TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

PART 17—WASHINGTON, D.C.

(Positive Aspects)

OCTOBER 14, 1971

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

62-264 WASHINGTON : 1972

For sale by the Superintendent of Documents, U.S. Government Printing Office
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[1] Senator Winston Prouty, Vermont, served as ranking minority member of the committee from September 1969, until his death, September 10, 1971. Senator Robert T. Stafford, Vermont, was appointed to fill the vacancy on September 17, 1971.

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TRENDS IN LONG-TERM CARE

(Positive Aspects)

THURSDAY, OCTOBER 14, 1971

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 1114, New Senate Office Building, Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senator Moss.

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

OPENING STATEMENT BY SENATOR FRANK MOSS, CHAIRMAN

Senator Moss. We welcome you here this morning as the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging meets for its 17th hearing in the current series entitled "Trends in Long-Term Care."

When we began these hearings late in 1969, I made known my search for America's finest nursing homes which can serve as models for the future. At the time of my first hearing I said: "Let our purpose be clear to all concerned; we do not seek to expose, to accuse, to assess blame, or to indict all nursing homes under a blanket indictment. There are many fine homes across the country, but there are also a great many with much room for improvement. Accordingly, we seek to emphasize the positive in this hearing today. It is our hope to go beyond delineation of problems and look at root causes. We must take that extra necessary step of offering constructive solutions."

This policy perspective, I believe, is even more important today than it was at that time in view of the presidential initiatives to irradicate substandard nursing homes. In fairness to the President, he did acknowledge the existence of good homes, but the primary tenor of his remarks, and certainly the publicity accompanying them, was negative.

Our search for constructive programs in our previous hearings has been fruitful, and we have been privileged to hear from representatives of many of our finest nursing homes. However, because of limitations of time and staff, I became convinced of the need for a hearing devoted entirely to the search for innovative and positive programs.

Our purpose continues to be to build a Senate record which we will draw upon heavily to construct our report to the Congress with legislative recommendations. For this reason, I asked for nursing home spokesmen to submit written statements to me, all of which would be incorporated in the hearing record. From these written

statements we have chosen about a dozen witnesses to appear at the hearing today to give us brief oral presentations.

I congratulate the witnesses who have been asked to appear today. Their selection is an indication that they are trying to provide the best possible care for their nursing home residents.

Because our witness list is long, I will not extend these remarks. I will also remind the witnesses of the necessity to keep their presentations within the 10-minute limitation. In fairness to those well down the witness list, this rule will be rigidly enforced.

I look forward to a very constructive hearing today, and because of the importance of these issues I want to announce that the record will remain open for 30 additional days to accommodate any additional representatives from the industry who feel they have positive programs which should be called to the attention of the committee. I welcome any and all proposals on this subject and will ask that they be incorporated in full in the record.

Senator Church, chairman of the full committee, had planned to be here this morning, but unfortunately could not be present. Without objection, his prepared statement will be inserted at this point in the record.

PREPARED STATEMENT OF SENATOR FRANK CHURCH

I am pleased to be here this morning for this hearing by the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging. This Subcommittee under the able direction of Ted Moss has been investigating nursing home problems for more than two years now. Ted Moss knows of my very great interest in these matters and I want him to know how very pleased I am with his efforts to improve the quality of life for our infirm elderly.

In our investigations of nursing home problems we must inevitably deal with problems. We focus on bad providers and ponder ways to eliminate the abuses, the poor care and the profiteering that characterizes some members of the industry.

Seldom in our investigations have we paused to publicly applaud those nursing home operators who devote their lives to providing the finest care possible for the patients in their facilities.

I understand that at today's hearing we will hear from the representatives of several of these very fine nursing homes who will describe some of the programs which have made their nursing homes the institutions that they are. I believe this will be a valuable hearing.

Senator Moss. Our first witness is Mr. Stanley Wilcox, outgoing president of the Virginia Nursing Home Association, speaking for the American Nursing Home Association.

Mr. Wilcox.

STATEMENT OF STANLEY P. WILCOX, OUTGOING PRESIDENT, VIRGINIA NURSING HOME ASSOCIATION, AND MEMBER OF THE AMERICAN NURSING HOME ASSOCIATION'S NATIONAL HEALTH INSURANCE COMMITTEE

Mr. Wilcox. Mr. Chairman, I am Stanley P. Wilcox, president of the Cedars, Inc., Charlottesville, Va. I am also the outgoing president of the Virginia Nursing Home Association and a member of the American Nursing Home Association's National Health Insurance Committee. I also had the privilege of serving on the Virginia State licensing board for nursing home administrators.

I am accompanied by Mr. Norman Burch, who is the Federal liaison of the American Nursing Home Association.

The American Nursing Home Association is a federation of State associations which represents some 7,000 long-term care facilities, with a bed capacity of over 400,000. Our association membership includes both proprietary and nonproprietary facilities located throughout the country. A substantial number of the membership participates as providers of long-term care under the Medicare and Medicaid programs. In addition, a number of our member facilities participate in the VA community nursing home program for veterans.

Mr. Chairman, we appreciate very much having the opportunity to appear here this morning, in behalf of the nursing home industry, and to offer some comments and observations on some issues which have been discussed here and elsewhere in recent times.

Mr. Chairman, while we understand this morning's hearing will focus on some of the positive, more innovative programs that are being conducted on a voluntary basis by members of the nursing home industry, I would like to make some general comments in light of the increasing congressional interest and public attention being given to nursing homes and nursing home problems in recent months.

None Above Criticism

In these modern times, no institution is above criticism. Society in general, including government and industry, should be subjected to criticism; however, such criticism should be constructive and all facts should be given equal weight before incomplete facts are used to draw generalizations which become tomorrow's headlines. Members of the nursing home industry ask only for fair play. We are ready to stand up and accept justifiable criticism—and even move in a positive way to bring about solutions to such criticism. Mr. Chairman, we do respectfully urge that the entire industry not be tarred and feathered for the mistakes of a few, and we further ask that the sole blame for questioned conditions not be placed at the health provider's door, when it more properly belongs at the door of Washington, or Baltimore, or one of the State capitals.

Mr. Chairman, in your recent speech before the 24th Annual Conference on Aging, at the Institute of Gerontology, Ann Arbor, you spoke of seven problems in the long-term care area, and you identified them as "challenges." You stated, "The first challenge is to spell out a clear policy in the United States with regard to the infirm elderly." You said, "We have no national pattern in America for the care of those who are old and ill." In your third challenge you cited "the lack of effective enforcement of nursing home standards by the States." In this context you suggested:

> The real reason for State laxity, I believe, is that the States are pushed for revenues and have not made funds available to their respective Health Departments. When funds have been made available, the chief health officer of the State has allocated them to other health programs, holding that nursing homes have lesser priority.

We agree with you these views reflect more accurately the true and actual conditions. However, this is not the way it often comes out in the press. When retroactive denial of benefits occurs, for example, the fault is ascribed to the nursing home—not to Washington, or Baltimore. Frequently statements are heard that the Federal Government provides over $1½ billion each year for Medicare and Medicaid.

But it is seldom heard that this billion dollars provides as little as $6 a day in some States for skilled nursing home care.

As you know, Mr. Chairman, you cannot even enter the front door of the current day hotels and motels at these prices—and they do not provide skilled nursing services. But these facts are not frequently reported and when they are, criticism is heaped upon the nursing home, not government.

Mounting Effort To Discredit Nursing Home Industry

Before moving to the positive side, I would like to make one final observation. In recent months there has been a mounting effort to discredit the proprietary nursing home industry in this country. This attack has come in many shapes and forms. The most despicable and the one heard with most frequency centers on the fallacious principle that "nursing homes cannot be patient-oriented and profit motivated." This is the most unfair conclusion and cannot be supported or substantiated in any way whatsoever.

Such statements can only be characterized as self-serving and uninformed. Such attacks misrepresent and do irreparable harm to the entire long-term care field. Our members in good faith entered the Medicare program which provides for reimbursement on the basis of reasonable costs—yes, reasonable costs—but only those actual costs that are allowable under the program.

Almost all of the problems encountered in the administration of Medicare in connection with retroactive denials and other arbitrary and capricious actions have resulted from the Department's attempt to protect the so-called "reasonable cost" formula. These actions have caused, in turn, a phasing down by most ECF providers who have not dropped the program altogether.

I know that you were one of the first to oppose the present reasonable cost formula under title XVIII. I know that you attempted to have a different type of cost related reimbursement enacted for title XIX in 1967. At that time ANHA was leary of this because we thought it would impose the same so-called reasonable costs under title XIX.

We admit we were probably wrong. We are willing to join with you in fulfilling the idea you, Mr. Chairman, first put forth in 1966. No health delivery system can work that is based on the present reasonable cost concept. Everyone recognizes this, few admit it, and still less are willing to try to do something about it as you tried to do.

One of our national officers, who happens to represent the nonproprietary member facilities conference, recently stated:

> The corporate structure of a nursing home should have little or no effect on the type of care rendered a patient. Patient care is a matter of philosophy and personal motivation on the part of those rendering it. To group all of the homes who do not pay taxes and have a not-for-profit corporate structure together as an entity and claim that because of this particular corporate structure they somehow render better care than privately owned or proprietary homes is absurd.

In fact, the American Rehabilitation Association made a study and comparison of the welfare program of the State of Minnesota as administered by the nonprofit and proprietary nursing homes in the State in 1968. On the basis of its study, the ARA concluded that the form of corporate organization, i.e., whether proprietary or nonprofit,

had nothing to do with the quality or quantity of care given. A similar study undertaken by the New York State Welfare Department several years ago came to the identical conclusion.

No Criticism of "For Profit" Medical Profession

Why should nursing homes be criticized for providing care to the aged ill when doctors, dentists, nurses and other health professionals are not criticized for rendering patient care for a profit? We respectfully suggest, Mr. Chairman, that profit-motivation and good patient care motivation are not diametrically opposed to one another. We believe the proprietary nursing home has and will continue to make a contribution in the care of our elderly. We respectfully suggest the time has come to challenge the system, instead of the provider. Let us put our energies together to improve the system and make it work better in providing better patient care, rather than misdirecting our energies in an effort to undermine the foundation of our health delivery system.

Now turning to the issues for which this hearing has been called, the American Nursing Home Association, its State affiliates and members have been moving forward in an aggressive manner to search out solutions to problem areas. We have made much progress in achieving a full partnership status in today's health care delivery system. Our member facilities have made many advances and developed a number of unique and innovative programs that center on patient care needs and rehabilitation.

ANHA was instrumental in the drafting of the intermediate care facilities provisions in Medicaid in 1967 and we put all efforts into having the program enacted. Originally, we asked that the medically indigent be included and that the program be placed under title XIX. We were resisted in both these proposals by HEW. We are thankful that the Senate Finance Committee last year in H.R. 17550 and the Ways and Means Committee this year in H.R. 1 rectified the matter and finally recognized our position. In fact, it was always intended that some professional nursing service was to be provided in such facilities. HEW issued meaningless guidelines which we protested. Later these minimal guidelines were further weakened. Curiously enough ANHA was blamed for watering down these regulations.

In an allied area involving standards, I would like to state that H.R. 1, the Social Security Amendments Act, contains two amendments, one relating to nurse staffing and another dealing with the requirements for the licensure of nursing home administrators. These amendments have been interpreted as another effort to lower standards in nursing home care. Again, however, the ANHA Executive Board has adopted a resolution which opposes efforts to lower these standards. We have communicated these views to the House Ways and Means Committee. The American Nursing Home Association is making a determined effort to take affirmative action in specific areas which have been subjected to legitimate criticism.

In another important endeavor, Mr. Chairman, you have pointed out from time to time areas which deserve special attention. For example, in your address before the ANHA Annual Convention in Miami last year you challenged the industry to do more self-policing.

On this point I am happy to report that ANHA is increasing its efforts in this area and is attempting to encourage effective peer review within the Association. While there has been demonstrated enthusiasm for such a concept, we are still endeavoring to formulate a national policy.

While ANHA is still attempting to implement the peer review concept, I would like to point out that the Association's Executive Board and Governing Council approved in March a revision in our Philosophy and Code of Ethics which encourages member facilities to provide good patient care, employ qualified staff, to be "fair and honest in all their transactions," "to engage in research and education," and to "clearly delineate their policies and receive and act upon complaints and suggestions * * *" The ANHA Accreditation and Standards Committee is now charged with the responsibility of writing the standards for implementation of the revised philosophy and code of ethics. The ANHA is pleased with these developments and we look forward to more positive actions being taken to accomplish more self-policing.

At this time, Mr. Chairman, we would like to comment on a rather significant project which ANHA has undertaken to develop—a long-term health care plan to meet the needs of our senior citizens. I am referring to a health plan which our executive board has authorized for study and development.

This plan has been designated as CHRONICARE. We have, in recent years, been watching with increasing alarm the costs of health care move steadily upward and rapidly outpacing the cost of living, and we have become increasingly concerned about the ability of the present health care system to handle demands put on it.

Long-Term Care for Chronically Ill

After months of study we have come to the conclusion that the existing methods of financing and delivery of long-term health care for the chronically ill must be recognized and brought up-to-date. The study has prompted ANHA to develop a national health insurance program to cover patients now being served and to extend our resources to the many neglected other Americans with disabling chronic ailments not now receiving adequate long-term care. CHRONICARE was developed with two major factors as a backdrop:

1. Over the years, various attempts have been made by this country to provide long-term care for its citizens with serious chronic health problems—the older American, the mentally ill and retarded, the blind, the seriously physically handicapped and disabled.

2. The major national health insurance proposals now being considered fail to include any new long-term care provisions. At best, they leave standing the present inadequate programs. One major sponsor frankly admits the problems of long-term care were too immense to deal with at present and proposed a 3-year study to try to come up with answers.

We believe the CHRONICARE program deals with these problems. To understand CHRONICARE, it may help to look at the type of patient the nursing home has been serving in recent years.

In a 1964 survey made by the Department of Health, Education and Welfare of 54,000 patients in nursing and personal care homes, only 4 percent had conditions that would be covered under today's Medicare yardstick and yet 96 percent had three or more chronic conditions. ANHA believes that most of the 96 percent should be covered by national health insurance. Let me emphasize, today's Medicare program is operating only to cover the 4-percent patients: SSA's latest figures indicate there is only a 5-percent Medicare census in extended care facilities.

This, then, is a major part of the Nation's health problem. This is part of the catastrophe. This is what breaks families and puts them on welfare when they have a health-induced reason for being there. The long-term patient with the chronic arthritic problem, the chronic heart ailment, the chronic brain syndrome, the chronic retardation is the catastrophe. But this kind of catastrophic illness has not been included in the proposed broad national health insurance programs.

To cover the gap left by the major national health insurance proposals, to correct past neglect and deal with present inadequate programs, ANHA is building the CHRONICARE program around the following nine points:

I. Every American, regardless of income, age, race, creed or sex has a right to high-quality and convenient long-term health care or services.

II. The nature and extent of services will be determined by the needs of the patient—physical, mental, emotional, and socioeconomic—and not the structure of the health care system, the preference of the health professions, or the requirements of the financial support mechanism.

III. CHRONICARE will provide incentives for the maximum use of home, outpatient and nursing home care as alternatives to hospitalization regardless of the corporate structure of the provider or facility.

IV. CHRONICARE will be a payment system with payment for services made to provider on a per capita plus a service basis as projected by a prospective budget. The cost of CHRONICARE will be financed by a payroll deduction tax on the employer, employee, and the self-employed with matching moneys from the Federal Government's general revenues.

V. The CHRONICARE administrative structure will include consumer participation in determining facility utilization and the efficacy of services, with a formal administrative and judicial system established to assure due-process-of-law for both patient and provider grievances.

VI. A Federal CHRONICARE Administration will be created within the Department of Health, Education, and Welfare to administer the program.

VII. Individual State CHRONICARE commissions will be established with members appointed by the State governors to arbitrate all matters of CHRONICARE providers of a State relating to their prospective budgets, facility construction or remodeling, utilization of services, and other operational activities.

VIII. To secure objectivity of program information, a CHRONICARE Data Center will be established, independent of all Federal,

State or local, governmental departments, administration or agencies involved in health care administration or payment, to factually compile reports for use by the CHRONICARE administration State commissions and providers.

IX. Federal performance standards for CHRONICARE services, facilities and personnel will be established. To assure that the standards are properly reflected, a review system—implemented by a corps of qualified surveyors—will certify all CHRONICARE facilities and providers.

The preceding nine points, we hope, will assist in creating a quality, efficient and comprehensive long-term health care system for this country by utilizing all present health care resources and stimulating the development of new means to meet America's future health needs.

Mr. Chairman, as we understand it, the hearing this morning is to focus on innovative programs voluntarily being developed by members of the nursing home industry. CHRONICARE is such an innovation. It is a positive progressive answer developed by a committee of nursing home administrators—as a possible answer to the financial catastrophe of the chronically ill or disabled who require repetitive skilled but subacute treatment on an inpatient or out-reach program basis.

Properly legislated and properly administered, the concept of CHRONICARE could extend and rebuild meaningful life for that special type of American who must have repeated attention (mental or physical) to remain at a functional level of existence.

Mr. Chairman, we feel that the beneficiaries of a program such as CHRONICARE are potentially every American and we hope that such a proposal may create a health care system with which the people of this country can live.

Mr. Chairman, we are very optimistic that our efforts to develop CHRONICARE and other programs with which we are engaged will prove to be beneficial—especially in our efforts to provide better patient care for the elderly ill. We believe we can accomplish our goals in the not too distant future.

Mr. Chairman, we thank you for the opportunity to share our views with you and the subcommittee. The American Nursing Home Association and its member-affiliates stand ready to join with you and others to meet our health care needs. We commend you, Mr. Chairman, for the leadership role you have played over the years to implement and perfect long-term care health programs for the elderly of the Nation. We are hopeful as we move into a new era that by working together we can bring about a unified effort to provide the type of long-term care our elderly citizens so richly deserve.

Senator Moss. Thank you very much for that fine statement. CHRONICARE is a very interesting proposal for long-term care providing a broad spectrum of service for those chronically ill in our society. I am studying it and I commend you for bringing that innovative concept here and putting it in our records so that we will be able to determine whether it is ready now for introduction to the Congress. I am grateful to you.

Mr. WILCOX. Thank you very much.

Senator Moss. Thank you very much. We appreciate your appearance.

Mrs. Florence L. Baltz, former president of the American Nursing Home Association and president, Washington Nursing Center, Inc., Washington, Ill.

Welcome from Washington to Washington.

STATEMENT OF FLORENCE L. BALTZ, FORMER PRESIDENT, AMERICAN NURSING HOME ASSOCIATION, PRESIDENT, WASHINGTON NURSING CENTER, INC., WASHINGTON, ILL.

Mrs. BALTZ. Thank you, Mr. Chairman.

I would like to submit my complete prepared statement which includes eight exhibits.[1]

Senator MOSS. That may be done. We appreciate it.

Mrs. BALTZ. I welcome this chance to appear before you to discuss some aspect of good patient care in nursing homes. I am testifying here as an experienced nursing home administrator of 20 years. I am a registered nurse and have 9 years hospital administration experience.

Today I wish to emphasize two positive programs which I feel have assured patients in our nursing center of good care. The first one is the rehabilitation nursing program and second our weekly nursing care rounds.

As you see in exhibit I,[2] "Rehabilitation Program Is Education for Living," which is a detailed report on a 1957 demonstration project called rehabilitation education service, Washington Nursing Home was one of the first to participate in the project. Today this program continues to be a major part of our nursing service.

SELF-HELP STRESSED IN REHABILITATION PROGRAM

Rehabilitation means a variety of things to many people, but with us it means to help the patient to do more for himself and to become a more independent person. We see and treat patients as a whole person and stress their abilities and not their disabilities. We must understand the patient as an individual, a member of a family and community; we must understand his demands and sense his needs and help him to realize that he is still important and make him feel that someone sincerely cares. At times it seems easier to see what a patient cannot do for himself. In rehabilitation one must recognize what the patient can do without help—many times these are things he has not done for himself in years. When a patient does for himself, he uses his own muscles which helps him to feel stronger and begins to do more of his own care and activities. While he is doing more, he is making use of his mind as well as his body and he becomes more alert and interested in people around him.

We chose the rehabilitation nursing aspect to concentrate on patient care because it is a 24-hour-a-day program which includes a strong in-service training program for all employees. We use our registered physical therapist and other specialists as consultants to strengthen our nursing program, which makes their service available to all patients. Rehabilitation nursing is included in our daily rate so whether the patient is private pay, Medicare, Medicaid, or has insurance, it makes no difference financially to management or staff.

[1] See app. 1, p. 1816.
[2] See app. 1, p. 1821.

When a patient is under the Medicaid program, we receive an allowance for an approved rehabilitation nursing and activity program. While this usually is below our customary rate it does give some financial reward for the cost of the program as all patients benefit and the homes are not penalized by getting them to do more themselves. This approval is granted by a team of specialists from the Department of Public Health. There is an occupational therapist and a rehabilitation specialist and a physiologist and regional health and dental health personnel on the on-site visit. No longer is this a voluntary or extra program but is considered a part of the total patient care.

Written into the Illinois licensure laws, the hospitals must have a rehabilitation nursing program, the skilled nursing homes must have rehabilitation nursing and activity programs, and sheltered care homes must have an activity program. Illinois will need more teaching teams to train staffs in all these facilities.

