles, proper labeling of potentially hazardous household products and other ways to reduce accidental poisonings. It will continue to work to insure safety of household chemicals and to reduce misleading advertising in public mass media involving health care products. It will step up its activity in rural and industrial health, preventive medicine, and military medicine.

SUPPLEMENTAL REPORT OF DR. ROBERT P. HALL

At the Hearing on Nursing Homes, November 10, 1961, Walla Walla, Wash., you requested a supplemental report regarding adequate staffing of group I nursing homes. It is our understanding the reason for this request was due to apparent conflict in testimony:

1. Mrs. Roxie Kendall, manager and supervising nurse, Blue Mountain Infirmary, testified she had been advised she employed more registered nurses than needed for adequate care of the type of patients served by the infirmary.

8. Mr. Edmund Jacobs, executive secretary of the Washington State Nursing Home Association, testified that the majority of group I nursing homes employ registered nurses "around the clock."

Your request for a supplemental report on adequate staffing of group I nursing homes was directed to Mrs. Vera McCord, coordinator, hospital and nursing home section, State department of health. However, Mrs. McCord has referred your request to this department because: (1) the classification of nursing homes is determined by staffing requirements; (2) classification of nursing homes is the responsibility of the State department of public assistance; and (3) of the 334 licensed nursing homes, all but 22 are classified, i.e., 93.4 percent of licensed nursing homes are classified by the State department of public assistance. In an effort to clarify the apparent conflict in the testimony given at the hearing, we make the following comments:

1. According to staffing reports from all licensed nursing homes (classified and unclassified) received in this office during June and July 1961, the majority of "heavy care" homes did not have registered nurses around the clock. Of the 141 group I homes as of July 1961, 51 (10.6 percent) had a registered nurse on every shift for the week reported; 7 homes (5 percent) had all shifts covered with a registered nurse except for 2 night shifts when the regular registered nurse was relieved by a licensed practical nurse; 71 homes (50.4 percent) had day and evening shifts covered by registered nurses and all night shifts covered by licensed practical nurses; 22 homes (15.6 percent) had registered nurses on every day and evening shift, licensed practical nurse coverage on night shift, except for 2 night shifts when the licensed practical nurse was relieved by a registered nurse; an additional 23 homes (16.3 percent) had varying combinations of registered nurse and licensed practical nurse coverage; and 3 homes (2.1 percent) had 5 to 7 night shifts covered with aids only (a situation representing

serious noncompliance with classification requirements and violation of the nursing home contract which was corrected by a warning to the defaulting operator).

2. It is our considered opinion the majority of group I homes are usually in compliance with minimum staffing requirements which stipulate registered nurse coverage of day and evening shifts, with night shift covered by a licensed practical nurse. We have no basis for considering the staffing requirements for group I homes to be too low. Classification nurses and screening physicians seldom report instances of inadequate care in group I homes. The State department of health has the authority to require any nursing home to employ more registered nurses than this department requires for classification, but the department of health has never suggested that group I classification standards be upgraded to require a registered nurse on all three shifts.

3. Blue Mountain Infirmary, although a licensed nursing home, is not classified because it is not a vendor in the sense of proprietary nursing homes. The cost of operation is met from an appropriation earmarked for county hospitals and infirmaries, expenditures controlled by the division of medical care, State Department of Public Assistance. On two different occasions, patients in Blue Mountain Infirmary have been screened by a classification nurse (not the same nurse each time). Both nurses reported no essential difference in the type of patients in the infirmary than in the average group I home. Mrs. Kendall, manager and supervising nurse of the infirmary, would like to have more registered nurses than the operational budget permits. We have taken the position the State cannot justify higher staffing standards in Blue Mountain Infirmary than those required for the 141 group I proprietary nursing homes.

It is our opinion, the staffing requirements for group I classification of nursing homes represent a minimum standard. Even though it might be desirable to have every shift covered with a registered nurse, such a requirement would be unrealistic. There is a well-recognized shortage of available registered nurses in the State of Washington, and the hospital demand takes precedence over the demand of nursing homes.