Still Only Two Teaching Teams

Today, 14 years after Illinois' original rehabilitation project, we still have only two teaching teams with one less number on a team to go into homes and teach rehabilitation nursing techniques. They have about a 4-year waiting list of nursing homes wanting their services. If some of the money being made available for inspectors could be used to recruit and train team members to go into homes and teach staff members throughout the United States as we have in Illinois, I am sure you would see patient care improve as well as a reduction in medical care cost. As you will see in my prepared statement,[1] admission, length of stay, and additional discharge information. We have discharged 53 patients, or 33 percent of our discharged patients, to their own homes.

We have three rehabilitation nursing courses being offered in Illinois for registered nurses. The one I am familiar with, which incidentially is an excellent course, is in Peoria at the Institute of Physical Medicine and Rehabilitation. This is a 3-week course and in November they are accepting their first licensed practical nurses for a 1-week course.

Aides carry out the majority of care and techniques, so we sent the RN's and the LPN's to increase their skills in teaching. Now teaching skills is easy but the philosophy is harder to come by but an absolute must in an on-going successful program. That means even the maintenance, laundry, housekeeping and all other personnel must be involved in inservice training.

Several States over the years have patterned programs after Illinois. How they have progressed, I don't know. I am sure the Illinois Department of Public Health would be glad to have others inquire as to the success and continuation of their program. Certainly more available funds are needed for the rehabilitation education service teams. As I said earlier, rehabilitation means different things to different people. This language is really intended to mean when it comes to the licensing.

The second positive program is our weekly rounds which are done by a team composed of a physician, therapists, nurses, consultants and staff members. All newly admitted patients are included in rounds

[1] See app. 1, p. 1817.

plus those that have been booked for reevaluation. This team assesses and evaluates the patient's condition, decides with the help of the patient on short and long range goals and how he is to achieve these goals. His patient care plan is developed in accordance with the necessary written orders of his physician.

While the goals are established in the presence of the patient with his help, the actual planning, prognosis and records are studied by the team members without the patient being present so that final, practical and realistic goals are set for him with each team member contributing their ideas and recommendations to help the patient realize his goals. We evaluate 10 to 12 patients a week.

The remaining couple of minutes I wish to mention two State programs which enhance good patient care in Illinois, the first one being the Sangamon-Menard County continuity of patient care program. The purpose of the program is to improve continuity of care of patients who move from one institution or agency to another in these counties; to send with the patient, at the time he moves, information about his medical orders and nursing needs, his personality and his abilities; to help make his transition smoother and less traumatic.

Continuity of care refers to planning together by all members of the health team with the patient and his family so there will be no break or lapse in his gradual restoration to health. The coordinator meets with the Utilization Review Committee of the hospitals and nursing homes. By better utilization of beds, not only improved care is realized but one day earlier discharge from the hospital and/or extended care facility can mean the saving of thousands of dollars over a year's time. As recently as Tuesday, Governor Ogilvie announced a new program and set by establishing a set length of stay. On diagnosis they hope to save one less day of hospital care for the medical patient which would save an estimated $12 million a year.

Also, patients benefit from having adequate and proper transfer information immediately available upon his admission to insure continuity of care.

The other State program is a response to the edict issued by President Nixon to Federal health agencies to improve the nursing home industry. The Illinois Department of Public Health has developed an automated system to assist in more effectively meeting its responsibility. This is detailed in my prepared statement. This is a mechanism that can be used for both the delivery of health service and safety of patients in a long-term care facility.

Also, note my few comments on Medicare.

In summary, the material presented for the record contains programs within a facility and within the State of Illinois which can enhance good patient care throughout the Nation.

Senator Moss. Thank you very much.

I am pleased by the way you are all finishing right on the 10-minute deadline.

That is an excellent paper. I was impressed with the fact that you said 33 percent of your discharged patients were discharged to their own homes, and certainly that ought to be an objective that we strive toward.

In some of our hearings we have run up against the fact that commonly there is higher remuneration for patients that are bed bound

and there is accordingly sort of a tendency to keep them that way and keep the larger income, whereas the whole thrust of what you are telling us is this evaluation and effort to get them up. Making the patients ambulatory and in a condition where they may be discharged to their own homes is commendable, since naturally that is the preferable place for them to go.

Mrs. BALTZ. It is a very challenging aspect.

Senator Moss. That is fine.

I am pleased to have you also tell us the efforts of the State of Illinois with its licensure requirements that are certainly pointed in the right direction.

I thank you very much for coming to tell us as you have about not only your own home there in Washington but also about the whole Illinois program.

Thank you.

Mrs. BALTZ. Thank you.

Senator Moss. Mrs. Ethel Hudson from Shoshone County Nursing Home in Wallace, Idaho.

Mrs. Hudson is a neighbor of mine, next State north.

STATEMENT OF ETHEL HUDSON, DIRECTOR, RESTORATIVE ACTIVITIES PROGRAM, SHOSHONE COUNTY NURSING HOME, SILVERTON, IDAHO

Mrs. HUDSON. I am privileged to be the director of the restorative activities program at the Shoshone County Nursing Home, Silverton, Idaho. I am equally privileged at being selected to appear before this distinguished committee.

I wish to take this opportunity to commend this committee for its efforts to bring the positive aspects of nursing home care of the aged to the forefront.

On behalf of our patients, our nursing home staff, the peoples of Shoshone County and of the State of Idaho, I express to you our deepest gratitude for this opportunity. We all sincerely hope that our contribution to this committee's efforts will bear fruit in the form of constructive ideas aimed at bettering the lot of the aged nursing home patient.

The philosophy of patient care at our nursing home is simply this:

The total care of our patients is the only reason for our existence. Every effort of each member of our staff must be aimed toward this end.

Total care of the patient includes all efforts required to provide an environment which contributes to the mental, physical, emotional, and social restoration of the patient to a normal, dignified individual.

My contribution to this total care effort rests with the restorative activities program. This program is specifically tailored to fit into other patient care programs such as nursing, dietary, care of the physical plant, and the outside volunteer effort, all of which effect the restoration of the aged patient.

Prior to December 1968 there was no activities program. Until the program was initiated, our patients had little to look forward to except eating, sleeping, and dying.

Before the restorative activities program was initiated, historically two-thirds of our patients were of the "heavy-care" variety. This

simply means that aside from being substantially bedridden, these patients needed assistance with eating, with taking care of their hygenic needs, and were convinced they could never advance mentally or physically toward more normal lives.

After much soul-searching on the part of the medical and nursing home staffs, interested volunteers, and the administration, the realization was discovered that a program of patient activity was needed to more successfully render total patient care.

I should add at this point that before initiating the program the attitudes and the philosophies of patient care were aimed at keeping the patient as comfortable and as quiet as possible. This was thought to be the total effort required. This mode of operation did absolutely nothing toward encouraging or challenging the patient to become self-reliant and as independent as his ability permitted.

Before proceeding further, I wish to say that a large measure of the success that we have experienced with our program is due to the direct, faithful, and cheerful assistance we have received from the volunteers. These interested and concerned citizens of our community give very freely of their time to assist us in every way and on every occasion we need them.

Perseverance Gains Results

At the beginning of the program in December 1968, meager results were indicated, small promise of success was in sight, and an air of skepticism prevailed. However, due to the perserverance of a few staff members, including the program director, and due to the interest of a very few patients, the program began to show slight growth.

Beginning with two 1-hour craft classes each week, attended by only three patients at each class, these craft sessions grew to three 2-hour classes each week, with an average of 35 patients attending each session. Less than 15 months from the beginning of the program the activity room had to be doubled in size. At present, this room is too small and must once again be enlarged.

I want to make one point absolutely clear. None of our patients are ever forced to attend any activity. They are encouraged by concerned members of the staff and by other patients, but this is of the gentle type absolutely void of badgering, pestering, or other such questionable means.

By the end of 1969, movies and bingo sessions were scheduled once per week, at separate times. The attendance at each of these sessions increased from the beginning of five patients at each session to the capacity audience of 40 at each session presently.

During 1970, social hours—cocktail parties at which light alcoholic and nonalcoholic beverages were available—picnics, birthday parties, and like events were scheduled. At these occasions free live music, compliments of the local civic groups and the musicians union, playing the older traditional songs, are made available. The patients themselves furnish the singing and dancing to enliven these occasions. These activities added social confidence to our patients, and brought back many of their earlier, pleasant memories. This, in turn, whets their memory recall, thus enhancing their mental alertness.

In 1969, one of our "heavy care" patients, a chronic, severe arthritic, produced a four-act play depicting the birth of Christ. The actors,

directors, and stagehands for this play were patients. Actually only one performance was scheduled but due to demand and to limited seating capacity four performances were given with a total of over 600 patients, staff, and public attending.

Other special accomplishments of our patients include:

Fishing, fly-tying, cabinetmaking, and furniture repair and finishing by one of our patients, a paraplegic;

Huckleberry picking, winemaking and to-scale dollhouse making by another of our patients, a double amputee;

Maintenance of a patriotic flower garden which keeps four of our patients busy during this season;

Other activities too numerous to mention.

We have recently installed a chapel for use by all denominations. Aside from worship services, this chapel is used for prayer and meditation, as well as an area for patient-family-minister solace and conferences. The finished decoration and the drapes for the chapel will be completed by the patients.

We hope soon to acquire and install a six-leather-pocket pool table for the use of our men patients.

Each week at a scheduled period we have a session of card playing for men only. At these sessions the men patients play poker, pinochle, cribbage, and so forth, for 2 hours. Although money is not involved, chips are used for example in poker. The one who finishes with the most chips, the highest score, or runs the cribbage board most, wins a six pack of beer to take to his room to consume at his leisure, with his physician's permission.

The workload of our restorative activities program coupled with our patients' demand for more activities, required the addition of an assistant activities director. We were fortunate in having available a lady who was not only compassionate and concerned for the betterment of our patients but was highly skilled and experienced in the art and the teaching of sign language. She taught the deaf and dumb muted patients and the staff the basics of this language. This, of course, opened new channels of communications and improved immensely the outlook of the affected patients.

In addition, the assistant activities director uses the craft cart to take craft work to patients unable to attend craft classes.

Astounding Results

The results of this program have astounded us. During the period December 1968 to date, the "heavy care" patient load of 67 patients has been reduced to nine "heavy care" patients. Well over two-thirds of the patients admitted to our facility are considered "heavy care" at the time of admission.

Our patients, who average 81.9 years of age, have taken a new outlook on life. The rather heavy Restorative Activities schedule, which is geared to patient interests and demands, gives our patients little time for idleness or for worrying about their condition or their problems. Due to a natural fatigue resulting from this active schedule our patients are, for the most part, sleeping naturally and without the use of sleep-inducing medications.

The most rewarding aspect of the program is to see the alert, contented expression on the faces of patients who once wore a constant expression of one without hope or any other meaningful expression. We have had patients actually cry when leaving at discharge because they did not want to leave their "home."

Our Restorative Activities program, despite what we feel as a phenomenal success, does not meet any particular criteria of State Licensure or Medicare Certification requirements. Rather, we designed it to meet the needs of our patients. This program is under constant review for purposes of change when such change will better meet the needs of our patients.

It is interesting to note at this point that Medicare surveyors, while acknowledging the accomplishments of our program, consistently criticize our facility for not meeting their technical requirements regarding such programs. For example, we have no Master Social Worker or Registered Occupational Therapist on our staff or on a consulting basis, as Medicare requires. In remote areas, such as our own, these specialists are virtually unavailable, except at prohibitive costs. At the present time our program costs 31 cents per patient day. Provided we fulfilled the total requirements of Medicare, this program would cost a minimum of 75 cents per patient day.

We have been blessed with great success with our program in terms of more closely approaching total patient care. We at the Shoshone County Nursing Home stand ready to pass on our experiences and techniques to other facilities and other agencies who are interested in them.

I have some slides and if I have time I will show them.

Senator Moss. Yes, you still have 3 or 4 minutes.

Mrs. HUDSON. This is a picture of our nursing home. You can see the flower garden that the patients worked in.

This is one of our picnics we have each month—one each month during the summer.

Another view of the picnic.

The men at a picnic.

This is some of the volunteers who helped at the picnic.

This is some ladies getting ready to go to the St. Patrick's Day party.

This is a birthday party.

Another birthday party.

This is at a baby shower one of the patients gave at the nursing home.

That was her great-great-granddaughter, she gave her a shower.

This is a picnic.

This is a picture of the poker party.

This is the one I was telling you about the patient writing the Christmas play.

There are the three angels.

Three wisemen.

The shepherds.

And this is the manger scene.

Senator Moss. Well, thank you. Those were very interesting pictures and they illustrate your statement. I think it is a very happy and heartening report. It pleases me immensely to have you point out that in a period of a few years you have made such tremendous changes

in the outlook and the welfare of those who reside in your home. I am sure you must have a great esprit de corps.

I received a telegram directed to me that said:

"Send our deepest gratitude for your interest and concern to the aged and nursing home patient. To our Ethel Hudson we send our best wishes for a successful, convincing appearance before your Committee."

Now you fulfilled your part of the bargain, you have done very well. This is signed by all those people (indicating).

I think that illustrates a point that is very important, and that is that you have a group of people who are really concerned about doing for those that they serve in the nursing home.

Mrs. HUDSON. We have wonderful people out there.

Senator Moss. Well, it indicates it is not just a routine job that they do and get off shift when it is time, they are really concerned with our functions, and I think that is wonderful.

We appreciate your testimony very much.

Mrs. HUDSON. Thank you very much.

(Applause.)

Senator Moss. Thank you. She deserves that.

Senator Moss. Mr. Harvey R. Wertlieb, administrator, Randolph Hills Nursing Home, Wheaton, Md.

Mr. WERTLIEB. It is nice to feel you are doing a good job but it is wonderful to be appreciated.

Senator Moss. It is, indeed.

STATEMENT OF HARVEY R. WERTLIEB, ADMINISTRATOR, RANDOLPH HILLS NURSING HOME, WHEATON, MD.

Mr. WERTLIEB. Mr. Chairman and members of the Senate Committee on Aging, I am honored to be able to address you today. My name is Harvey Wertlieb. I am presently the administrator of Randolph Hills Nursing Home and have been a nursing home administrator for over 7 years. I have a master's degree in hospital administration from George Washington University. At the present time I am also an assistant professional lecturer at George Washington University in long-term care administration. I am the president of Health Facilities Association of Maryland and am a fellow in the American College of Nursing Home Administrators.

I might add that my students all volunteered to come here today.

Senator Moss. We are delighted that they are here; we are glad they wanted to come.

Mr. WERTLIEB. Thank you.

FAMILY INTERVIEWS

One of my main duties as an administrator in a nursing home is to interview families who are placing their relatives in the facility. In effect, the nursing home administrator becomes an advisor to the family and must analyze the situation and suggest the proper placement for the prospective patients. Over the past 7 years I have become acquainted with several instances where a patient would benefit from a structured daily supervised program but who should not have to remain in the facility overnight. Some examples would be

couple living at home, one of whom is debilitated and needs constant supervision. The other is capable but is tied to the home 7 days a week, 365 days a year.

Another instance is where the older person is living with his or her family but has no peers to stimulate him or her during the day. A structured program such as ours is very beneficial 1, 2 or 3 days a week. This is good for the elderly patient living with children who work every day. This person may need the proper diet, the proper medication regimen, and again some social stimulation to lead a healthy and satisfying life at the day care center and go home evenings and be with his or her family.

Lack of Medicare and Medicaid benefits have also made this program essential. Patients whose Medicare benefits have been discontinued on short notice must leave the institution because they cannot afford the costs on a long-term basis but they find that he or she needs to have constant supervision, specific treatments such as injections, medication regimentation, physical therapy, speech therapy, occupational therapy, and other medical services. These services, already being provided by the extended care facility, could be utilized on an outpatient or day care basis at a reduced cost to the Government program. At the same time more beds would be filled up without costly construction and duplication of resources.

This concept is not really new because in England Dr. Cosins has established a very active day care program.

After several years of contemplating the problem we at Randolph Hills Nursing Home—our director of patient relations, medical advisor and members of our nursing and dietary staff—developed an experimental program for day care for chronically ill patients. A description of the program follows:

The day care program at Randolph Hills Nursing Home operates according to the procedures set up for inpatients. All patients are under the care of an attending physician. A nursing chart is kept and all medications and treatments are administered by professional personnel at the direction of the physician. A very active activities program is available and every effort is made to encourage the patient to get involved. A typical schedule of events would be as follows: The patient would check in with the charge nurse on duty between 8 and 8:30 a.m.

He or she would immediately be made comfortable and given our continental breakfast which is a routine part of our four meal a day plan for in-patients. After this snack the patient is able to watch the morning TV shows, read the daily paper available to him, or another similar activity. At 10:30 our brunch is served and the patient will eat with other patients in our main dining room. After brunch, it is time for one of our daily activities programs which could be any of the following: Arts and crafts, reading groups, discussion groups, Bible class or special projects.

Every afternoon another activity is planned such as: Singalongs, movies, bingo, or special programs such as visiting musical troops, dancing schools, or visiting friendly neighbors. At 3:30 dinner is served. Sometime between 4 and 5:30 the patient is picked up by his family.

I have included a sample schedule in my statement.[1]

Mr. WERTLIEB. Please note that the program is very flexible and that a person could schedule the program on a daily, weekly or even partial daily basis.

As far as the staffing is concerned, at the present time we are able to utilize the personnel already on the job and have not had to increase our staff. However, if we did, one of our goals would be to utilize key professional people available and not add more of these positions unless the case load would overwhelm us. We have on our staff at the present time a director of patient activities who is a certified occupational therapy assistant, three registered physical therapists, a speech therapist, a director of nurses and R.N. supervisors 7 days a week as well as an A.D.A. dietitian. All of these people are active in planning and supervision of the day care program along with the responsibilities for our inpatients.

The average extended care facility today after having geared up to professional staff levels finds that there is an under-utilization of these people because the Medicare program disallows most services provided by them within the institution. We find that we have more professional staff and less patients for them; therefore, the day care program would insure the more proper utilization of our staff.

DAY CARE BENEFITS

I would like to give you some specific examples of the kind of patient who would benefit from the day care program. We have some actual case histories.

Case A.—Mrs. K called the nursing home in tears and told us she has been caring for her husband who is a retired colonel in the Army for several years and has been unable to get someone to come in and stay with him. He is suffering from severe arthritis and has periods of senility. This is a very devoted couple, and she wants to care for him at home but she can't leave him to even go to the store. We suggested that he come into the home on Tuesdays and Thursdays so that she could get her chores done and also be able to get some rest and relaxation. This proved very successful and both the husband and wife were able to live a more normal life than they had before.

Case B.—Mrs. Y was living with her mother in an apartment. Mrs. Y had to work and her mother had developed Parkinsons and other illnesses that require specific medications at specific times. She also discovered that her mother was not eating properly and was subject to blackouts while home alone. Mrs. Y had already used up all of her annual leave while taking care of her mother and she, too, could get no one to come into the home on a regular basis. Her doctor recommended our day care program and it was very successful in allowing Mrs. Y to keep her job and keep her mother healthy and her mind at ease.

Case C.—Mr. J retired from the telephone company after 30 years and found his health and mental condition going downhill. He sat at home and watched television for 4 years while his wife continued working toward her retirement. He started having spells of depression and crying and was very despondent. He came to our day care program

[1] See app. 1, p. 1854.

and got interested in several hobbies and before long a noticeable change had taken place. He was also able to go home and stay with his wife.

Case D.—We have a male patient, 45 years of age, who had incurred an injury on the job and had been confined to hospitals and mental institutions for more than a year because of the injury. He improved to the point where his main disability was Jacksonian seizures if the proper medication was not followed. He could not be left alone because he also had a memory problem so he could not take his medication properly. His wife had to work and no one was in the home. This man would have had to stay in the institution if no place could be found in the community. Randolph Hills Nursing Home was called by the patient's insurance company. This man is thriving on our activities program, is receiving the necessary medication and supervision, and is able to spend evenings and weekends with his family.

We encourage our patients to go home if they are able but we also find there are many patients who need the constant supervision that the nursing home can provide but who also could live at home if these factors were provided. The program is able to meet the social and medical needs of the individual and his family while maintaining a place for the patient in the community..

There is also the potential that there might be a very great savings in cost to the patient and to society as a whole. However, there are many problems associated with the expansion of this experimental program.

Senator Moss, I would like to allude to a statement that you made back in 1965 when the Medicare bill was first proposed or was being voted on and probably passed and you warned society and the providers and everyone else concerned that the Medicare program was not a nursing home program, it was a program to take care of the acute short-term needs of chronically ill patients.

Senator, it has taken 6 years for the United States and our society to wake up to the fact of what Medicare really is, and finally we have cut back the program to where it probably should have been in the beginning to take care of a far lesser percent of our elderly patients. But there are many, many more older people in our society that need the constant supervision that was provided by the Medicare program and the Medicaid program.

My own fear with expanding the home care program or the day care program is that too many people use it. Again the program would probably be cut back because it would be too costly.

Prohibited Use of Key Personnel in Dual Role

In addition to the cutbacks in the Medicare and Medicaid programs the State licensing authorities do not allow us to use key personnel in combinations of services. An example of this is the home health concept. Even though the extended care facility has the key personnel available for the administration and development of the program in order to be certified as a home health agency, we must have a duplicate office, director of nurses, a duplicate physical therapist and, in fact, a duplication of every service already provided by the extended care facility.

Another inequity is that the patients being treated by a physical therapist under Medicare cannot be treated by the same therapist under part B unless the patient moves down the hall to another section of the same facility. At the present time our three physical therapists are not allowed to treat patients on an out-patient basis because of the above problems. This is true for occupational therapy, speech therapy, and all other medical services available.

Just think what a savings it would be if the patient was able to come into the community based nursing home for a needed injection instead of having a visiting nurse travel to the patient at a cost of $23–$27 per visit. What I am really saying is that where the institution perceives a need to fill a void, has qualified staff, is willing to develop a program—sir, our system destroys all incentive, initiative, and practical realization for that program. Some of my observations follow:

1. Many nursing homes in the country could establish a day care program for five to 10 patients within existing space and staff requirements under Medicare and Medicaid.

2. An extension of a day care program to 15 to 25 patients a day is not unrealistic with some expansion of staff and facility.

3. The inclusion of a day care program under Federal programs such as Medicare or Medicaid. I am certain, would save some money but more important it would allow two more important factors:

(A) It would insure better utilization of health care resources already available without greater expansion.

(B) It would help solve a sociological need of many patients who desire and are able to maintain more active contact with their families and friends.

Mr. Chairman, I suggest, as a member of the nursing home profession, that we are willing and able to make changes and innovations to meet the needs of our patients and their families. Randolph Hills Nursing Home day care program at the present time is a miniscule part of the changing process but with a lot of work and study the concept could be one more spoke in the health care spectrum the public wants and we want to provide. But we can only mark time unless the Government officials change their attitude and stop passing the buck. Assume responsibility, make some decisions, and let us work together in partnership to meet the solutions to the problem.

Senator Moss. Your description of the day care services is an innovation that certainly is most welcome. I can see the possibilities from that, and the case histories you recited are people who fitted exactly that kind of need. So this is fine. I think we ought to give our attention to considering amendments to titles XVI, XVIII and XIX of the Social Security Act to perhaps cover that day care function in order to encourage its use in other parts of the country. It sounds very good.

Mr. WERTLIEB. Thank you.

Senator Moss. Thank you. I congratulate you on a good statement and I am grateful you came.

[Applause.]

Senator Moss. I think the class gave the professor a good mark.

Mr. WERTLIEB. They need a good grade.

Senator Moss. Mr. Marshall N. Horsman, Administrator, Beaumont Convalescent Hospital, Beaumont, Calif.

Very glad to have you, sir.

STATEMENT OF MARSHALL N. HORSMAN, ADMINISTRATOR, BEAUMONT CONVALESCENT HOSPITAL, BEAUMONT, CALIF.

Mr. HORSMAN. Mr. Chairman and Members of the Committee, I am Marshall N. Horsman, Administrator and President of Beaumont Convalescent Hospital—which is a 62-bed hospital, I might add—Beaumont, Riverside County, Calif.; member, California State Board of Examiners of Nursing Home Administrators; also, member, Board of Directors, California Association of Nursing Homes.

Today I wish to give examples of positive and innovative ideas in providing compassionate care to the aged and chronically ill patients in our facility.

First Example. In 1967 we started a plan whereby the staff of nurses voluntarily agreed to play the role of a patient for 24 hours so they can better understand the problems of the patient. It works this way. Three nurse aides from the staff were selected to assist in coordinating the project. As beds are available, staff aides are selected and scheduled to become "patients." A nursing care plan with fictitious diagnosis and other chronic health problems are described, along with orders for special diet, treatment, bath schedules, etc.

On the day of admission, the "patient" is met in the parking lot and brought in by wheelchair to her room. She is helped into the patient gown, the usual hospital type open in the back, and put to bed. She is greeted by the administrator and the director of nurses and made comfortable by the aides. The ward clerk fills out the admitting forms and a chart started.

A nursing care plan for each "patient" is filled out, which includes a diagnosis of a typical problem, such as stroke, with paralysis of the right side. She may be described as aggitated and confused with a salt-free soft diet, as may be ordered by her physician.

SENSITIVITY TOWARD REAL PATIENT

An amazing awareness generally comes over the "patient" as he lays there pondering his new role and a new sensitivity towards the feelings of the real patient is the result. We do this role playing in earnest with no special favors or horseplay allowed. The aid is paid for a normal day's work while participating in the project.

When the "patient" is prepared to take a shower, and transferred from the bed to the mobile shower chair, draped with a flannel sheet and taken down the hall, it becomes evident to the "patient" for the need to be carefully draped for complete privacy. How humiliating it would be to be even partly exposed while going to the shower room.

When put to bed for the night, how important it suddenly became to be given a smile, a reassuring word. During the night, the sound level of nurses talking in the halls and squeaky carts became so obvious.

At meal time, the manner in which food is delivered and the words spoken can set the tone for the acceptance or rejection of the meal.

At the close of the 24-hour role-playing experience, the nurse is asked to fill out a questionnaire—and I have attached a questionnaire at the end of my statement—giving her reactions to the care given and suggestions of better ways to improve our care.

Thus, having experienced a brief insight into the problems of being a "patient" from their point of view, by observing the sights, the

sounds, the smells—our staff has developed a much closer relationship to the patients they serve, with a more acute awareness of their needs; their feelings of being wanted, loved, respected.

Attached are exhibits of the evaluation form, the project as published in Western Care, May 1969.[1]

Mr. HORSMAN. Now the *2d example.* In an effort to bring a fuller life to patients, we take them on fishing trips to a nearby trout farm. This requires a bit of logistical planning, with permission from each patient's physician, a picnic style lunch with some special diet foods included, and sufficient staff and volunteers to supervise care away from the facility. We even take camp stoves and fry the fish for lunch, then refrigerate the rest to save for later. I can't begin to tell you of the joy and therapeutic benefit this brings to those who are able to go on a trip like this.

I might mention out of 62 patients there are probably about 10 that are able to go on such a trip.

With all respect to physicians, I must say that these trips provide a form of therapy unequalled by many medications. A few photos are attached.[2]

Mr. HORSMAN. The *3d example.* Similarly, we purchased a special ambulance type stretcher in order to take invalid and bed-ridden patients on rides in our station wagon. This breaks the monotony of staring at the same four walls and brings hope and cheer by seeing familiar sights of their community, schools, churches, shopping centers, the countryside, trees and animals, etc.

4th example. We have a Volunteer Service Corps, similarly as hundreds of facilities have. We have 27 members, which includes 3 men, all under the direction of a full time Activity Director, who also has organized a Teen Volunteers with nearly 16 high school girls who come on a regular schedule to provide activities and services above and beyond the routine nursing care. In addition to what you normally might expect from such a program, we arrange for young children and even babies as you saw on the slides that were shown earlier. We arrange for these babies to visit patients on a regular basis, as this enriches the life of the aged and ill. It is important that they come regularly over a period of time so the elderly patients can follow their growth and other activities, which gives them something to look forward to. We call this our "Adopt a Grandma Club."

5th example. So we can better evaluate services to our patients, we send a questionnaire form to each patient and/or his family during the stay and again 2 weeks after discharge, asking for objective reaction to the care received as to: nursing, dietary, housekeeping, administration and their physician. We get valuable feedback which is then shared with our staff. I might say parenthetically we photograph some of these and send them on to their physician. The questionnaire need not be signed, if they wish to remain unidentified. The majority, however, do sign their names.

These and many other examples of worthy projects could be given from the various States. We will continue to develop newer and better programs for a "better life" for our long-term patients.

I almost forgot, Senator Moss, as a result of the first project I described of the staff playing the role of the patient, one of our nurse

[1] See app. 1, p. 1856.
[2] Retained in committee files.

aides developed a private enterprise business. While she was laying in bed there for that 24-hour period in that white muslin type gown that is open in the back with the strings, which is a rather degrading experience—have to have it open in the back—she thought up the idea for a whole new line of patient garb involving pretty colors and pattern and little lacy things that still open in the back but use the Velcro type snaps, Her name is Sally Patterson and she calls it Sally Ho of California and distributes them around the country. I thought that was very exciting to have one of our nurse aides, fairly low pay, develop a whole business out of this.

Senator Moss. Well, thank you. You certainly do have many examples of innovative care for people to accomplish what is really the objective purposes; not to care for them and feed them and keep them in bed, it is to revive and stimulate and keep their interest alive in the things about them and the people about them and this feeling of worth which we all need in order to be happy. I do commend you. This adds greatly to our record and it makes it seem so much better as to what we are doing now in some of our nursing homes. We have come a long way in the last four or five years, and we can come a long way further yet.

Thank you very much.

Mr. HORSMAN. Thank you for the opportunity.

Senator Moss. I see Stanley Wilcox on here again and this time he is going to be talking as president of Cedars, Inc., of Charlottesville, Va.

We are glad to have you back with your second presentation.

STATEMENT OF STANLEY WILCOX, PRESIDENT, CEDARS, INC., CHARLOTTESVILLE, VA.

Mr. WILCOX. Thank you, sir. I am still Stanley Wilcox from Charlottesville but I wanted to talk about my own project for just a few minutes.

The project is called the Towers Continuing Care Facility, and it is a six-story building across the street from the University of Virginia connected by an umbilical cord to a medical office building which is an eight-story building. It is a private, taxpaying institution which we own and operate.

In the beginning of the brief summary that I supplied it tells basically the functions on the floors.[1] Our ground floor has a pharmacy, medical records, and laboratory.

The first floor has admissions; transportation; rehabilitation in both speech and hearing, physical therapy, occupational therapy, and activities of daily living; patient dining room; gift shop, beauty shop and a chapel.

On the first patient floor, the Towers second floor, is a connection to that medical office building I mentioned, a full diagnostic X-ray department, and basically the beds on that floor are all related to the orthopedics primarily in process and brace work and this type of thing.

The Towers third floor is basically internal medicine, which includes dialysis as well as internal medicine and other diagnoses.

The Towers fourth floor is for general admission from other hospitals in the area.

[1] See app. 1, p. 1861.

Our fifth floor is basically a psychiatric floor.

The posture of this new facility is one of a subacute general hospital which does not conflict but supports the two acute hospitals in the city by supplying complementing services at significantly less cost per day.

Where Is the Crisis?

Congressional legislators and the administration are talking to themselves and the press about the crisis in health care, but where is the crisis? Acute hospitals are doing well and expanding, so where is the crisis? Doctors are busier than ever, so where is the crisis? The crisis is in the total cost of individual illness to be met by the individual taxpayer. The crisis includes the premium dollars the public must pay for third-party protection or Medicare protection in a poorly structured health delivery system.

When national health insurance comes, it will have to address itself to this basic problem. Health organizations must reorient their thinking to the delivery of services in a suitable and matching environment—be it the home, supervised residential living, or the ICU of an acute general hospital. "Services related to environment" is the problem that must be resolved.

In Virginia, in a comprehensive Health Region 10, we are fortunate in that we do have many of the piece parts required to structure a comprehensive health plan. The Towers Continuing Care Facility needs to be used by the medical community if the cost per illness is to be controlled and if the higher cost acute beds in the region are to be used effectively.

At the outset let me say that the Towers Continuing Care Facility has been designed and built specifically to support the University of Virginia Hospital and insofar as possible to be an integral part of the University's medical center. This, however, does not mean the proper use by other facilities in the area would not be welcomed; they are.

Direct supporting services for the above mentioned facilities of course means on-going therapies including speech, pathology, and activities of daily living therapy. Our Hubbard tank unit will directly support orthopedics, neurologic, and plastic surgery cases from any acute institution. Our renal dialysis unit will afford advanced training in the mechanics and use of these machines for acute patients on their way to a home setting. A periphery service is transportation, at no additional charge, between the continuing care facility and other institutions as the need arises.

The delivery of health care to the community has gradually and finally taken on a new look. The old European idea of the "infirmary" and "lying-in-hospital" is changing toward what can be done to keep the prospective patient out of that hospital bed. Preventive type medicine to work must include established institutions being interested in clinical out-patient services both to forestall a direct patient admission and as a followthrough on post discharge cases.

Community involvement then is out-patient services in nature. Our X-ray unit will service the out-patient clinic, the children and youth center, and the clinical demands of the orthopedic-orthotics center.

Both our laboratory and X-ray units will work with the new multiphasic screening service in the Towers office building. This service has

a relationship with business employment physicals, pre-admission physicals, etc., and appears to be not only preventive in nature but predictive in nature.

The continuing care facility is heavily involved and committed to the training needs in this region; in fact, the affiliation with the University of Virginia revolves around the ability of the continuing care facility to be a significant teaching experience for both their medical students and students in the school of nursing. Resident physicians with specialties in orthopedics, internal medicine, neurology, and neuro-surgery will be part of a rotating assignment plan affording the student a 45-day experience in this type and level of care.

Sensitivity to Consumer Needs

Consumer participation: Sensitivity to consumer needs and areas of concern can best be handled by the involvement of nonconnected public spirited citizens whose level of understanding is adequate for objective evaluation. The patient and his needs are the key to public acceptance. The ability of that patient to enter the health field at various levels due to the availability of consumer oriented services should visibly enhance consumer acceptance of this project. The hospital will have a seven-member "Towers Advisory Board" made up completely of nonmedical and noninvolved consumers whose recommendations to the corporate board will be of first importance.

The summary,[1] basically of the project, is headed toward our need and function in three aspects:

1. Meaningful rehabilitative care;
2. Significant cost control per illness; and
3. A learning experience for student nurses and resident physicians.

Senator Moss. Thank you very much, Mr. Wilcox, for giving us this review of your Towers Continuing Care Facility. That is a good term for it and certainly this is an area in which we do need this kind of expansion. As you well pointed out, the costs of medical care and acute hospital absorbs such a high rate now that there has to be some place that we can care for people who do not require all of the services of an acute hospital but who may be relegated to going there if we don't have some intermediate type of unit such as you describe in the Towers.

Mr. Wilcox. A significant item would be that the University's cost per day is running around $75. Our daily rate, semi-private, is $32 and our private rate is $36.

Senator Moss. Just about half of what it would cost.

Mr. Wilcox. And the extended care facility in the same town is running about $22, so that is again down from the hospital setting of cost.

Senator Moss. Well, it is very fine and we appreciate your bringing this to us to help our record.

Mr. Wilcox. Thank you.

Senator Moss. Mr. Derril Meyer and Barbara Tuck, administrator and director of nursing services of King's Garden Senior Citizen Community, Seattle, Washington.

[1] See appendix 1, p. 1863.

I must report to you that Senator Magnuson wrote me a note and told me what fine people you were and recommended that we have you in to tell your story about King's Garden Senior Citizen Community.

STATEMENT OF DERRIL MEYER, ADMINISTRATOR, KING'S GARDEN SENIOR CITIZEN COMMUNITY, SEATTLE, WASH.

Mr. MEYER. Thank you, Senator Moss.

Thank you very much for the opportunity for just allowing us to testify this morning.

My name is Derril Meyer, administrator of King's Garden Senior Citizen Community located in Seattle, Washington, which is a not-for-profit organization. I presently serve as chairman of the nursing home licensure board of Washington State. I have a master's degree in health care administration with specialized studies in long-term care.

As one observes the field of long-term care it is painfully apparent that levels of care are greatly fragmented in our Nation. Often, the levels of care are totally independent of each other; provided in separate locations and under separate management.

Undoubtedly, governmental programs have contributed to this fragmentation of care. The various Federal programs of Medicare, Medicaid, intermediate care and housing for the elderly all too often encourage specialized facilities to be developed providing only one level of care. As a result, the senior citizen or chronically ill person is transferred from one facility to another depending upon the level of care he or she may require at that particular time.

It is well known that an older person often suffers from a series of health assaults from which he can be rehabilitated during the aging process. These changing needs all too often result in moving the person from one facility to another on a number of occasions during his retirement years.

To provide continuity of care with the resident in mind, there is an urgent need to develop total complexes in the long-term care field. Retirement homes should be providing nursing care facilities and skilled nursing homes should be adding intermediate and residential care facilities.

It is my personal opinion that the provision of levels of care within a total complex will best meet the physical and social needs of the resident needing long term care. Progressive care, in a long term setting, enables us to provide a continuity of care within the facility that the resident knows and trusts. This means that residents admitted to King's Garden Senior Citizen Community are provided a home to meet their needs even as those needs might change over the years.

Senator, if you will refer to section 1, there is a description of the levels of care. We presently have 295 residents with seven separate and distinct levels of care. Briefly described, we have 48 apartments for the active retired persons able to enjoy independent living. We have residential care for active independent residents not requiring personal care.

We have a personal care unit for ambulatory residents requiring some personal services such as assistance with bathing and hair care, but not skilled nursing care. We have a special care unit which was

innovated for the ambulatory resident dependent upon others for decisionmaking or requiring close supervision. We have two levels of skilled nursing care and then we have the convalescent or the extended care unit. Mrs. Tuck, your next speaker, will expand a little further on this concept of progressive care.

I would like to add just some brief side comments concerning the fiscal matters relating to our community. Senator, would you please refer to section 3 of the article entitled "Impact of Medicaid."[1] Approximately 40 percent of the residents living in our resident care units are supported by public assistance funds. The 40-percent level was set by administrative decision and has been maintained at that level for the past 3 years.

Approximately 60 to 65 percent of the patients in skilled nursing homes or in ICF facilities are on public assistance in the State of Washington. Our community has a substantial spread in the average income per day between private pay residents and public assistance residents; $12.77 per day for private pay residents and $9.49 income per day for public assistance residents. The average public assistance income for the title XIX Medicaid program, the skilled nursing care programs, is $9.83 per patient day in our community.

One can readily conclude from these facts that the scope of the services we are able to provide is somewhat dependent upon the proportion of public assistance residents living in our community. When it is understood that there are some skilled nursing home facilities with approximately 90 percent or more of their resident load on public assistance, it is no wonder to me why they struggle and attempt to provide adequate care. It has been my personal observation that the rates allowed for the care of public assistance patients is a major factor in determining the adequacy and scope of services provided in nursing homes. I dare to even go so far as to state that the low public assistance rates are probably the greatest single cause for substandard nursing home care in our Nation.

I would like to make a final comment about our activities program. In section 6 of our document, we have listed some of the principles that I would like just to briefly mention to you.

Involve Patient in Program Planning

For example, we say that the program should be nonrepetitious and involve the patient in the planning process. We believe that a well planned activity program can transform the nursing home into a meaningful place to live. The program of social or craft activities may seem to be highly successful to the visitor or casual observer but to the patient it may be plain drudgery. Variety must be an integral part of the program offered.

In addition, it is very important to involve the patient at least to some degree in helping to decide on the activities they want. Some form of self-government, no matter how small, is a valuable aid in motivating the patient. Self-government is a very important aspect of King's Garden Community. A resident council along with a variety of other resident committees actively participate in the planning of resident activities and programs.

[1] Retained in committee files.

I think probably the most significant principle we have is the fact that the program should be meaningful and permit the patient to give of himself to others. Dr. Richard Filer of the Veterans' Administration once shared with me the statement that "Activity for activity's sake is meaningless." All too often volunteers or employees have the attitude that they are giving of their time to the poor helpless patients who have nothing to give in return.

It is essential that the patient be provided opportunities to give. Many times the community can be called upon to provide a meaningful project. It may be the simple task of putting letters into envelopes for the heart or cancer society. There are numerous opportunities for patients to assist each other. For example, the active alert resident can visit or read to the blind or bed patient. When we deny the right of a person to give of himself to others, we often take away his will to live and his right to have purpose in his last years of life.

Life without purpose is tragic. Without a clear understanding of the vital principles of living it is very possible to provide safe, sanitary and even luxurious facilities and yet fail to meet the basic needs of patients entrusted to us.

Thank you very much.

Senator Moss. Thank you very much.

We will be glad to hear from you, Mrs. Tuck.

STATEMENT OF BARBARA TUCK, DIRECTOR OF NURSING SERVICES, KING'S GARDEN SENIOR CITIZEN COMMUNITY, SEATTLE, WASH.

Mrs. TUCK. Mr. Chairman, members of the committee, I am Mrs. Barbara Tuck, director of nursing services of King's Garden Senior Citizen Community. I am an RN, I have a bachelor's degree from the University of Washington.

Separating levels of care has not only provided continuity of care for the resident but has also provided the opportunity for continuity of performance among personnel. The effect of this has produced two highly desirable changes: that of improved patient care and heightened job satisfaction.

A thorough explanation of the reasons for these changes is to be found in section I, just following the page that Mr. Meyer was discussing, in an article that I have written entitled "Separating Levels of Care."[1]

Another vital link in the chain of continuity of care in our facility has been provided by the restorative nursing concept which has been developed for the rehabilitation and maintenance of the long-term patient. Being highly aware of the realistic need of the chronically ill for the professional attention of a registered physical therapist, we were just as aware of the unreality of the prohibitive cost of the provision of this care on an extended daily basis.

Though professional evaluation is necessary, and daily treatment required, routine restorative care does not require daily one to one treatment of the RPT. Accepting this fact as the basis for our program, we changed the role of the RPT to that of case consultant, who evaluates the patient initially at the physician's request and works out a treatment plan in coordination with the physician. The case consultant then instructs the restorative aide in the day to day facilitation of the individual patient plan.

[1] Retained in committee files.

Each patient is re-evaluated on a weekly or biweekly basis by the consultant, and the plan is changed as required. By using the services of the professional therapist in this way, he is able to provide his valuable judgment toward the treatment of 10 times as many patients at one-fifth the cost per treatment to the patient. And we are able to provide restorative care to 10 times as many patients as were previously treated.

Since the restorative aide is a qualified nurse aide, and employed through the nursing department for this special training, this program has fostered a close working relationship between the two departments—a definite advantage toward improved patient care.