POST FALLS, IDAHO, *November 16, 1961.*

DEAR SENATOR CHURCH: Thank you for your kind invitation to testify. Having emphysema, I could not make the trip and go into a crowded room, and get up on my feet and speak. Our social security check amounts to $139.60 and out of that comes $50 for my medicine. I send to Spokane for it and save 30 percent over Idaho drug prices, so you see the cost it would be buying in Idaho. Also it doesn't leave much for living, as my wife finds the cost of groceries rising all the time, and she doesn't buy any of these frozen foods, or package mixes. If we didn't own our own little home I don't know how we would manage. I can't sign my home over to the State as that wouldn't be fair to my wife, so no relief. If some help on medicine could be had for people in my category it would be wonderful.

Two years ago I was in the hospital in Newport, Wash. No surgery, and they charged me $50 per day, for the bed and just oxygen, so you see I can't afford a hospital bill. I guess if we had no property everything would be furnished, so you see there is a penalty for thrift. I know of people who have never contributed a dime toward Idaho economy who get everything furnished. I hope this will make my position clear and thank you very much.

Yours very sincerely,

MARTIN WILLIAMS.

WALLA WALLA, WASH.

DEAR SENATOR MORSE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

Why is it necessary to substitute another medical care plan for the aged in place of the Kerr-Mills plan, which was passed last year by Congress? If the present plan was thought worthy enough to become law, I think it should be given a fair trial. I believe if all persons past the age of 65 thoroughly understood the present plan, and the proposed social security setup, they would choose the one we now have. Not all persons past 65 are going to need assistance in the form of medical aid and yet the plan you support will force everyone to use the plan whether they need it or not if they come under social security. Many needy aged will not benefit by your plan because they will not qualify.

If the Kerr-Mills medical care plan is not a worthy one, why are so many States already implementing it into their programs for care for the aged? I think that decisions on who are deserving of medical care assistance can best be decided on the local level rather than decisions and rules that will be made in Washington, D.C.

Personally, I want to always be able to choose my doctor and hospital. When I lose these two important privileges, I will have lost a sense of security.

Mrs. CHESTER C. MAXEY,
304 Bryant Avenue.

WALLA WALLA, WASH.

DEAR SENATOR MORSE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

Considering the projected growth of the population of the United States from the present 180 million (an increase of 63 million in the past 70 years), to 700 million, a possible increase of 520 million in the next 70 years (source: Rand-McNally Co.), it must be recognized that the first objective of our Government should be the provision of low-cost facilities for the education of the large number of men and women required and the expansion of less expensive hospital facilities for patient care.

To increase requirements for services first can only lower the quality of services and increase the costs for everyone individually and the government, also.

The writer trusts that you will not vote for socialized medicine and will vote to sustain the Kerr-Mills bill as favored by the medical profession.

ARTHUR A. CAMPBELL,
204 South Park Avenue.

WALLA WALLA, WASH.

DEAR SENATOR MORSE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

I think that the Kerr-Mills bill, which was passed last year by Congress, will provide adequate care for the needy aged. The proposed social security medical aid plan, if passed, will discriminate against many old people who are not covered by social security.

If there is an obligation on the part of the Government to give assistance to those past 65, I think it should be handled locally, as provided in the Kerr-Mills bill instead of from Washington, D.C.

Sincerely,

LLOYD M. PIPER,
314 Juniper Street.

WALLA WALLA, WASH.

DEAR SENATOR MORSE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

I am against the program of free medical care for the aged. The cost of administration alone would make the cost of the program prohibitive.

At the present time the withholdings from one's paycheck is terrific. This plan could not possibly be put into effect without further taxation or withholding.

My retired father lives with my husband and myself and I feel we could much easier pay for any medical expenses he might have than to be further taxed.

Mrs. EARL SANDERS,
Route 2, Box 296.

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