In section IV of the material [1] you have before you is a more detailed presentation of this particular restorative aide concept.

One of the major areas of concern to the health professional, and the major area of concern to nursing personnel, has been the difficulty encountered in providing for adequate medical coverage, both quantity and quality. Without it, there is no continuity of patient care, or possibility of quality care. Without physician leadership, there is no plausibility in the team concept.

In our facility of 250 beds in a large suburban area of Seattle, we found at one point that we had more than 60 physicians represented among our patients. Most of these doctors also had patients in other nursing homes of the greater Seattle area. One of the physicians had two patients in our facility and others in nine different nursing homes of King County. He also had a large private practice and was on the staff of three hospitals. This was not a unique situation, rather quite a common one.

Obviously, our patients did not see their doctors on a regular basis, and medical supervision was unsatisfactorily attempted through nursing observation and telephone orders. Realistically, there was no way the physician could be blamed for this problem, even though on the surface it appeared that he lacked concern for his elderly patients. We decided it was time to update our system of medical coverage.

Patients Seen on Regular Visits

The solution to the problem was quite simple—we needed a physician or a staff of physicians who would assume the medical supervision of many patients, thus making it practical to arrange time for regular visits to the nursing home. We would provide him with an examination room, nursing assistance and patients; he in turn would provide our patients with consistent medical supervision and our facility with medical advice and direction regarding patient care policies and procedures.

We found many physicians receptive to the plan and willing to cooperate in its implementation, since the problem was a mutual one. Those found to be most interested in a nursing home commitment were young men and women in the process of building a practice and desirous of geriatric experience, those particularly interested in geriatrics, and those considering partial retirement.

The selection of our primary physicians was made very carefully by the administrator, according to proven ability and reputation of each

[1] Retained in committee files.

prospective physician. The doctor was then invited for a personal interview to discuss institutional policy, requirements of the law, fees and mutual expectations that a thorough prior understanding might be reached. We have found this to be a satisfactory approach to all involved. Our physicians are not paid by the facility, but we have assumed the responsibility of patient billing as expedient to the separation of the nursing home facet of their practices.

The advantages of the primary physician role in the nursing home over the old system provide little ground for comparison. It is rather like attempting to compare the horse to the engine, the change has been so profound. Each of our physicians allows a specified time every week to visit their patients. They effectively supervise the medical care of 40 to 50 patients each in much less than the time it would take to cover the miles between several nursing homes to see far fewer patients. This does not mean that they see 40 or 50 patients in one day; few patients require a weekly visit. It does mean that they can see that many patients every 30 days and be available for those who do require more attention. The regular visits have greatly limited telephone calls from the nursing staff, except for emergencies.

Interest Shown by Nurses

The positive effects of continuous medical supervision on the nursing staff have been just as evident as upon the patient. The nurses are taking a great deal of interest in upgrading their own observational and organizational skills. They feel deeply obliged to arrange their time for the weekly visits, having patients prepared for examination and ready with an accurate description of symptoms, pertinent information and questions. In-service meetings for continuing education are eagerly attended, as well as outside workshops and seminars, because our doctors expect us to keep informed. Job satisfaction has heightened perceptibly.

Our physicians are vitally interested in quality patient care and in the reputation of the facility with which they are associated. They are thus concerned with patient care policies and in the nursing performance of procedures. Regular meetings are held with them to discuss problems as they arise and to review policies and procedures. They have also arranged to take emergency calls for each other in case of individual absence, so we have continuous constant coverage.

Probably the greatest single advantage to the new system is that we are now able to provide preventive medicine for the geriatric patient. Preventive medicine, in a slightly different context, is as important to the elderly as it is to the young. It takes preventive medicine to maintain the status quo which, in the case of the elderly, is often the goal to be desired—not necessarily to prevent disease but to prevent a disease condition from becoming worse, disrupting the equilibrium of the latter years. This is the type of medical supervision generally required by the geriatric patient. The primary physician can provide this type of care. Because he sees his patient on a regular basis, he can often arrest a problem before hospitalization becomes necessary.

The long-term care facility is a vital part of the health care system of our country; few thinking people will deny this fact. Long-term care with continuous medical supervision takes over when the general

hospital lets go—and let go it must if it is to continue care of the acutely ill. What the nursing home needs is an honest acceptance of the necessity of its existence, an acknowledgment of efforts, and public and political cooperation toward improvement, rather than destructive criticism, and the highly unrealistic denial of need. We believe that the implementation of the role of primary physician is the cornerstone to building quality health care on a long-term basis and will help to place the nursing home in its proper perspective as an equally significant, functioning part of the complex health care system of our country.

In section V of this material [1] what you have is backup material for the plan I have discussed, and we will be happily available for any questions that you might have.

Senator Moss. Thank you, Mrs. Tuck, for a very fine presentation and discussion of the adjustments you made, particularly this idea of having a physician there, rather than having a series of them trooping through on a somewhat irregular schedule because they have one or two patients and they have to make a lot of rounds.

I can see how that is a great innovation and a key to good care, to have the type of medical advice that is necessary and to have it on a regular basis concentrated there during the period of time that people are to be examined or need is the highest. This is certainly fine.

I did appreciate the delination of the various types of care that Mr. Meyer gave us describing each one of them and how to utilize the appropriate type of care for the patients so that each receives what he needs.

Indeed, you do have very fine facilities in Kings County.

Your presentation was excellent. This is a well put together document. The whole thing, of course, is going to be most informative for us.[1]

Mr. MEYER. Thank you, Senator.

I want to emphasize that the programs we share with you were not costly programs. We were innovative. This did not involve a lot of cost. The community concept is getting much more mileage from our health care dollars than if we had combined loans of care in one unit.

Thank you very much.

Senator Moss. Thank you both.

We are now going to have what amounts to a panel of several witnesses who will come to the table together.

Mr. Berkley V. Bennett and Elizabeth Connell, executive vice president and public relations director, respectively, National Council of Health Care Services, Washington, D.C.

Miss Joanne Hogg, Richard Berman, and Kenneth D. Relyea.

Miss Hogg is from Manor Care, Inc., Silver Spring, Md.

Mr. Richard Berman is president, American Society of Consultant Pharmacists, Chelsea, Mass.

Mr. Relyea is president of Drustar Unit Dose Systems, Columbus, Ohio.

We are glad to have all you people at the table.

We will ask Mr. Bennett, if you will, to lead off.

[1] Retained in committee files.

STATEMENT OF BERKLEY V. BENNETT, EXECUTIVE VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CARE SERVICES, WASHINGTON, D.C.

Mr. BENNETT. Thank you, Mr. Chairman.

The private nursing home represents a pioneering approach to care for the ill-elderly brought on by changes in family living patterns and the assumption by Government of an increasing share of the cost of caring for the aged.

Before the Social Security Act of 1935, care of the aged was generally in county "poor farms" and other locally supported public institutions. The Social Security Act of 1935 made Federal funds available to pay for nursing home care—but no funds were available for care in public institutions. This led to the beginning of the modern nursing home—mainly private, and mainly for profit.

During the period from 1935 to 1951 and the passage of the Kerr-Mills Act, when all of the States gradually adopted licensing requirements for nursing homes, a new approach to care for the ill-elderly was born.

After licensing became mandatory, those who entered the nursing home field were forced to be courageous and resourceful * * * Others in the health care field had rejected the ill-elderly—thus, the nursing home operator was a special brand of entrepreneur—a pioneer in his field.

Today's nursing home illustrates the giant steps which nursing homes and those who operate them have taken since those first path-finding years of a quarter century ago. Modern technology and new Government programs such as Medicare and Medicaid have enabled the modern nursing home to provide a far more sophisticated range and type of care than could be achieved some 25 or even 10 years ago.

One indicator of nursing home growth is the dramatic increase in the average number of beds in a nursing home. In 1954, the average nursing home contained 26.3 beds, while, by 1969, nursing home size averaged 58 beds.

I mention the increase in number of beds since, up to certain levels, an increased number of beds in a single nursing home allows for far more efficient use of trained personnel. In fact, it is only when a nursing home reaches a certain size that it becomes economically feasible (regardless of whether the home is voluntary or for-profit) to properly utilize certain highly skilled personnel such as registered nurses, dieticians, social workers, et cetera—especially in a time of acute health manpower shortages. Members of the National Council of Health Care Services, in addition to being able to realize the advantages to patient care which multifacility operation can provide (for example, centralized services, mass purchasing, attractiveness to high quality personnel, et cetera), operate nursing facilities which are substantially above the national average in size. The average number of beds of Council members facilities is 107 beds. Thus, Council members are often better able to utilize scarce manpower and expensive equipment than are many smaller institutions.

Concern for Welfare of Patient

But one factor has remained constant throughout the modern, private nursing home's history. The operator and staff of the nursing home which provides high quality patient care have always and continue to exhibit attitudes of concern for the welfare of the patient above all other considerations and they are committed to the maintenance of the elderly patient's individual dignity in the provision of the care they render.

The members of the National Council of Health Care Services have adopted this credo enthusiastically and recognize that their first obligation, as operators of health facilities, is to the patient entrusted to their care. We believe that any health care facility that fails to show proper concern for the patient's welfare does not deserve to stay in business.

The National Council of Health Care Services represents a select group of high quality, patient-oriented health care companies which operate approximately 20,000 convalescent care facility beds, several hundred acute hospital beds, and home health agencies throughout the United States.

Formed to represent multifacility health care companies in Washington, the Council presently accepts as members only those companies whose facilities meet the stringent accreditation standards for long-term care of the Joint Commission on Accreditation of Hospitals.

In addition to ownership and operation of convalescent care facilities, general hospitals, pharmacies, ambulatory care centers, and home health agencies, Council members are actively planning to participate in innovative health care delivery options of the future, such as health maintenance organizations, prepaid health care plans, and for those of the elderly who are not in need of institutionalization, the development of alternate care to enable them to live at home as long as is possible.

The National Council of Health Care Services believes that the existence of healthy competition between voluntary and proprietary nursing facilities will work to improve the quality of care and efficiency of operation of every type of health service.

More important, it was felt that there should be an attitude of complete cooperation and voluntary exchange of information between all providers of health care working together with government to achieve the goal desired by all—the delivery of quality health care at a reasonable cost.

The National Council of Health Care Services strongly believes that there is no reason that any legitimate and properly motivated provider of health care should apologize for the fact that in providing that care, he also realizes a profit. The Council is dedicated to creating a national climate where that provider who provides the best health care for the dollar is allowed the opportunity to make a profit.

In light of this, Senator Moss, I would like to introduce the people at the table as we go along and each of them with their particular area of innovative care.

To lead off will be Miss Elizabeth Connell of our staff.

Senator Moss. Very fine. Go ahead.

STATEMENT OF MISS ELIZABETH CONNELL, PUBLIC RELATIONS DIRECTOR, NATIONAL COUNCIL OF HEALTH CARE SERVICES, WASHINGTON, D.C.

Miss CONNELL. I would like to speak for Frank Klein, who is a new owner of a 200-bed nursing home, Fairview Nursing Home, accredited by the JCAH, and is located in Forest Hills, N.Y.

About 2 years ago, Mr. Klein began looking for solutions to the problem of getting the home's personnel to pay a sufficient amount of attention to patients.

He was particularly concerned about what he regarded as a lack of supervision in his home—and in many other nursing homes—of both personnel and patients between the hours of 9 p.m. and 5 a.m.

In most nursing homes, patients are in bed during these hours, and it is during these nighttime hours that most accidents occur. Often accidents during nighttime hours escalate into full-scale tragedies, merely because patients are not checked on a regular schedule.

Mr. Klein was also aware that several of the home's second and third shift employees were holding down other jobs and, therefore, their concentration and attention to their patients might be materially reduced—especially during the slow night hours, when activity is at a minimum.

After a period of investigating various potential solutions to this problem, Klein introduced a system into the fifth floor of his nursing home, which has been dubbed by his employees "Big Brother".

Fairview's fifth floor was thought to be an ideal place for experimentation with Big Brother since this floor houses the home's most confused and ill patients—those requiring the greatest amount of attention on a constant basis.

Big Brother, which is a modification of a time-clock system, works as follows:

On the panel above each patient's bed which contains his call button is a white pearl button which is connected to Big Brother. Charge nurses on the second and third shifts divide up the fifth floor patients among aides.

The aides are given a schedule for visiting each assigned patient once every half hour. The aides are required to visit each patient on schedule every half hour between the hours of 8 p.m. and 5 a.m. At the time of each visit, the aide must record her visit by pressing the white button on the patient's call panel.

When the Big Brother button is pressed, the date, time and a patient identification number are recorded on the "Big Brother 300", which is kept locked and is located in the home's main office.

Once each half hour, a supervisor checks the record-tape of patient visits, and is able to see at a glance whether or not a patient has been visited during the last half hour. If a patient has not been visited, according to Big Brother, then someone is immediately dispatched to look in on the patient.

While the only requirement of the Big Brother system is that the aide press a button on a regular schedule, the button which activates the recording is located directly above the patient's head, and it would be virtually impossible for an aide to avoid looking at the patient and noting his condition.

The Big Brother system has been in use for 2 years on the fifth floor of the Fairview Nursing Home. It is on this floor that Fairview keeps its most confused and senile patients—those who are statistically most likely to have accidents in a nursing home.

70-Percent Reduction in Accidents

According to Klein, use of Big Brother has been responsible for a 70 percent reduction in accidents and injuries on the home's fifth floor. Because it has been so successful, Klein plans to install the system on the other patient floors in the home.

While Klein feels that the Big Brother system is far from perfect, he believes that it is at the least a large initial step toward the development of methods of measuring patient care in terms of actual time spent with patients, rather than arbitrary requirements of a certain number of nursing/hours/personnel per patient.

Employee reaction to Big Brother was negative and resentful at first, according to Miss Dorothy Balz, Fairview's administrator and a registered nurse, as well. However, most employees now accept Big Brother, and, says Miss Balz, "No one who is doing his or her job properly resents Big Brother."

In conjunction with Big Brother, and for mostly the same reasons, Klein has employed a night inspector, for the past two years. The night inspector, who Fairview shares with two other area nursing homes, is a licensed nursing home administrator. He is employed full time to visit the three nursing homes on an unannounced basis at nights.

When he visits, the night inspector carefully tours the entire nursing home, including dining and recreation areas and the kitchen. He keeps a notebook in which he records any problems which he finds, as well as what actions are taken to correct these problems. The notebook is turned over to the home's administrator, who follows up on problems or deficiencies noted in the book, and who keeps up the record book.

Klein feels that use of the night inspector gives Fairview a continuity of nursing home administration which is not possible in homes where the administrators are present only 8 hours per day. Both he and the home's administrator feel that the unannounced visits of the night inspector have served to keep all of the home's night shift personnel "on their toes".

The Big Brother system, notes Klein, monitors the performance of the little people—the aides, who have primary contact with the patient. But the night inspector system monitors the performance of supervisory personnel as well.

Since good patient care demands a team effort, and since good patient care must be maintained 24 hours per day, we feel that the methods we have evolved here at Fairview to monitor care around the clock can only result in improvement of patient care.

Because it's late, because it's very quiet at night, sometimes nurses and aides become less alert, less attentive to the patients in their care. Sometimes, the fact that the administrator is not present in the home during the evening and early morning hours may lead to carelessness.

Also, even at night, one can't discount the importance of a clean kitchen, et cetera. Often visits by the night inspector allow the administrator to discover—and correct—problems with sanitation, kitchen procedures, et cetera, which might never have been discovered.

We have found since we started using the night inspector that personnel working in the home during the two night shifts have drastically improved the quality of their work. Part of the improvement may be due to their knowledge

that there is someone around during their shifts to appreciate what they are doing and the problems which they face. Whatever it is, the night inspector system works to produce better patient care at Fairview.

We are pleased with the results of these programs and feel that they have served to improve the patient care we give here at Fairview, concluded Mr. Klein, and we will continue to look for new programs and solutions, because good patient care demands it.

Senator Moss. Thank you.

That is a very interesting innovation. It is sort of like the watchman who has to punch his clock on his rounds to make sure he has gone to all the right places.

This is filling in a place where there are obviously some gaps because, as you have pointed out, the higher percentage of accidents occur during the late hours so it is obvious the people weren't getting the kind of supervision and inspection that they are getting during the rest of the day.

Mr. BENNETT. Senator, I would next like to introduce Miss Joanne Hogg, who comes from a family which has been active in the nursing home field for 25 years. Miss Hogg's background includes studies at college level in pre-med and psychology.

Before coming to Manor Care, she was a nursing home administrator some two and a half years.

Miss Hogg is intimately involved in the operation of Manor Care's 10 nursing facilities. They have 1,404 accredited beds in Virginia, New Jersey, North Carolina, and Texas, as well as six homes in Maryland.

She has been especially instrumental in involving physicians and the community with the patients and activities in Manor Care facilities. We hope her presence here today will lend added emphasis to the concern of responsible young people for the elderly and quality of life which our society is able to provide.

STATEMENT OF MISS JOANNE HOGG, MANOR CARE, INC., SILVER SPRING, MD.

Miss HOGG. I will briefly run down the programs that I am involved with individually and on a community level.

We went on TV and were involved in a special series on the radio. This program was to inform the public on the Medicare and Medicaid problems. They were having it to answer a lot of the questions.

A lot of the public seems to be under a misunderstanding as to the procedures to follow, who to contact, what the benefits are, and on what level.

So, on TV, through a panel session, we were able to clear up a lot of the problems.

In the Winston-Salem area, we have taken on "A Five-Day Plan To Stop Smoking," in which a community comes in——

Senator Moss. In Winston-Salem, did you say?

Miss HOGG. Right.

It has been very beneficial. A lot of the churches have really helped to sponsor the program.

Because it has been so well received, we started it in other hometowns. We have meeting rooms and our newest facilities have rooms specifically for entertaining outside clubs, such as the Rotary, Red Cross.

In our Richmond nursing home, we are sponsoring a program in which expectant mothers can come in and from the Red Cross learn how to care for the children. The father comes, too.

Also, they sponsor an RN to teach how to care for the geriatric in the home. In other words, if you have an elderly member of your family who is not in need of nursing care, you have a family, we will teach them within a home and train them.

We sponsor programs on drug addiction.

We are involved with school counselors trying to get youth inspired to join the health care field because they are desperately needed.

We have around 1,500 senior citizens in the Maryland suburban area and for their benefit we provide many programs throughout the year, including transportation.

In Hagerstown, we support the vocational and technical institute which trains LPN's and we let them train at the Manor Care Nursing Home. This program has been well received.

We have a new program that is starting. It has been going extremely well. This is the grandmothers and grandfathers.

There are orphanages in the different areas. We bus them back and forth.

This is a tremendous way to fulfill all the love gaps that we can't get to during the day.

We found out that the grandfathers are just busy as can be in our craft shop because they are making little trinkets for their special charges and the grandmothers are knitting mittens and gloves. It is taking on a whole new aspect. Especially these children need the love of a dad. A lot of them have trouble identifying with a male. By bringing the grandfather in, we have story times and other activities. It has been a great program.

We have a volunteer lady that is on our home office staff. She is in charge of coordinating volunteer programs with the Red Cross and on the church level to bring volunteer services into the home, and complementing the regular nursing services.

10-Hour Active Day

We started a full-day campaign. This is based on the 10 hours in which a patient has literally nothing to do outside of just roaming around.

So, we have geared these hours with a concentrated setting on not only craft, recreational purposes, but outings and involvement within the home, helping-one-another type thing.

We have instituted a wine therapy program in our Hyattsville Nursing Home. We have a favorable response not only from the families but from the physicians in that this program seems to have reduced a lot of the medical cost, by not having a tranquilizing effect but they have been using this wine in place of their sedative at night and it is doing just as well.

We have started a motion musical therapy program. This is for the senile individuals in our home. It is motion in harmony with music. There are different exercises performed. Like a beachball is thrown around, getting their coordination back again.

We have started a Swedish walking program which involves outdoor recreation for a half hour a day. At 5-minute intervals, there

are five elementary exercises that are performed. We have found that so many of our patients become acclimated to a building, they are afraid to go out; they are afraid to walk on grass, on anything that feels different to their feet. They go out on this walk on a very small scale.

Several of the patients that have had canes for the past 5 or 10 years have discarded them.

We have in-service training. This involves the psychology, the abstract feelings of the patient, and how to relate, as well as the family. This helps eventually in easing the guilt that so many families feel when placing a patient in a nursing home.

On the company level, we have increased our employee benefits greatly. We are now sponsoring volunteer scholarship programs, allotments to those who want to further themselves in the health care field. We were able to secure a national contract. This was a tremendous thing to families. It was almost a 50-percent saving to the family. They could not get over it. By this measure, we maintain a reasonable rate and are quite competitive.

We have seminars in which we bring in our administrators and assistant administrators along with the department head each time. We have factual seminars as well as teachers coming in and training. It is almost a psychological orientation because sometimes people seem to be so professional but not very sensitive. We are trying to correct this.

That basically sums up what we are trying to do and the goals we are trying to promote.

Senator Moss. Thank you, Miss Hogg, for a description of the great many activities and innovations you are working on.

We are glad to have that contribution to our record to try to put together all the things we might do or might recommend be done in this field of the elderly.

Mr. Bennett. I guess Maryland is rather in the forefront here. I would like to speak for a few minutes about what Medical Services Corp. in Baltimore are doing. They operate 13 accredited facilities. This is the role of the medical director. There is a lot of talk about this and the need for a medical director.

Medical Director Supervision

In another example of advantages to the patient which the multi-facility health care company is able to provide, Medical Services Corp., headquartered in Baltimore, Md., employs a physician to serve as medical director for six of its nursing facilities located in or near Baltimore.

The company's medical director is responsible for planning, directing and supervising the over-all health and medical services of the six nursing facilities. In carrying out these overall responsibilities, Dr. Benjamin Siegal, the medical director, makes regular visits to each of the homes to evaluate on a continuing basis the medical care and services being provided by each facility.

One special concern of Dr. Siegal's is to make certain that each facility maintains complete medical records on each patient. Since deficient or nonexistent medical records represent a constant problem

and source of criticism for nursing home operators, Medical Services Corp. has spelled out this duty specifically in Dr. Siegal's contract.

The medical director is authorized to take whatever action he feels is necessary to keep complete medical records, including the provision of direct medical care to patients where needed.

In addition, the medical director maintains up-to-date health records for all employees of the six medical services' nursing homes, and he conducts employment and annual medical examinations for employees.

Medical Services Corp. uses its medical director to conduct staff training sessions for the facilities he serves.

Another of Dr. Siegal's duties is to establish medical policies for the six homes, as well as to coordinate the activities for a medical policy committee for the nursing facilities.

The company has also made it one of Dr. Siegal's duties to accept direct responsibility for a limited number of patients in one of the six nursing facilities so that he will be better able to evaluate the needs and problems associated with the physician-patient relationship.

But the duties of the medical director are not limited to inside the facilities. One of his important responsibilities is maintaining contact with the appropriate medical and social personnel and agencies, including hospitals. In addition, he is often called on to interpret the facilities' medical program to community groups and relatives of patients.

The full-time employment of a physician to act as medical director to a single nursing facility would be economically unfeasible to say nothing of the wastefulness of such a use of a scarce health resource.

Yet, many nursing home critics, bothered by the absence or infrequent presence of physicians in nursing homes, advocate making a full-time physician medical director mandatory for all nursing homes. It should be patently obvious that this is an impossibility.

The efficient and effective use of the physician-medical director is undoubtedly an advantage the multifacility operator possesses over the free-standing single facility in rendering high-quality patient care. The council would recommend that single nursing facilities join together in the hiring of a medical director.

I would like to have Miss Connell comment very briefly on a very interesting experiment in resident government in a nursing home.

Senator Moss. Miss Connell.

Miss CONNELL. A complaint often heard about long-term care facilities is that the patient/resident/consumer has no voice in the running of the facility and is given no opportunity to effect changes in matters affecting his life style.

ELECTED RESIDENT-GOVERNMENT COMMITTEE

One member of the National Council of Health Care Services, National Health Enterprises in Milwaukee, Wis., has changed that situation. In their 770-bed Mount Carmel nursing facility, a resident government committee, elected annually by the home's patients makes most decisions for the home regarding food, table and dining services, housekeeping, and the hours of operation for the facility's store and its bank.

In addition, the resident government committee represents patients with grievances to management. The major purpose of the committee is to provide patients with a voice in the day-to-day affairs of the facility and to bring about better understanding and communication between the residents, staff and management.

Members are elected annually from each wing of the home to serve on the resident government committee. Committee members meet twice each month, and each meeting is attended by a management committee adviser, a representative of the facility's management. Committee members are required to maintain close contact with the patients they represent.

One of the committee's major accomplishments has been the development of a resident guide, which lays out rules for visiting hours, trips outside the facility, safekeeping of valuables, telephone rules, et cetera. These house rules were not arbitrarily promulgated by the home's management but were developed by the elected representatives of the patients themselves.

Patients, staff, and management alike agree that the resident government committee has been a huge success. The patients know that they have had a voice in shaping the rules by which they must live, the staff and management are both kept informed about patient desires and problems, and patients are more likely to abide by rules which they have drawn up.

Mr. BENNETT. To summarize, this section of our panel, Mr. Chairman, we have attempted to tell you today about a few of the programs and innovative approaches to patient care which some member companies have adopted.

I believe all these examples illustrate a common philosophy—the patient and his welfare are paramount over and above all other consideration.

The council and its members also believe that the patients' welfare demands that attention be paid to the maintenance of human dignity of the patient just as much as to his medical welfare.

All of our facilities providing care for the long-term patients encompass the complete individual. In this regard, I would like to point out all members of the council operate for profit taxpaying nursing facilities.

We have heard a great deal of criticism about substandard nursing home care. In many cases, that criticism has been justified. What has not been justified is the alacrity of nursing home critics to lay the blame for the substandard care at the door of profit motive.

We strongly believe that our proprietary taxpaying status, itself, has encouraged our facilities to lead the way in the development of innovative approaches in the long-term care of the elderly.

I would like to introduce Richard Berman, a registered pharmacist residing in Chelsea, Mass. He is a cofounder and president of the American Society of Consultant Pharmacists, a specialized pharmacy association with 500 members throughout the country. His own company, Nursing Home Consultants, serves some 35 facilities with over 3,500 ill-elderly patients.

Specifically, a few of the objectives and purposes of ASCP are:

To promote and improve consultant pharmacist services to health care institutions, nursing homes, hospitals, home health agencies, industry, and other institutions.

To define the professional standards required of consultant pharmacists and the resultant core of knowledge required of its practitioners, to promote the certification of the profession.

To sponsor and encourage the development of educational facilities and courses for the advancement of the profession.

To promote wider public acceptance of consultant pharmacy through collective public information efforts.

To provide instruments of self-regulation and arbitration of disputes among the membership. President Berman has stated:

> For the nursing home administrator to appreciate the importance of a conscientious, well-versed consultant pharmacist, he must first be aware of the fact that today, we are enjoying the most sophisticated and specialized levels of therapeutic care in history.
>
> Who, in the institutional facility, shall be responsible for the wealth of knowledge necessary to protect our patients from these dynamic medications, as well as to guarantee the optimum therapy available from their most prudent application? The overburdened nurse? The harried physician? I believe neither. Unfortunately, both have responsibilities and duties which prevent them from expending the endless hours needed to thoroughly study and comprehend the complexities of today's therapeutics.
>
> Herein lies the all-encompassing role of the consultant pharmacist in the institutional facility. By virtue of his education, training, and background, he remains the only logical choice to provide the knowledge necessary to oversee the entire spectrum of patient drug therapy.
>
> The Consultant Pharmacist must be totally aware of the mechanics and activity of each and every therapeutic agent used in the facility. Armed with this knowledge he can act in the best interests of the nursing home patient.

I believe our next panelist will provide new insights into innovative approaches to patient care.

Senator Moss. We will be very glad to hear from you, Mr. Berman.

STATEMENT OF RICHARD BERMAN, PRESIDENT, AMERICAN SOCIETY OF CONSULTANT PHARMACISTS, CHELSEA, MASS.

Mr. BERMAN. Thank you, Mr. Chairman.

As president of the American Society of Consultant Pharmacists, I welcome the opportunity to discuss the responsibilities, functions and progress of the consultant pharmacist in the extended care facility, skilled, and supportive nursing facility.

To understand the important role of the consultant pharmacist in long-term-care facilities, one must be acutely aware of the many problems related to drug distribution and utilization in these facilities.

As I have met with consultant pharmacists throughout the country, I find these problems persist in nearly all facilities in which a bona fide pharmacy consultation program is not in evidence. I would like to review them with you at this time.

1. Traditional medication distribution procedures and techniques represent a breeding ground for potential medication error. As one observes internal recordkeeping, medication storage, packaging, labeling, lighting, and logistics, as well as time-honored procedures for pouring, administering, and documenting medication doses, statistics relating to institutional medication error frequency become frighteningly believable. Documented statistics verify that 18 percent of all medications administered in acute care facilities are administered in error, and more recent statistics in medium- to long-term-care facilities range from 10 to 40 percent.

2. Documented time studies suggest that a 120-bed extended care or skilled facility with three 40-bed medication stations expends approximately 30 nursing hours per day pouring, administering, charting, ordering, and auditing medication. This represents poor utilization of nursing hours better used in bedside care.

3. The overutilization of medications often resulting in drug reactions and interactions through duplications and even triplications of diuretics, tranquilizers, sedatives, and other maintenance medications represents a dangerous deviation from optimum drug therapy.

4. The virtual absence of meaningful, constructive in-service educational programs for nurses relating to drug distribution and pharmacology leaves the nurse lacking in one of her most important skills. Most nurses in long-term-care facilities are not recent graduates of college or hospital nursing programs. Consequently, many of them are out of touch with current trends in medication therapy, new drugs, and progressive distribution techniques and systems. The educational vacuum in this area finds most of them vulnerable when assigned to administering and handling today's sophisticated and complex medication therapy.

5. Poor communication between pharmacy, nursing, and medicine as it relates to medication therapy and utilization affects the smooth operation of patient care. In most skilled and extended care facilities, physicians, nurses, physiotherapists, occupational therapists, social workers, and dietitians meet frequently at URC and staff meetings to discuss the delivery of patient care. We find, however, that all too often in the absence of a bona fide pharmacy consultant program, the pharmacist is conspicuously missing as a member of the institutional health team.

In thoroughly understanding and being sensitive to these complex problem areas, the role of the consultant pharmacist begins to crystallize. It is to research and develop and implement a series of systems, techniques, and procedures which will eliminate or minimize the aforementioned problems, and effect efficient and economical institutional medication therapy and distribution.

As a member of A.S.C.P. whose philosophy and direction represents that of our members, I would like to outline the consulting program of our company, Nursing Home Consultants Corporation, in Boston. We provide pharmacy consultation and service to 35 long-term care facilities in that area.

1. We have established an active and functional Pharmacy and Therapeutics Committee which meets regularly to discuss Stop Orders, Emergency Drugs, drug therapy, drug reactions and interactions, and new medications with the physicians and key nurses in the facility.

2. We provide documented evaluations of all procedures and techniques relating to drug distribution, making weekly surveys of patients' drug regimens, charts and medications, and monthly evaluations of entire medication delivery systems.

3. Our pharmacists implement and enforce a functional, effective Stop Order policy to help prevent overutilizations and redundant drug therapy.

4. We provide a comprehensive emergency kit tailor-made to the needs of the physicians in a given facility.

5. A comprehensive In-Service Education Program consisting of monthly presentations of either film or lectures on important aspects of drug distribution, therapy, and pharmacology is regularly provided.

6. A comprehensive drug reference library both in the facility and at the pharmacy is maintained.

7. Patient medical and drug profiles from which our pharmacists can monitor the drug utilization of all of our patients, help prevent overutilization, drug allergic reactions, and drug interactions are constantly updated.

8. We use electronic transmission of the original physician's orders in his own handwriting from Nursing Station to the Pharmacy through facsimile transmission equipment.

9. An automatic reorder system for refill medications is implemented which saves a 120-bed facility about 700 nursing hours a year and helps to eliminate medication ordering errors.

10. A unit dose system with mobile medication carts saves a 120-bed facility about 4,500 nursing hours a year and greatly reduces the possibility of medication handling errors.

11. An effective, expedient control system for narcotics, barbiturates, and potentially harmful drugs, which can be effected in 20 percent of the time expended on traditional systems, is available.

Programs similar to ours are being instituted by many well-motivated, innovative Consultant Pharmacists throughout the country, resulting in a dramatic upgrading of drug distribution and therapy in many long-term care facilities.

The Committee should note, however, that less than 20 percent of the long-term care facilities in the United States receive the pharmacy consulting programs essential to optimum patient care, while 80 percent still flirt with the danger and inefficiency of mediocre or substandard pharmacy participation. There are many reasons for this dilemma, which I shall cite to the Committee with the hope that they will make suitable recommendations.

1. There is a great need for more continuing educational courses and post-graduate seminars for consultant pharmacists.

2. There is a need for education of nursing home administrators and personnel as to the merits of a bonafide pharmacy consultant program.

3. There is a great need for the education of Medicare and Medicaid surveyors and inspectors as to what represents bona fide pharmacy consultation. As of now, there are at best vague guidelines to direct these people in their evaluation of institutional pharmacy programs.

4. There must be closer liaison between pharmacy consultants and governmental agencies which set standards, provide reimbursement, and effect laws relating to institutional pharmacy practice. This includes Boards of Pharmacy, State Departments of Health, the Social Security Administration, State and Federal legislatures, and State Welfare Agencies.

5. There must be provision for adequate reimbursement for pharmacy consultation for both the title XVIII and XIX programs.

There is a great need for the perpetration of certification or licensing programs for consultant pharmacists to separate the "paper" consultant from the bona fide consultant.

As President of the American Society of Consultant Pharmacists, a young dynamic group of 500 men dedicated singularly and collectively to upgrading patient care by providing safer and more efficient pharmacy programs to long-term care facilities, I am excited by the progress we have made, and frustrated by the roadblocks which seem to stifle incentives.

However, if all the disciplines of health care delivery and government pull together in a common effort, I am confident that we can deliver optimum responsible patient care to long-term patients in this country. ASCP stands willing to help in any way possible.

Senator Moss. Thank you.

That is a very helpful and hopeful presentation on pharmacy and the consulting services that a pharmacist can render. Thank you.

Mr. BENNETT. Senator Moss, as anchorman, we would like to introduce Kenneth Relyea, who will talk about unit dose, a timely innovation in pharmacy service.

Mr. Relyea is a registered pharmacist, president and general manager of Drustar Unit Dose Systems in Grove City, Ohio. His 17 years' experience includes retail and institutional pharmacy as well as field selling for a major drug manufacturer.

In 1962, he left pharmaceutical sales to become co-owner and manager of a retail prescription pharmacy in Grove City, Ohio. While in this retail enterprise, he became interested in the professional challenge and opportunity offered by the developing nursing home industry. Subsequently, he organized a new company, Drustar Unit Dose Systems, Inc., which specializes in developing and marketing methods of medication distribution, specifically designed to meet the needs of the nursing home patients.

Early in the development of his approach to drug handling problems in the nursing center, he sought the advice and counsel of nursing and administrative professionals who were wrestling with the day-to-day problems of getting the right medication to the right patient at the right time, in the safest and most economical manner. What he discovered about drug handling problems in the nursing center and how the unit dose system of drug distribution solved these problems is the subject of Mr. Relyea's statement today.

Senator Moss. Very well.

We will be glad to hear from you, Mr. Relyea.

STATEMENT OF KENNETH D. RELYEA, DRUSTAR UNIT DOSE SYSTEMS, COLUMBUS, OHIO

Mr. RELYEA. For most nursing homes, the daily dilemma of accurately distributing medications is a tedious and demanding job which costs a lot of money, wastes a lot of time and is prone to serious mistakes.

One solution to this dilemma is a unit dose system which might be described as a systematic method whereby the consultant pharmacist in his pharmacy prepares the nursing medication trays and delivers them daily with each individual dose labeled with the name and strength of the medication and patient's name.

Surprisingly enough, this can be accomplished with little increase in pharmacy manpower time but can save as many as 300 nursing hours per month per 100 patients.

A typical home of 100 patients will require 500 to 600 individual prescriptions at any one time for its residents. Traditionally, these prescriptions will probably be supplied by several pharmacies, each dispensing in differing multiple-dose containers and usually on a bottle-by-bottle basis.

You know the standard procedure: Doctors prescribe the drugs needed by each patient and pharmacists reach into bulk containers of tables or capsules and measure out a specific quantity, label each bottle, note the charge and possibly deliver it to the nursing center. Once there, these hundreds of bottles cause a major storage and distribution problem. Each time a nurse prepares medications, she must reach into practically every bottle, doling out the right dose, making sure that each patient gets the medication his doctor ordered.

Also, if we examine the work load in terms of total drug doses which have to be administered in a 24-hour period from these 500 to 600 bottles, we see an incidence of about eight individual patient doses per day. That means for our same 100 patients, that not only are the 500 or so containers handled each day, but 800 doses are removed from these containers and the resultant opportunities for confusion and error are obvious.

Additionally availability of anywhere from 15,000 to 20,000 doses at any one time represents a source of drug abuse.

Here are some typical examples reported by our field consultants who observe traditional drug handling techniques while conducting on-site medications handling surveys.

For example, a medication aide in an Indianapolis nursing center recently said:

"I usually pour the drug doses from memory. It's the only way I can get the job done in the amount of time I have."

Discontinued Medications Accumulate

In that particular nursing center, the average number of doses per patient per day exceeded 14. Also, in that same facility, records of discontinued medications documented the fact that in a 9-month period from September 1970 to June 1971, there accumulated more than 850 different prescription bottles containing over 17,000 doses of medicine, not counting narcotics.

In a similar survey conducted in a New York nursing center, the average number of doses per patient per day amounted to nine. The nursing staff there, observing strict professional techniques of drug preparation, spent an average of nearly 1 minute per dose in the laborious task of positively identifying each prescription container, then transferring the proper dosage to a paper medication cup for subsequent administration to the patient.

Ours and other studies corroborate the evidence that multiple-dose prescription dispensing for the nursing center patient is dangerous, inefficient, and counterproductive to the efforts of conscientious pharmacy and nursing personnel who are trying to upgrade the quality of care for the convalescent patient.

Unit dose solves these problems when implemented as a system which provides daily delivery medication, daily review of patients, drug regimens and dose-by-dose accounting.

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With these forces at work, it seems paradoxical that progress would be difficult. Moreover, since unit dose appears to be a timely innovation in patient care services for the nursing center, it is ironic that one statement I frequently hear from nurses and nursing home administrators goes something like this:

"Unit dose is so good, it's only a matter of time until we'll be required to do it."

It seems that many nursing centers and pharmacists are waiting for someone to say, "Get going."

Evaluation of the unit dose system requires comparison of two components—relative costs versus relative benefits.

Economics of Unit Dose

In terms of costs to the patient, unit dose, on a dose-by-dose comparison, should reflect the extra costs of packaging materials of perhaps 1 or 2 cents per dose. If the comparison stops there, however, wrong conclusions usually follow since no consideration is given to the aggregate charges for medication usage over a period of time.

Assuming that all doses of a particular prescription medication were consumed by each patient all the time, then one can properly conclude that drug charges would be slightly more under a unit dose system than in multiple dose containers.

The evidence, however, suggest that a great many prescriptions supplied in typical 30-day quantities are not consumed in their entirety by the patient, for various reasons: drug incompatibilities; physician order changes due to changing therapeutic objectives; theft of the drugs; spillage; borrowing; death of the patient, or perhaps discharge from the facility.

With a unit dose system, the problem of unused drugs is eliminated because patient charges are based on actual drug consumption rather than on predicted drug consumption which, of course, is the accounting basis for drug charges under the traditional multiple-dose bottle method.

Another important cost advantage with the unit dose system is eliminating the problem of accounting for medication refills. Unit dose precludes the possibility of patient drug supplies exceeding the term of coverage as provided for under the formula of the particular reimbursement plan. In other words, unit dose eliminates stockpiling of drugs in anticipation of the expiration date for insurance coverage.

In most cases the unit dose system usually costs the nursing center nothing in the way of capital investment. These costs are usually borne by the pharmacists.

However, consider this concept for a moment: The proprietary pharmacist invests in unit dose equipment which may earn him additional business but sells fewer doses of medicine because he doesn't dispense any wasted or unused drugs. This accrues to the economic benefit of the patient or reimbursing agency. However, if he were permitted a surcharge per dose, on the order of 2 cents, he could still maintain about the same overall cost base as presently experienced with traditional methods.

Benefits of Unit Dose

The benefits of unit dose includes better utilization of nursing personnel, at all levels of experience and competence; enhanced patient

safety through better nursing and pharmacy surveillance over the availability and compatibility of different drug doses; more nursing time each day to spend in direct patient contact—10 hours or so per 100 patients—enhanced physician confidence in the reliability of drug administration to his patients; accuracy of drug administration; reduced nursing confusion and worry; minimum problem of wasted or leftover drugs; a reduction in losses from breakage and theft; and, enhanced accounting controls.

In the nursing home industry, which daily cares for nearly 1 million patients, the total annual savings in nursing time alone to be realized from unit dose programs amounts to more than $125 million.

Additionally, there's at least another $12 to $15 million worth of wasted or leftover drugs annually which are not reusable and have to be destroyed, the bulk of which are paid for by taxpayers through various welfare programs. Add to that the unaccounted for economic loss due to breakage and outright theft, and the dollars become significant.

Thoughtful change based on timely innovation such as unit dose is clearly one way to enhance operating efficiency, meet the problem of nursing personnel shortage, cope with medication mismanagement and drug error and come to grips with overall problems of drug control in the nursing center.

As you assess the effect your recommendation in favor of this concept may have on present nursing procedures, these facts may be helpful:

The capability and interest of the practicing pharmacist is available now and growing.

Industry can deliver the necessary products and system components and will respond to the traditional inducements of our free enterprise system, if there's reasonable evidence of acceptance and demand.

Timing and the mechanics of converting to a unit dose program aren't complicated.

Guidelines for implementing and evaluating the unit dose system, as well as identification of the core components, have been abundantly published.

The pharmacy economics are feasible, though should be enhanced.

The patient benefits are indisputable.

Without belaboring the documented benefits of unit dose, consider the results of a recent study published by Eckel at the University of North Carolina in regards to nursing time and medication error alone. The 16-month study was conducted in a 50-bed North Carolina nursing home. Converting to a unit dose system of drug distribution saved nearly 6 hours of nursing time per day that was previously devoted to the repetitive chore of sorting out bottles, counting and pouring drug doses.

Even more significant was the reduction in the incidence of medication error. When the best standards of traditional drug handling procedures were being practiced, the observed medication error rate was 49.5 percent. When the nursing center in question converted to a unit dose system, the medication error rate fell to a negligible 1.7 percent, and all of these errors were intercepted prior to administration to the patient.

That was possible because of the controls and counterchecks that are inherent in the unit dose system. That's a remarkable advantage and, by itself, warrants the widespread implementation of the unit dose concept in the nursing center.

On behalf of better patient care, I urge your evaluation of the unit dose concept and your support in accelerating the acceptance of this pharmacy innovation so that new benchmarks of pharmacy service to the nursing center can be established within the framework of a sound and equitable economic base.

In conclusion, I would like to outline what I think good drug control really means:

To the nursing home administrator, it's the method of receiving, storing, and distributing drugs that proves to be the safest, most economical, and easily accounted for procedure.

To the nurse, good drug control means knowing, that part of the burden of her daily responsibility is eased to the extent that she can focus her attention more intensely on some of the many other day-to-day problems of patient care.

To the consultant pharmacist, good drug control means getting the right dose to the right patient at the right time to assure optimum effectiveness and response.

To the physician, good drug control means insurance that his prescribed treatment has the best chance of succeeding.

And, to the patient, good drug control means the possibility of a reasonably bright and comfortable day with the prospect that when tomorrow comes, perhaps there will be a chance to feel better again.

Unit dose is the only sensible way to achieve good drug control and efficiently service the needs of the nursing center patient.

In conclusion, I do have a reprint of an article that appeared in the January 1970 edition of Modern Nursing Home that I would like to have included in the record for explanation.*

Senator Moss. That may be included in the record for our study. That is a very interesting discussion you have on unit dose drugs. I am not familiar with it. Your discussion of it indicates that it has many great advantages and is really no more expensive, as you say, because of the savings on these unused amounts of drugs that are normally thrown away.

It has been a very interesting panel.

Mr. BENNETT. May I summarize this section, Senator Moss?

The American Society of Consultant Pharmacists was formed in January 1969 to help establish and maintain the highest levels of pharmaceutical care for nursing home patients by uniting consultant pharmacists throughout the country in a common effort to research, develop, and share new concepts, techniques, systems, and educational programs.

As has been described here today, the conventional method of prescription filling for the nursing home by retail pharmacy doesn't quite make it, mainly because it was never intended to. The question is: How long can nursing home management afford to absorb the inefficiencies and shortcomings that result from a pharmacy service designed to meet a set of needs and conditions that bear little resemblance to the requirements of the nursing patient?

*See app. 1, p. 1863.

A SYSTEM IS NEEDED

So a system is needed. What are the elements of a well-thought-out, tested distribution plan?

Unit-of-use medication packaging, mobilization of the med room, inventory control, drug identification, how the delivery of the drug to the patient is accomplished, and elimination of the nurse's task of making up med trays are the prime components of what the future will bring to nursing home pharmacy.

New and innovative approaches to the packaging of medications for nursing home patients have been introduced that assure clean, sterile packaging, identification of the drug to the patient's mouth, elimination of timely counting and pouring, reduction of inventory losses, and the virtual elimination of time-consuming counting of controlled drugs.

Such systems as developed by Medikard Patient Care Systems, Drustar Unit Dose Systems, McKesson & Robbins Co., Medispenser, and Unisystems, are all designed with the nursing home patient's safety in mind and the importance of saving valuable nursing hours.

We thank you for the opportunity to be here.

Senator Moss. Thank you very much, Mr. Bennett, and all members of the panel.

You have given a very comprehensive and interesting and effective presentation. We appreciate it. It has contributed greatly to the information that we are trying to gather in this record.

Thank you very much.

Mr. Frank Zelenka is ill and unable to be here today. He was scheduled to appear.

Mr. Zelenka is acting director of the American Association of Homes for the Aging.

Mr. Paul de Preaux, president of the Connecticut Association of Nonprofit Homes for the Aging and Administrator of Avery Convalescent Center in Hartford, Conn., will be our final witness on this hearing this morning. We have had him with us before and we expect we will have the very fine presentation that he always makes. He runs a very good home, I will say.

STATEMENT OF PAUL de PREAUX, PRESIDENT, CONNECTICUT ASSOCIATION OF NONPROFIT HOMES FOR THE AGING, ADMINISTRATOR, AVERY CONVALESCENT CENTER, HARTFORD, CONN.

Mr. DE PREAUX. Thank you, Senator.

I did not really have an opportunity to make a written statement since I found out about the meeting rather late.

I was very happy to hear earlier that the gentleman from Seattle has approximately the same type facility that we have at Avery.

Senator Moss. Very good.

Mr. DE PREAUX. We, however, have not delineated the levels of care to the extremes that they have. However, we feel that this is a move in the right direction.

The concept that we call the village is outlined on the board. We have five levels of care that we consider necessary for the total care of the patient with total concern. One segment is the apartment. These

are for those people who are completely independent, able to live by themselves, cook for themselves, even maintain themselves in the community, working, visiting, driving their own cars, and so forth.

The second level of care that we consider is the congregate living area. This is the area where the person who decides that they no longer wish to cook or clean for themselves can have it done for them. We have a central dining room. In fact, it is hotel-type living.

The third area is the rest home with nursing supervision, which is commonly called the intermediate care facility. This area is for those people who require some nursing surveillance or nursing supervision between visiting nurse care and intensive nursing care.

The fourth area we define is the nursing home or the convalescent home or extended care facility where they receive intensive nursing care covered by RN's over a 24-hour period.

Now, the fifth area which we consider almost as important or even more important than the other four is the area which we call the village center. This is the area which we call the area of community involvement. You see, we believe that unless the other four areas of care are involved in the community, then you find yourself an island of care in the community that doesn't care. If they don't know about you they don't care about you.

Involve Patients in Community

So, we attempt to involve both the community of the village, which are our residents and patients, into the life of the adjacent community, itself, and reciprocal movement back and forth. The community must know that the people living in these facilities are not the "old crocks" on the hill but still are viable, intelligent, humorous at times, a very important segment of our society, that even though they are no longer the producing members they can still produce intelligence, wisdom, and wit.

For example, on the second sheet you will see the 12 areas we have at Avery. Now, these we consider extremely important.

The administration and supervision, for example, operates in the top four areas. Visiting nurses can be utilized to visit the congregate living and apartment area. These visiting nurses come out of the nursing home section.

Recreation moves into the community and the other four facilities.

Incidentally, these lines are not one-way lines. We have resident councils or patient councils in each one of the facilities and we meet monthly. They tell us what is wrong with our administration, our supervision and especially our meals, since this seems to be one of the two most important necessities of their life.

We have a chaplain who operates in all five areas.

We have the village center which operates in all five.

We are starting an elderly day care center and this was described earlier so I will not continue it but we would like to take this just a little bit further.

We feel that this concept is the only concept for complete total care of the elderly. Most Government programs at the present time have aimed at the extremities, public housing for the elderly on the one hand and nursing on the other.

There is a tremendous area in between of need, of concern, and of care which has been totally disregarded. In fact, the emphasis on the extremities leading to the point where it is dehumanizing, it is categorizing, and computerizing the elderly so that they become what we call computerized vagabonds. They are transferred from a free standing facility to a free standing facility, probably not even in the same town, willy-nilly at bureaucratic whims, regardless of their physical disabilities or capabilities, and this is wrong.

If you have all of these functions in one locale, in one little area you call your village, they have something that no Government program gives them—a home. With the exception of having to go to a general hospital for that type of care, they never need leave their home.

For example, at Avery we have at the present time six husbands and wives who under the present Government programs would be separated but they are not because they are still in their home, they are still in Avery. One is, for example, in the congregate living area; one is in the nursing home; but they still visit. They even have their meals together.

This, to us, is more important than the categorizing individual facilities placed far apart and separating families, loved ones and treating them as computer cards.

The most damning indictment that I have ever heard of the present programs and the utilization review committees which are being considered to move people from facility to facility at the whim of whoever is making the decision is about a year ago the last time I was in Washington I visited one of the nursing homes in this area. I was told by the administrator that there was one little woman 84 years old who refused to leave her room. She refused to become involved with anyone or anything.

". . . I Am Too Old . . ."

I went in and spoke to her. After about a half hour of conversation I asked her, "Why don't you go out and make friends? Why don't you become involved in the religious and recreational and the social programs that are available?"

Her answer to me was, "Son, I will be 84 years old. As soon as I am able, they are going to move me from here and I am too old to lose any more friends."

Consider that.

This is computerizing to the point of idiocy.

Now, the concept of the village, we feel, has a greater innovative method of utilization. If this village can be taken and actually constructed on a college campus—we feel that at the present time the lack of knowledge about gerontology is so vast that it makes the Mojave Desert look like a sand pebble—for example. I am taking a course on sociology on the aging. The course was held up for one semester because they could not find textbooks. It is unbelievable how little we know about a subject which we try to deal with so expertly.

Therefore, we are suggesting that on four or five college campuses an entire village be built utilizing the village center for training programs, research programs, and using the village as not only a method of better caring for the elderly, better learning what their needs are, but better training the people who are going to care for them in the future.

For example, I have a list of areas that could be utilized. The entire village could be utilized as a training and research center. Various units of the village could provide a site for coordinated programs on research and training in gerontology.

Existing colleges, schools, and academic departments would be able to augment their specialized research interests as indicated below:

Academic unit	*Educational activity*
Psychology	Research, clinical experience, and graduate training.
Sociology	Research and graduate program in social gerontology.
Social work	Practicum and casework experience.
Nursing	Clinical experience and degree work in nursing home administration.
Home economics	Research and training in housing, foods, clothing, institutional administration, and dietetics.
Physical therapy	Training, internship, and field experience.
Recreation	Experimental programing, training, internships.
Business administration	Degree programs in long-term care administration and housing administration.
Continuing education	Noncredit courses for elderly residents plus training for all campus professionals in gerontological specialties.

Why, when they suddenly become 65, do we have the terrible facet in this country of basing everything on an alphabetical age?

Why is somebody old at 65? Some people are old at 20. Some never grow old.

Academic unit	*Educational activity*
Medicine	Clinical experience.
Dentistry	Clinical experience.
Life sciences and biology.	Specialized research.
Hospital administration	Training, internships, and field experience.

We can train practically every person in a hospital or in a field of gerontology using this concept built on a college campus.

In addition to that, we have one other little touch of frosting on the cake, as I call it.

Need to Communicate

The young who are in the colleges at the moment find it very difficult to talk to us because we are "the establishment." The 40–60 age group is considered the one which is the repressive group. They consider the elderly the other end of the stick. They feel they are also "disenfranchised." They feel that they are also out of the mainstream of things. Truly, they are. But if we can get the intelligence, the wisdom and the maturity on the one hand to talk to the intelligence, the youthful exuberance, and idealism on the other hand, we have accomplished something that none of these programs have yet accomplished.

The greatest need we have in this world today is for communication. We talk to each other but we don't listen. We have the greatest medias of communication in the entire history of the world but we still don't hear each other.

If we could get just 10 of these in one campus to communicate effectively, we have accomplished something that no program has.

This is my proposal, that we utilize the concept of the village, place it on a college campus, utilize it for training of the people who are going to care for the elderly in the future, utilize it for research programs, finding out what their needs are.

We don't know what care they need, what sociological, physiological, psychological needs they have. When we do learn, it is too late because we are part of it.

Putting People in Boxes

The last item I wasn't going to even mention today but I just thought of it. I have asked for 3 years now why public housing is as it is. Public housing again started as a tremendously concerned concept of care for people. But, actually, what it has deteriorated to is, we take a person, we put him in a box, we stack a lot of little boxes together and we call it public housing.

In too few areas do we have, for example, a person on call 24 hours a day to answer their needs, if they have any. Too often we forget that they have more than a housing need; they have social needs. They have religious needs. They have recreational needs. Even more than any of these, they have nutritional needs.

I have asked why, for example, can't someone propose a program of building in every single public housing project for the elderly in this country a kitchen, a restaurant, and a bar? Why couldn't that area be leased to a national franchiser, and I don't care which one it is, Valle, Red Coach, Howard Johnson, any of them, with the stipulation in the lease of the franchiser and also in the lease of the individual living in the facility that he is required to eat one hot meal a day in that restaurant at no charge. This could be in the lease of the franchiser.

I believe that this would amortize itself over a 4½- to 5-year period because you would still have funds coming in from the franchise.

The answer I get is that it is difficult to put a profitmaking organization into a nonprofit facility. I find this rather a backward thought. We are attempting to care for people. Why should we care who does it?

Two years ago we conducted a survey in the State of Connecticut in the nonprofit facilities. We discovered that 60 percent of the patients admitted to nursing homes, and, as you know, they all have a multiplicity of diagnoses, but included in 60 percent of those multiplicity of diagnoses were three very important ones. In 60 percent, we found that they were suffering from either nutritional deficiency, anemia or malnutrition.

Now, this does not speak well for our system of providing care. So, if we can just make them eat one hot meal a day in a dining room, we have again not answered all their needs, none of us have all of the answers, but, Good Lord, we are at least doing something.

I don't care if a proprietary unit provides it, or if a nonproprietary unit provides it, we are trying to take care of people. I think that the only way we are going to do it is to utilize the facilities and make maximum utilization of all of the people and the talents that we have in this country. We are not going to do it by saying, "Well, we can't touch those because they are not like us."

I think this is wrong.

I wish to thank you for asking me to come here today.

I wish to say that I am very happy that you were reelected.

Senator Moss. Thank you, Mr. de Preaux.

As we knew you would, you have given us some very good information and some food for thought on this problem of better providing for our elderly.

Your last discussion of public housing and the lack of other attention to those who do utilize public housing has a great deal to be said for it and I think your proposal makes good sense. Of course, I am strongly in favor of this campus idea. As you know, I have talked about that in some of my speeches, suggesting that this might be a very desirable thing. You have spelled it out even better today. I am glad of it.

I am especially glad to have that discussion and analysis of the way your center is set up and the way it is working now in Connecticut.

Do you have a smaller size chart like that that we can reproduce for the record?

Mr. DE PREAUX. If I had had one, sir, I would not have had to carry these on the plane.

Senator Moss. Maybe we had better take a picture of it because I would like to have that in the record.[1] I think it is diagrammatically presented there and it is helpful in that respect. I do thank you.

As I have said before, you run an excellent home and we commend you for it.

We will excuse you, with those thanks.

We did have Mr. Labe B. Mell, Administrator of Moody Nursing Home, Decatur, Ga., and Mrs. Jeannette R. Kramer of Plum Grove Nursing Home, Palatine, Ill., who were invited but were unable to attend.

I said in the beginning I expected this to be a very interesting and helpful hearing and it was going to emphasize the positive, which I think has been borne out very well by the witnesses we have had. Our hearing is sort of like everything in the news media. If it is bad or there is something wrong with it, it gets a lot bigger play than it does if things are going well and going along as we would like to have them go.

I think for that reason over a period of years as we have had inquiries and hearings about nursing homes and care for the elderly that we tended to get publicity for all the bad situations. That is fine; they ought to be aired and they ought to be corrected. I don't think any of it should be excused. But it has perhaps blurred the picture, obscured the picture in part that we are making some very fine progress in this field.

There are some very excellent facilities in operation and there are a lot of devoted and dedicated people that are giving their energies and intellect and, in fact, their love to trying to better serve those who are elderly and infirm. These potential needs are not only physical but social and psychological as well and we have heard a good deal about how to cope with them this morning.

[1] See app. 1, p. 1863.

However, we should not be complacent. We still have much to do in all of our States. I commend particularly those of you who came here this morning and told us of the things that you are doing and that you have visualized for the future improvement of this field.

We hope, as we try to round out a rather long period of study of this long-term care problem, to be able to come forward with some recommendations and possibly some legislation or amendments to help us along toward the goal that we all seek.

Thank you very much for being here.

We are now adjourned.

(Whereupon, at 12:35 p.m., the hearing was adjourned, subject to call of the Chair.)

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL SUBMITTED BY WITNESSES

ITEM 1. PREPARED STATEMENT OF JEANNETTE R. KRAMER, ADMINISTRATOR, PLUM GROVE NURSING HOME, PALATINE, ILL., AND EXECUTIVE DIRECTOR, KRAMER FOUNDATION

How the Administrator Organizes a Therapeutic Program for Individualized Care

The most difficult problems that staff members of long term care institutions face are in the psychological and behavioral areas. In the physical diseases —stroke, cancer, heart disease, fractures, Parkinson's disease, multiple sclerosis—doctors and nurses generally know the accepted methods of treatment. There are few guidelines, however, when these chronic conditions are combined with depression, regression, frustration, loss and confusion in patients who also have deficits in seeing, hearing, memory, motivation and mobility.

The long term care administrator needs a road map for establishing a milieu which can incorporate medical and nursing therapy into a broader concept which includes treating the illness while concentrating on helping the patient regain his maximum level of both physical and psychological functioning.

This has been the concern of the Kramer Foundation over the last ten years. We believe that the answer lies in combining traditional medical and nursing care with the therapeutic community concept developed in psychiatric hospitals since the fifties, and the understanding of institutional and family systems. Then patients who reside temporarily or permanently in long term care institutions can be as free as possible to live their own lives while receiving individual programs of care.

We have coordinated and put into practice principles in organizations and communication which we believe are necessary if a long term care institution is to be fully therapeutic. We have used Plum Grove Nursing Home in Palatine, Illinois, a 69 bed proprietary facility in order to test our theories.

Enthusiasm for and belief in the therapeutic program must extend from the very top of the administrative hierarchy to every member of the treatment team, including all shifts and all disciplines. The patient himself is part of the plan, as well as his family and other important people in his life. Thus everyone concerned is working together with the same commonly known information.

When a patient is admitted to the home, he is at a critical point of transition. He can be admitted in such a way that there is the best chance for his therapy to be successful. Relevant social, psychological and medical data contribute to the staff's understanding of the family's involvement and their goals as well as the goals of the patient. A social history questionnaire is a good way to obtain this information.

Staff is chosen, trained and supervised to help, not hinder, the team goals. Besides being technically competent, each staff member must also believe it is worthwhile to work with disabled and dysfunctional elderly and gain satisfaction in seeing the patient do things for himself. This means giving up, as much as possible, the typical nursing role of doing for him. She is willing to take time to listen to the patient and use his ideas since he is also part of the team. She is open to a continuous personal learning and growing experience.

This in turn requires a training program which involves all levels of staff. Although responsibility is centered in the nursing supervisor, the nursing assistant is the one who spends the greatest amount of time with the patient. Supervisors share responsibility with nursing assistants as they develop to their fullest

capacity. Methods of communication evolve which cut across professional lines and allow staff members to respond to the patient and to each other.

At Plum Grove we have community meetings of patients and nursing staff members on each floor who meet together weekly to talk about both positive and negative aspects of the group living situation. Reality reo-rientation is both a 24-hour practice and a specific daily half-hour group meeting led by nursing assistants. Nursing assistants take turns as activity aides and all are trained as rehabilitation aides. Our mental health consultants have trained a group of interested staff members—including nursing assistants, supervisors and consultants—in family interviewing and we have an on-going program of meeting with all families of patients in the home.

General staff meetings are held weekly of all employees in the home—all shifts in nursing, housekeeping and dietary—so that all may learn consistent, practical and effective ways of integrating their efforts to care for the patient. Supervisors of all shifts discuss supervisory problems and patient care plans in supervisory staff meetings. The core group is composed of those with primary responsibility for patient care in the institution—administrator, assistant administrator, director and associate director of nursing, activity director, physical therapist and mental health consultant. This group has actively worked on its communication in a bi-weekly process group. We feel that the core group is the prototype for effective communication in the institution.

Basic to fee communication is a method of conflict resolution—whether among patients, among staff members, between patients and staff or in areas involving the patient with his family or with members of the outside community. Negotiation skills are taught to supervisors so they can get people together to resolve issues and find more funcional solutions. Airing opposing opinions is encouraged. Mistakes are corrected without establishing blame.

The administrator organizes a setting which allows freedom in communication up the hierarchy as well as down, while clearly establishing medical and administrative accountability. Every aspect of the institutional situation must be evaluated in terms of its contribution to the total therapeutic care. This includes the physical setting, the organization of staff, the educational program, and group and individual patient care programs. Mental health consultation allows for professional help and objective feedback.

We find that we are dealing with two systems—1) the professionals and their assistants working primarily within the institution as an organized team and 2) the patient and his emotionally significant family members who have requested service from the institutional system. We are using "system" as social scientists do who have in recent years applied general system theory to human interaction. Like all systems, the long term care system and patient-family system function according to basic principles or laws. Any happening which affects one part of the system affects the rest of that system and, in turn, the other system, which then sets up circular feedback patterns.

We believe it is not only possible but necessary to put into operation these psychosocial principles in combination with traditional medical and nursing treatment. As one looks at the total picture, disturbed behavior often becomes understandable and new ways of relating and changing become evident. Physical rehabilitation becomes part of the total program, concentrating on areas where there is still room for change and growth and relevant human experience.

Let me explain the interdisciplinary team more clearly. In order to provide the patient with an integrated program, we make nursing the central focus of all care. When consultants work with patients, they have to work through nursing. When the physical therapy consultant sets up an exercise and gait training program, she must train and supervise the nursing assistant caring for that patient.

We do not have a separate physical therapy room—our rehabilitation equipment is on the floor for nurses to use throughout the day and evening. This is by design because the patients we are caring for need a little exercise many times a day aimed towards taking over as much of their self care as possible themselves. The physical therapist is then also able to supervise the approach to the patient as well as the way the physical aspects are handled.

In the same way, the activity director (or adjunctive therapist or occupational therapist) works through the nursing department. She also works with volunteers—we have 45 at the present time—but it is essential that nurses also be involved; they have great leverage in encouraging or discouraging participation in activity programs. Nursing assistants take turns as activity aides for several

hours a day several weeks at a time and thus are knowledgeable about and help in the program.

Physical therapist and activity director must also integrate their programs with each other so that activities underline the planned rehabilitation. Families must also be involved; their attitudes towards the program and their pattern of visiting can encourage or thwart the patient care plan.

Plum Grove does not have a social work department as such. The mental health consultant spend most of their time—between one and two days a week—teaching staff to understand and work openly and constructively with patients, families and each other. Staff members closest to the problem accept major responsibility for managing a problem or situation and ask for help and supervision when it is needed.

The administrator must be coordinator, seeing that impasses get worked through and people ask for help when it is needed. This method of team organization helps to eliminate competition for power in departmentalization, and keeps the focus on the patient. It helps to integrate planning and eliminates barriers and red tape.

I have described how an administrator can organize an institution with an individualized approach to each patient. However, it seems to me that the field is going in another direction under the aegis of federally sponsored payment programs, following the general hospital model which centers on disease, diagnosis and treatment of physical symptoms. This model puts insufficient emphasis on the psychological and emotional areas which present the greatest problems to staff.

The trend is towards segregation of patients according to physical illness and medical treatment. Facilities are divided into extended care, skilled care and intermediate care. Seriously depressed and regressed patients are classified "custodial" and shunted to the lesser care facilities where there are fewer professionals and less money.

There is a growing departmentalization in the field, mirroring the general hospital. As physical therapy, occupational therapy and social service departments become entrenched and grow as separate units, their services are channeled to designated patients for appointments, thus separating the consultants from the nursing team. This discourages the use of their services in training staff to work with all the patients in varying combinations.

Institutions are getting larger, often up to 300 and 400 beds. Size itself is not a deterrent if the care units are organized as small, self-sufficient units around a stable interdisciplinary team. However, in the current focus on economy and efficiency, there is a growing dehumanization. Hospital-like physical plants as well as departmentalization and hierarchical communication patterns contribute to solidifying the staff member's role into "doing for" rather than "working with" the patient.

If those who set standards take skilled nursing home care seriously, they will also be concerned that there be enough money to carry out a professional program. If too little money is allotted, then professionals will not be interested in trying to make ends meet in a field that allows little for program. It will attract an administrator whose aim is purely custodial. If he has no interest in developing programs, he can provide adequate food, basic care and cleanliness and make money at $8 to $15 per day per patient. If his aim is therapeutic, it can't be done for less than one-third of local hospital cost.

The current philosophy of the federal government is that the government will provide all that is needed for the ill elderly on Medicaid and Public Aid. In Illinois this results in Public Aid setting a rate according to a point system, with no relation to the cost of care in the institution. The Home can either accept or not accept the patient. To take a $14 per day patient when the Home's basic cost is $24 per day is economic madness and the patient's family is not allowed to make up the difference because it is illegal. Therefore, the only recourse for a progressive institution is not to accept Public Aid or Medicaid patients or to limit the number accepted. As long as the policy of the state and federal government is to set the maximum rate for public aid irrespective of the cost of adequate program or cost of living increases, then the government itself is putting a lid on the quality of care and the type of administrator attracted to the field.

ITEM 2. PREPARED STATEMENT OF FLORENCE L. BALTZ, R.N., PRESIDENT, WASHINGTON NURSING CENTER, INC., WASHINGTON, ILL.

My name is Florence L. Baltz. I reside in the city of Washington, Illinois. It has a population of approximately 7500; a trading area of 17,000; and, being only 9 miles from Peoria, a metropolitan area of 300,000.

By the way of background, I am a registered professional nurse, former hospital administrator with 9 years experience, and during the past 20 years have been a nursing home administrator and consultant in the nursing home field. I submit this testimony as an experienced administrator.

When I entered the field of long-term care twenty years ago, my first reaction was one of depression for many reasons. The lack of standards along with little enforcement of those few standards. The desperation of the patients being admitted to nursing homes as the last step before death was most appalling. The attitudes of the public, professions, families, and the legislators were disheartening to say the least.

Today, I am happy to see so much interest and concern on the problems facing the long-term care patient, but it seems that everyone has his own ideas as to an answer to these problems. Unless those concerned can really see high standards of care at the grass roots level instead of only going into the so-called "horror facilities" that have contributed to a national exposé, in my opinion, we will continue to have unrealistic ideas and the long-term patient will be the loser.

Those of us who have been pioneers in the care of the long-term patient, including the younger as well as the aged patient, have worked long hours, traveled miles across the country to serve on committees and speak to nursing home groups as well as other interested groups in regards to the need of high standards and continuum of good health care from home to hospital to nursing homes and return to own home or to a less skilled and costly facility. We have seen vast improvement over 20 years.

I hope the following statements and enclosed material will portray how strongly I feel that private enterprise has made and will continue to make a great contribution to the health care of our Nation.

In December, 1950, I purchased a converted hospital and converted it to a 40 bed nursing home which was opened January 15, 1951. Six months later my husband joined me in this venture and we have worked together since that time for high quality care. We provided nursing care as I was trained to do; that is, do everything for the patient. In 1955 a picture began to form pointing up the need for programs of activities and activity of daily living retraining to make the patient more independent and therefore, a happier individual.

In Illinois, we have been fortunate to have people in the agencies and in the field who talked and planned together. Outgrowth of an informal conversation of the patients' needs, as a few of us saw them, the Illinois Public Aid Commission (subsequently, the Illinois Department of Public Aid) began to think and plan for a demonstration project grant which materialized. This project was under the sponsorship of national, state, and private foundation auspices, namely, the United States Office of Vocational Education, Illinois Public Aid Commission, and Forest Park Foundation of Peoria, Illinois, which was officially known as OVR Project Grant #29-56. After the demonstration project was finished, the Illinois Department of Public Aid continued the program until recent years. Since 1966, the program has been in the Illinois Department of Public Health.

The Washington Nursing Home was fortunate in being selected as one of the first homes in the nation to participate, and the program, today, is as much of our patient care program as it was in 1957 when it finally got off the ground as a full-fledged research project.

As you can see by exhibits #1-1A thru 1B that this program continues to grow, but like so many other programs, shortage of professional manpower and money hampers the impact that it could have on long-term care. Rehabilitation means a variety of things to many people, but with us, it means to help the patient to do more for himself and to become a more independent and happier person. We see the patient as a whole person, stress his abilities, understand him as an individual, a member of a family and community, and help him realize he is still important and that someone sincerely cares. Sometimes it is easier to see what a patient can not do for himself, but in rehabilitation, we must recognize what a patient can do without help and many times things he hasn't done for years.

We chose the rehabilitation nursing aspect to concentrate on patient care for it is a 24 hour a day program which includes a strong in-service training program for all employees. We use our Registered Physical Therapist and other specialists as consultants to strengthen our nursing program which makes their service available to all patients. Rehabilitation Nursing is included in our daily rate whether the patient is private pay, medicare, medicaid, or has insurance, it makes no difference to management or staff. When under the Medicaid Program, we have an allowance for an approved Rehabilitation Nursing And Activity Programs. While the rates are usually below our going rate, it does give some financial reward for the cost of the program as all patients benefit and the homes are not penalized by getting them to do more for themselves.

Written into the Illinois licensure laws, the hospital must have a Rehabilitation Nursing Program, the skilled nursing homes must have Rehabilitation Nursing and Activity Programs, and sheltered care homes must have an Activity Program; therefore, Illinois will need more teams to train staffs in all these facilities.

Today, 14 years after Illinois' original rehabilitation project, we still have only 2 teams with one less number on a team to go into homes and teach Rehabilitation Nursing techniques. They have about a 4 year waiting list of nursing homes wanting their services. If some of the money being made available for inspectors could be used to recruit and train team members to go into homes and teach staff members throughout the United States as well as in Illinois, I am sure you would see patient care improve as well as a reduction in medical care cost.

From the following statement you can see that a good nursing program really pays off in good patient care, but the economic aspect of considerably less staff turnover due to increased job satisfaction. It is gratifying to see the reduced costs of operation when the program is in effect.

Our 121 beds are fully certified for Medicare. Our occupancy is approximately 98% with only about 8% Medicare and 47% Medicaid patients.

During the year July 1, 1970 thru June 30, 1971, we admitted 196 patients and discharged 163, breakdown shown as follows:

		Percent	*Live discharges (percent)*
Admitted:			
From hospital	139	71	----------
From home	35	18	----------
Elsewhere	22	11	----------
Dismissed:			
To home	53	33	
To hospital	68	42	84
Elsewhere	15	9	
Deaths	27	16	16
Total discharged	163	----------	100
Patient days (used by those discharged)		35, 155	
Average length of stay		216	

	Percent
Total patients admitted, July 1, 1970, to June 30, 1971—196 (medicare—84)	42. 8
Total medicare patients discharged	87

	Percent		*Percent*
Expired	14		16
To hospital	34 (39)		
Own home	32 (37)		
Elsewhere	7 (8)	Live discharges	84
		Total	100

Total medicare days used by discharged patients, 4,027.
Average length of benefits of discharged medicare patients, 47 days.
Total inpatient care days, 41,080.
Total medicare patient days, 3,154 (7.6 percent).
Percent of total occupancy, 93 percent (new wing opened end of July 1970).

We have three courses being offered in Illinois for Registered Nurses. The one I am familiar with and is an excellent one is in Peoria, Illinois at the Institute of Physical Medicine. This is a three week course and in November, they are accepting their first Licensed Practical Nurses for a one week course. It is very

important to prepare the Registered Nurse and the Licensed Practical Nurse who are in supervisory positions in Rehabilitation techniques and philosophy so they in turn can help initiate and carry the entire concept back to their respective facilities and promote these concepts as part of their inservice programs.

All staff members, in our facility, are encouraged to attend the inservice training programs and especially the aides, the reason being based on the fact that it is usually the aides who carry out the majority of care and techniques used with the patients on a 24 hours, 7 days a week basis.

Several states have patterned programs after Illinois over the years, but how they have progressed I don't know, but I am sure Illinois Department of Public Health would be glad to have others inquire as to the success and know-how of their program. Certainly, more available funds are needed for Rehabilitation Education Service Teams.

To me, this has been a most challenging and satisfying program in which many patients have benefited and many more could do likewise if concentrated efforts throughout the nation were encouraged. Therefore, I call to your special attention the paper on Restorative Services in Illinois Health Care Facilities, to be delivered by Dr. Albert R. Siegel, at the Congress of Rehabilitation Medicine and the Academy of Physical Medicine and Rehabilitation Annual Meeting. November 7–12, 1971, in San Juan, Puerto Rico, which has been attached in its entirety for publication.

ADDITIONAL PATIENT INFORMATION—BREAKDOWN OF PATIENTS IN CENTER

	Number	Percent
Age:		
Under 50	13	11.0
50 to 75	46	38.0
75 and over	61	51.0
Total	120	
Patients requiring no assistance with ambulation	19	15.0
Patients requiring assistance with ambulation	69	58.0
Complete chair patients	33	28.0
Full assistance with eating	20	17.0
Partial assistance with eating	22	18.0
In-dwelling catheters	10	.8
Written orders for bowel and bladder training	7	.6
Patients with decubiti	11	.9
Those with decubiti on admission	11	100.0
Special skin care	22	18.4
Confused or disoriented patients	89	75.0
Patients seated in dining rooms	112	94.0
Special or modified diets	42	35.0
Regular diets	77	65.0

Of the Medicare patients admitted as covered care, the six most common diagnostic groups were as follows:

1. *Fractures* (femur, hip, humerus, shoulders, symphysis pubis, ankles, arm, and clavicle). Fourteen patients used a total of 656 days for an average of 46.8 days.

2. *Diabetes* (Hypoglycemic coma and Mellitus). Four patients used total of 141 days for an average of 35.2 days.

3. *Cancer* (prostate, lung). Two patients used total of 60 days for an average of 30 days.

4. *ASHD w/CVA and Cerebral Thrombosis.* Four patients used total of 133 days for an average of 33.2 days.

5. *Thrombophlebitis and Phlebothrombosis.* Two patients used total of 45 days for an average of 22.5 days.

6. *Pulmonary TB and Fibrosis* (not contagious state). One patient used total of 58 days.

The Utilization Review Committee meets monthly and subcommittee as often as necessary. The committee reviews all current covered care patients as well as recently admitted potential Medicare patients.

Number of cases reviewed for 6 months ending June 1971, 59.

Number of cases in which need for admission was questioned, 19.

Average number of extended duration cases reviewed per month, 4.

Members of the utilization committee have no financial interest in the facility. The committee is composed of: 2 Medical Doctors, Certified Social Worker, Director of Nurses, Assistant Administrator, Secretary. Other consultants are invited to attend when needed.

Rehabilitation Nursing Service is provided daily and involves the following procedures with some patients receiving 2 or more procedures 2 to 3 times daily.

Active Range of Motion exercises	40
Passive Range of Motion exercises	64
Gait training	[1] 58
Tilt Table	[1] 1
Pulleys	[1] 2
Intermittent positive pressure breathing	[2] 1
Total	166

[1] Under supervision of Registered Physical Therapist.
[2] Portable machine—patient does his own.

Our activity program is planned on a 6 days a week basis with Sunday open for uninterrupted family visits. (Our visiting hours are open at any reasonable hours everyday). (Exhibit II). At least 80 patients are actively involved in one or more activities. In this department, we have volunteer and volunteen assistance. They have contributed approximately 3000 hours in the past year with 11,000 accumulated hours.

Our nursing staff includes: Director of Nursing, Assistant Director of Nursing, registered nurses, licensed practical nurses, aides, ward clerk, rehabilitation nurse aide, and activity directors. Nursing hours per day per patient is approximately 3 hours. Other staff members include: Administrator, assistant administrator, part-time purchasing agent, office manager and assistant, and part-time receptionist. Other full-time personnel, 7 days a week, are cooks and helpers (5.5), Maids (2.7), Laundry (2), and maintenance men (2.3). (See Exhibit III for percentage breakdown).

We have a Medical Advisory Committee that assists in developing policies for patient care, plus a Medical Director who serves 2–4 hours a week. Our other professional consultants and time spent in the Center during a month is as follows:

	Hours per month	Frequency of visits
Certified social worker	12 to 15	Weekly.
Dietitian, ADA	8	2 times monthly.
Registered pharmacist	12 to 15	Weekly.
Registered physical therapist	12 to 24	Do.
Occupational therapist, registered	8 to 12	Do.

Most of the above consultants participate in our weekly nursing care rounds.

A few facts in regards to our physical plant: A Corporation was formed with our attorney as the third member, in 1960, and the same members make up the Corporation, today. In 1961, a 5 acre tract, within the city limits, was purchased and plans started for a new facility to be designed specifically for the care of long-term patients. The building was planned with no frills such as fireplaces, carpeted rooms and foyers, etc., but very functional with activity room, therapy room with our shop-made parallel bars, steps, exercise table and pulley boards to name a few items included in this room, plenty of dining room space, beauty and barber area, as well as lounge, porch and outside court area for the use of our patients. In 1962, we opened our first 50 bed Nursing Center (See Exhibit IV), in 1966 an additional 38 beds, and in 1970 another 33 beds for a total of 121 beds, fully certified for Medicare. Needless to say, patient and public areas expanded with each addition.

The second positive program I wish to mention is our weekly nursing care rounds where a team of therapist, nurses, and physician studies each patient's problems and progress so the staff can establish a plan for his care that will help him along the road to rehabilitation. All patients admitted since the previous weekly rounds are interviewed. Medical records including a preadmission questionnaire furnished by the patient's family on his social, psychological and financial history are reviewed. This team assesses and evaluates the patient's condition, decides with the help of the patient, on short and long-term goals and how he is to achieve these goals. His patient care plan is developed in accordance with the necessary written orders of his physician. While the goals are established in the presence of the patient, with his

help, the actual planning, prognosis, and records are studied by the team members without the presence of the patient so that the final practical and realistic goals are set for them with each team member contributing their ideas and recommendations to help the patient realize his goals. A definite day is booked for re-evaluation of the patient's progress at which time the patient is involved again. There are usually 10–12 patients involved each week. This program has attracted much attention since it was started in 1966. Nurses from other programs, Public Aid Department Caseworkers and other agency personnel have made rounds with our team of evaluators. (For detail description and forms, see exhibit V).

I hope the picture is clear to the sub-committee, of a nursing care facility offering the most comprehensive service for patients no longer in need of acute hospital care. Our reimbursement, under the Medicare program, is 94% of our charges.

In November, 1970, an 8 unit apartment building for the elderly was opened adjacent to the Nursing Center. (See Exhibit VI).

All financing for the projects described in this document was secured from local Savings and Loan Associations with the going rate of interest charged at time of mortgage. All buildings and equipment are assessed the going personal property and R.E. tax rate.

The Center has an agreement with the area Junior College for clinical training of the Associate Degree and Practical Nurses Student, and Medical Record Librarian assistants. So, to participate in this activity, means we have been approved by various agencies as a satisfactory facility.

We find that we must compete with several non-profit church homes, extended care wings in hospitals, two county nursing homes, and other non-certified but skilled proprietary (for profit) facilities; therefore, we must be the best with reasonable charges. As a tax paying organization, we are constantly looking for methods to improve and keep cost at a minimum, and unless there is a real desire on the part of government to utilize our services for the Medicare and Medicaid programs, there is little else we can do to help control the dramatic increases in health care costs.

A state program which has enhanced the care of long-term care patients is the continuity of care program which succeeded a demonstration project called the Sangamon—Menard Community Transfer Project. The purpose of the project is to improve continuity of care of patients who move from one institution or agency to another in Sangamon and Menard counties; to send with the patient, at the time he moves, information about his medical orders and nursing needs, his personality and his abilities; to help make his transition smoother and less traumatic. This transfer information was to aid employees of hospitals, extended care facilities, nursing homes and public health nursing agencies to provide better patient care because of the knowledge of his immediate past. Continuity of care refers to planning together by various members of the health team with the patient and his family so there will be no break or lapse in his gradual restoration to health.

Today, as an ongoing program, this team made up of all segments of health care, are involved in early planning for discharges. The coordinator meets with the Utilization Review Committee of the hospitals and nursing homes, knows what type facility is needed and makes sure the bed available is one that offers the type services and even philosophy that answers the patient's needs. By better utilization of beds, not only improved care is realized but one day earlier discharge from the hospital and/or extended care facility can mean the savings of thousands of dollars over a year's time. Also, patients benefit from having adequate and proper transfer information immediately available upon patient's admission to insure continuity of care. (For further information, see Exhibit VII).

Another state program, as a response to the edict issued by President Nixon to Federal Health Agencies to improve the nursing home industry, the Illinois Department of Public Health has developed an automated system to assist in more effectively meeting its responsibility. (For details, see Exhibit VIII).

Last, I would like to make a few comments on Medicare and how it affects our patients and the Nursing Center.

We have guidelines to determine whether the patient is covered care or not and have an understanding of the intent of these guidelines as we have

been under the Assurance of Payment Plan for a year or longer. It has been necessary for us to assess and evaluate the patient and get the admission notice with our evaluation into the intermediary office within 48 hours. Often the complete history and final diagnosis does not arrive until a day or two later which makes it very difficult to be fair to the patients and/or their guarantors. Extra time is consumed by our staff in calling for this information and sometimes sending in revised evaluations. This could be made simpler, and I believe less costly, if the pre-admission authorization by the hospital Utilization Review Committee and the patient's own physician could be effective for 10 days. If, at the end of this certified period, the patient is found to be noncovered care, a 3 day notice of termination of benefits, like the Utilization Review Committee notices, be approved to give time to make other arrangements. Another problem we in outlying areas, away from the large cities, have, is the transferring of the patients from their own physician to another one practicing in our facility who is selected by the patient, family, or his referring physician. Of course, the patient is returned to the referring physician when dismissed from the Center.

If the County Medical Society were to be responsible for all Utilization Review Committee determinations, there would be more uniformity in interpretation of certification of need for extended care facility care.

Another program which should be considered is the development of more than one level of care in an extended care facility—such as a semi-skilled care in addition to continuous skilled nursing care. This might discourage the patient being kept in a hospital days longer because of the grey area that he falls into when he might not be definitely in the skilled area. The physician has a primary interest in the welfare of his patient, both medically and financially.

The entire definition of covered care needs to be reconsidered and active, practicing nurses (especially those working with geriatrics) should be included on this committee to review skilled nursing care.

In summary, the material presented for the record, contain programs within a facility and within the State of Illinois which can enhance good patient care throughout the Nation.

[Enclosures.]

EXHIBIT I

REHABILITATION PROGRAM IS EDUCATION FOR LIVING

(By Jane Barton)

"Here comes that do-it-yourself gang again. Think they're going to rehabilitate me—ha! I'll be here till I die." The old lady grinned wickedly through the sidebars of her bed and burrowed deeper among her pillows, challenging the two young women who entered her room at the Washington Nursing Home, Washington, Ill., to budge her—if they could. The visitors, a rehabilitation nurse and an occupational therapist, grinned back at the old lady, patted her hand, and talked cheerful nonsense for a few minutes, then continued their rounds throughout the home.

They don't try to budge her—that's not their job—although they hope that eventually she will budge herself because she wants to. That, in essence, is their job.

Nancy Meehan, the nurse, and Janet Shermak, occupational therapist, are part of the Rehabilitation Education Service project currently in progress in a selected group of public and private nursing homes in Illinois. The three-year research-demonstration project, begun in 1957, is sponsored jointly by the U.S. Office of Vocational Rehabilitation, the Illinois Public Aid Commission, the Forest Park Foundation at Peoria, Ill., and the Peoria Institute of Physical Medicine.

The objectives of the program are to find out: (1) the rehabilitation needs among the patient loads of nursing homes; (2) how far those needs can be met by the existing staffs of the homes in cooperation with local doctors and state and community agencies; (3) what kind of training program can be developed for the nursing home staffs; (4) what kind of teaching materials are needed and how they can best be put together. (A summary of the program and require-

ments for participation by the nursing homes is presented in the accompanying material: How Rehabilitation Education Project Works.)

Leading the procession of nursing home administrators who pounced eagerly on the project when it was first presented was Florence L. Baltz who, with her husband, operates the Washington Nursing Home and the Baltz Nursing Home at Normal, Ill. Mrs. Baltz, president of the American Nursing Home Association, has been diligently seeking ways to raise the standards of nursing homes throughout the country and to bring them into partnership with hospitals and other health agencies in the care of the aged and chronically ill. In fact, the Rehabilitation Education Service is the outgrowth of the efforts of Mrs. Baltz and other nursing home owners and administrators in Illinois to get help in giving more effective care to their patients.

The pilot rehabilitation study seemed to offer an opportunity to solve the twin problems of doing a more effective job and raising standards. It also offers a considerable challenge to the nursing home administrator's resourcefulness in meeting the requirements for participation and his powers of persuasion in selling the project to staff members, to physicians, and, particularly, to patients and their families.

The staffs of most nursing homes, *i.e.* the nurses and aides, are pretty well set in their ways—and their way of handling both the aged and the handicapped of all ages is to do everything for them. It is much easier to give a patient a bath or feed him than it is to convice him that he can give himself a bath or force crippled hands to grasp the knife and fork and guide them safely from plate to mouth. It takes much more time and infinite patience. And most nursing home employes would have trouble deciding which is hardest to find—time or patience.

The whole purpose of the rehabilitation program, however, is to retrain the patients in the simple activities of daily living as the first step in restoring as nearly normal function as possible. That first step may be as far as the patient will ever go (although a number of apparently hopeless cases have progressed to the point of being discharged to their homes) but the proponents of rehabilitation are convinced that even that is worth the effort.

So nurses and aides must be shown that their patience and the added time expended will be rewarded not only by restoring the chronically ill to happier living but by actual reduction of nursing time, once the patients have learned to help themselves. This is what Miss Meehan and Miss Shermak and their coworkers on the rehabilitation consultant teams have been trained to do by Dr. H. Worley Kendell, medical director of the Institute of Physical Medicine and Rehabilitation and also of the program.

When the consultant team goes into a nursing home—at the request of the administrator—it first explains the program to the administrator, doctors, nurses, patients and patients' families. Team members hold class sessions five days a week for all members of the nursing home staff. The sessions are partly lectures on all phases of care and treatment and partly demonstrations and bedside work with individual staff members. The training program continues for five or six weeks, on the average, and at the conclusion of the training period the consultants return for weekly and, later, monthly visits to follow up with the staffs and see how the work is progressing.

In discussing the rehabilitation project, Mrs. Baltz pointed out that it is essential that all members of the nursing home staffs, including those on night duty, attend the lectures and demonstrations and added that all persons in the home who have any contact whatever with patients are involved in their rehabilitation.

Another aspect of the staffing problem is that the nursing home administrator must select the right people to supervise the nursing program and to take charge of the activities. The activity director must be someone who has imagination and ingenuity in developing activities that will enlist the interest of the patients plus a flair for teaching. She must also be adept at making the most of simple, inexpensive materials. The cost of the materials, it is explained, can largely be offset by the sale of articles made by the patients; still they should not be too elaborate.

A basic requirement for the success of the rehabilitation program is acceptance by the local physicians. No rehabilitation measures can be undertaken on any patient without permission of the attending doctor. In most instances, the nursing home owners discovered, the doctors had to be educated to an understanding of what is involved in the rehabilitation program, and that they must specify just

what can and cannot be done for each of their patients. Simply saying "Sure, go ahead" isn't enough. The doctor must write specific orders as to the type of therapy he wants each patient to have, the frequency with which treatments should be given, contraindications for certain procedures, and so forth. Once they understand the purpose of the program, Mrs. Baltz reported, and the benefits it offers their patients, most of the doctors are extremely cooperative.

The hardest people to sell on the idea of rehabilitation often are the patients and their families. Until they can actually see results in terms of restoration of function and improved morale, Mrs. Baltz says, the families are likely to suspect that the program is just a dodge on the part of the nursing home owner to get out of giving the care for which the patient is paying. "Why should Grandpa have to give himself a bath when we're paying someone to take care of him? They'll expect him to make the beds next" is the attitude of many families. And the patients themselves—like the little old lady mentioned earlier—are inclined to take a rather dim view of the project until their interest and curiosity can be aroused. They accept the program cautiously and it is impossible, as well as unwise, to rush them. Some of them never will accept it, but gradually, the consultants have found, most of the patients are willing to try and, as they gain strength and ability, they become very pleased with themselves.

Probably the greatest benefit derived from the rehabilitation program is the change in the patients' outlook from hopelessness and the dreary conviction that they are "in for life" to one of renewed interest in living and hope for the future. The "future" of an aged or chronically ill person may look very limited to a healthy, active individual, but to the patient who has been flat in bed and unable to do anything for himself for years, even sitting up and washing his face is exciting activity.

At the Walker Nursing Home in Peoria, for example, Mrs. Della Walker, who has taken an enthusiastic interest in the rehabilitation program from the beginning, points with pride to her two star "exhibits," an 89 year old woman and a teen-age boy. Months of patient effort on the part of Mrs. Walker herself, her nursing staff, and the rehabilitation consultants were necessary to bring these patients out of their shells but it paid off.

No one knows quite why, but the 89 year old woman developed a passion for making potholders, and the simple activity has changed her view of life and her fellow patients from one of hostility to cheerful, garrulous interest in everything that goes on in the home. The stacks of potholders are rising to alarming heights, but nobody would think of discouraging her.

The boy was injured in a diving accident and the resulting paralysis had a completely demoralizing effect upon him. Eventually, however, the rehabilitation program did its work. He has developed a talent for draftsmanship and design that keeps him constructively occupied, and has achieved a remarkable degree of independence.

Mrs. Baltz' patients, too, range in age from the very young to the very old, and like Mrs. Walker, she has found that rehabilitation has benefited all age groups. As evidence of the effectiveness of the program she cites several patients who have been returned to their homes and families—patients nobody had ever expected to be anything but custodial cases for whom nothing could be done. "And," Mrs. Baltz says triumphantly, "they haven't regressed since they went home. They are getting along fine."

John A. Hackley, who is the coordinator of the Rehabilitation Education Service, explains that "Although the infancy of this program makes the reporting of any findings impossible, the limited experience in this program fortified by the long experience of many nursing home administrators may justify a few basic educated guesses. The eagerness of nursing homes and their administrators for professional consultation in all areas should be acknowledged. Likewise, in the past most of the emphasis on nursing home programs and nursing facilities has been placed up physical facilities and conformity with legislative requirements; certainly there is an indication that more assistance from agencies and from medical personnel should be made available to these administrators and their homes for improvement of in-service training programs. This increased emphasis on *service* is sought by nursing home administrators and the professional people in allied fields can contribute much in this area."

HOW REHABILITATION EDUCATION PROJECT WORKS

The Rehabilitation Education Service project of the Illinois Public Aid Commission is a three-year research and demonstration program sponsored jointly by the Commission, the U.S. Office of Vocational Rehabilitation, the Forest Park Foundation, and the Peoria Institute of Physical Medicine and Rehabilitation. It is the first program of its kind in the United States and is unique in its multiple sponsorship by federal, state and private foundations' funds.

In order to achieve its primary objective of determining the extent of the need for rehabilitation among patients in selected nursing homes, both public and private, and to find out how best to meet the need, the following subsidiary objectives were established:

1. To recruit a group of cooperating homes, desirous of providing more constructive service to patients, to serve as research laboratories.
2. To develop and make available to cooperating homes a rehabilitation education program for their staffs, with technical supervision given by the Institute of Physical Medicine and Rehabilitation, Peoria.
3. To publish information in the most appropriate forms for use in establishing programs of instruction in universities, professional schools, health departments, and public assistance agencies. Manuals for superintendents of homes will be made available also.
4. To conduct research into the nature of the vocational and physical rehabilitation needs of nursing home patients and the effects of rehabilitation in meeting needs.
5. To carry on local programs on the possibilities and value of vocational and physical rehabilitation, using cooperating homes as a basis for interpretation.
6. To develop more nearly adequate concepts of what may reasonably be required of nursing and county homes in assisting in the rehabilitation of their patients if adequate instruction is given to home staffs.

Criteria used in determining eligibility for participation in the program of the Rehabilitation Education Service are:

1. The applicant must be currently approved and licensed by the Illinois Department of Public Health.
2. At the time the training team is conducting the program in the particular nursing home, there must be one or more public aid recipients as patients in that home and the home must continue to accept public assistance patients.
3. A written request for the services of the Rehabilitation Education Service must be received from the nursing home administrator or an authorized representative of the governing body.
4. A registered nurse or a licensed practical nurse must be available on a full-time basis during the training program and thereafter so that there will be continuous supervision.
5. There must be on the professional staff of the nursing home an interested individual to develop and maintain a recreational program.
6. The administrator and the governing body of the nursing home must appreciate the need to cooperate in periodic evaluations of the effectiveness of the Rehabilitation Education Service program in that nursing home and be willing to maintain and make available whatever records are deemed necessary for research data.
7. The administrator and governing body of the nursing home must provide a comprehensive orientation of the nursing home staff and auxiliary personnel, the physicians, and the community at large to the purposes and goals of the Rehabilitation Education Service program.
8. The staff of the nursing home, including the administrator, must be aware of the potential community resources and willing to develop an adequate community education and public relations program to stimulate and utilize these resources.

CHART FOR TESTING ACTIVITIES FOR DAILY LIVING

NON-WALKING ACTIVITIES

Bed Activities:
1. Move in bed.
2. Sit with legs over edge.
3. Cross legs.
4. Procure objects from stand.

Hygiene (Toilet Activities):
1. Brush teeth.
2. Incontinent.
3. Wash pubic area.
4. Comb, brush hair.
5. Shave or put on cosmetics.
6. Wash hands and face.
7. Wash extremities.
8. Manipulate bedpan.
9. Take shower or bath.
10. Clean and trim fingernails and toenails.
11. Use toilet or commode.

Eating Activities:
1. Cut meat.
2. Eat with fork.
3. Drink from glass.
4. Pass food at table.

Dressing and Undressing:
1. Put on and remove pajamas.
2. Put on and remove underclothes.
3. Put on and remove socks and shoes.
4. Tying tie.
5. Put on and remove corset; braces; prosthesis:

Hand Activities:
1. Write.

Wheel-Chair Activities:
1. Bed to wheel chair and wheel chair to bed.
2. Propel and lock wheel chair.
3. Open, go through, and close door.
4. Wheel chair to automobile.
5. Wheel chair to standing position.

WALKING AND CLIMBING ACTIVITIES

Progressing Activities:
1. Walking.
2. Open, close door.
3. Walk on rough surfaces (outside).
4. Up and down ramp.
5. Up and down stairs with or without handrails.

Gait (underarm, crutches, canes, other):
1. 4-point alternate.
2. 2-point alternate.
3. Use cane.
4. Use walker.

Does Patient Participate in:
Group Activities—
1. Actively:
a. Never.
b. Occasionally.
c. Most of the time.
d. Always.
2. Passively:
a. Never.
b. Occasionally.
c. Most of the time.
d. Always.

Family Visits in the Home—
1. Never.
2. Occasionally.
3. Frequently.

Family Visits Out of the Home—
1. Never.
2. Occasionally.
3. Frequently.

Volunteer Activities—
1. Never.
2. Occasionally.
3. Most of the time.
4. Always.

Craft Activities—
1. Never did, still does not.
2. Did, but does not now.
3. Did not, but does now.
4. Did and still does.
5. Occasionally.

Tangible evidence of the patient's progress is recorded in the Activities for Daily Living chart kept at the bedside. Opposite each group of activities is a block of squares in which the staff checks off what the patient is able to do and the amount of progress from time to time. Patients are graded by numbers that indicate their capacities, as follows: 1—Unable (Impossible); 2—Able but with assistance (Possible); 3—Independent but slow; 4—Normal; 5—X if not applicable; *—Able but not doing it at this time.

EXHIBIT I–A

RESTORATIVE SERVICES IN ILLINOIS HEALTH CARE FACILITIES

In Illinois, as in most other States, complete and intensive rehabilitation services are limited to a few urban areas. Yet Federal and State programs recognize the importance of these services and make them a part of their requirements in order for groups or individuals to participate in their programs. In the average community, knowledge, and appreciation of the benefits of re-

storative services or the rudimentary techniques of such care has increased over the past ten years.

However, the shortage of professionally trained personnel available to facilities in these communities not only to provide direct patient service, but more importantly education and consultation to the staff, continues to be not only a State but a national problem. As a result of this problem, a study was made (the Campbell Report, Education in Health Fields; June, 1968). The results precipitated the recommendation of training health personnel on all levels to perform those services of which they are capable; thus breaking from the traditional idea that all specialized services must be performed by professionally trained persons.

The Rehabilitation Education Service, though initiated eleven years prior to the Campbell study, was the State of Illinois' early recognition of this need and its method of developing restorative services in long-term care facilities. This program began as a three-year research-demonstration project which was supported by the Federal Government through the Office of Vocational Rehabilitation, by the State of Illinois through the Illinois Department of Public Aid, and by local funds through the Forest Park Foundation of Peoria, Illinois, which was officially known as OVR Special Project No. 29–56, began in February 1957 and ended in December of 1959. It was an educational program for existing staffs in all interested long-term care facilities. The original objectives of the project were as follows:

1. What were the rehabilitation needs, including the needs for vocational rehabilitation, among the patient loads of a selected group of public, private, and voluntary nursing homes?
2. To what extent could these needs, once defined, be met by the existing staffs of these homes in cooperation with local physicians, other services of the community, and the State Division of Vocational Rehabilitation?
3. What kind of a training program could be developed to provide nursing staffs with a functioning knowledge of rehabilitation techniques and to increase their appreciation of the general philosophy of physical and vocational rehabilitation?
4. What kinds of teaching materials could be developed for use by other agencies and schools in order to increase the competency of nursing home staffs to share in the vocational and physical rehabilitation program?

As these objectives were met, the continuing objective of the program has been to upgrade the level of care provided to all patients in health activities.

The staff for the Rehabilitation Education Service program is made coordinator, rehabilitation nursing consultants, occupational therapy, a consultant physiatrist, and clerical staff. The rehabilitation nurse consultants and the occupational therapy consultants work together in teams, usually made up of two nurses and one occupational therapist. Since its inception in 1957, and still today, there are two teams that cover the entire State of Illinois with this educational program.

The question is often raised as to why a physical therapist was not and is not included in the team composition. The reasoning behind this concept was that since the major service offered in long-term care facilities is nursing—then restorative nursing, as an integral part of good nursing, should be presented by nurses to nurses. The occupational therapist, at the time the Rehabilitation Education Service program began, was felt to be the person best qualified to train an individual on the staff of the facility to be an activity director. However, it should be noted that it has been the continuing practice of the Rehabilitation Education Service to encourage facilities to engage local persons, professionally trained in various restorative services to serve as consultants and to assist the staff of the facility with their on-going programs.

In facilities where consultants are used, it has been noted that in those instances where the professional consultants are utilized primarily to evaluate patients, to help develop patient care programs, and to teach staff, the facilities' program becomes much more effective. In those situations where the professional consultants are used for direct service only, the full-time staff of the facility too often developed the attitude that restorative care is something that "somebody else does" and, in effect, this fragments the program and the delivery of care to the patient.[1]

[1] All the findings and the outcome of the research project are available to anybody who wishes them upon request of the *Final Report of the Rehabilitation Education Service.* This may be secured by contacting R. F. Sondag, M.D., M.P.H., Chief, Bureau of Personal and Community Health, Department of Public Health, 535 West Jefferson Street, Springfield, Illinois 62706.

In 1960, the Rehabilitation Education Service became a permanent program with the Illinois Department of Public Aid. At that time, the Department of Public Aid was receiving matching funds from the Federal Government so that the program could continue to function. It should be noted that since the day of its inception, the Rehabilitation Education Service has been a free program to any health care facility interested in requesting it. In 1966 with the advent of Medicare, the Federal Government informed the Department of Public Aid that the services offered by the Rehabilitation Education Service should be with the Medicare certifying agency. In Illinois, this was and is the Department of Public Health. Therefore, the program was transferred to the Department of Public Health rather than have that agency develop duplicating consultation services. Today, the Rehabilitation Education Service is still an active program within the Department of Public Health.

In Appendix A attached to this paper can be found more information regarding the procedure for securing and conducting the Rehabilitation Education Service program within a facility. Briefly, the presentation method is an, in the facility, in-service program lasting from three to six weeks, four days a week at least eight hours a day.

Due to the demand by health care facilities throughout the State of Illinois, the Rehabilitation Education Service presently has a four-year waiting list for the service of a team. This has necessitated a modification in the procedure which is used by the Rehabilitation Education Service. Although essentially the same program content is being presented, the manner of presentation is through the workshop method. These workshops are called Area Training Programs, and facilities within a fifty-mile radius of a central point are contacted and asked if they wish to participate in the program. The response is more than the limited number of staff can handle and enrollment must be limited.

The goal in this method of presenting the Rehabilitation Education Service program is to "teach teachers" who in turn return to their respective facilities and instruct the staff in the philosophy and various restorative techniques. A copy of the program used for the workshop method of presentation of the Rehabilitation Education Service program can be found in Appendix B of this paper.

In evaluating the results of the two types of presentations, it has been found that the first method mentioned, is the one of choice having resulted in stronger, more stable programs. This, it is felt, is the effect of having the team members in the facility for a prolonged period of time, available to work with all staff as needed thereby helping the facility build a total program through utilization of ideas, skills, and knowledge of anyone having patient contact (this includes family and community). Through the use of a workshop presentation the close relationship established with staff is limited to a select few, thereby effecting the feeling of total staff to their part in the program.

In both methods of presentation, there is follow-up consultation from a Rehabilitation Education Service team. The purpose of the follow-up consultation is for continued training of staff, to assist the staff of the facility with problems that may occur in either the restorative nursing or the activities area of their program, and for exchange of ideas and new information.

The program is built on a very simple philosophy of restorative care. This philosophy is emphasized throughout the presentation of the program by stressing the following four basic principles:

1. Start treatment early.
2. Activity strengthens; inactivity weakens.
3. Stress the patient's abilities not his disabilities.
4. Treat the whole person.

These four basic principles are brought out and demonstrated in class as well as in the patient areas, and practiced with the staff of the facility in both nursing and activities. Although all staff are encouraged to attend as many classes as possible, to help develop an understanding of their role in the team concept, the aides are the staff members who receive the concentrated efforts of the team nurses. The reason for this being based on the fact that it is usually the aides who carry out the majority of the care and techniques used with the patients on a twenty-four hour, seven days a week basis. This does not by any means infer that the professional staff is shunned. To the contrary, the material presented to them is supplemented with more indepth information and instruction of not only the restorative techniques, but also concentrating on in-service and teaching skills as they must be the ones to carry on the promotion of the program after

the team leaves. The other areas of emphasis are helping the professional staff with patient evaluation, patient care planning, and meaningful documentation. The Activity Director is also involved in this.

As has been proved or stated many times and as stated again, teaching skills is easy; the philosophy is a little harder to come by but is an absolute must in an on-going successful program. The four principles must be used in all areas of the restorative program being presented in order for it to be a truly integrated, individual patient oriented, program.

It should be noted again that the Rehabilitation Education Service encourages the facilities to use local consultants to assist them with the continuing development of their programs, with the consultant being used primarily in the area of patient evaluation and in-service education of staff.

Although the manner of presentation varies with individual facility situations, depending upon the amount of program which they may have already developed on their own, the class outline for the most part contains the following material:

I. PHILOSOPHY OF RESTORATIVE CARE

This includes a film, entitled "Proud Years", which deals with restorative care of the elderly and also, a discussion of restorative care, especially as it relates to the long-term care situation. (If this program is being presented in a hospital, it will be related more to the acute care situation.)

II. TEAM APPROACH

There is much emphasis placed on the team composition in the facility including maintenance, housekeeping, dietary, laundry, administrative staff, nursing staff, activity personnel, plus community and family involvement in the total program. And since this is the class which emphasizes the need for understanding and cooperation of all staff members in order to develop a "total program", the requirement for total staff involvement in all classes becomes evident at this time.

III. APPROACH AND MOTIVATION

What is it that makes a patient behave in a particular manner, and if this behavior needs to be altered for the benefit of all concerned, what can be done to effect this alteration?

IV. RESTORATIVE NURSING

What is restorative nursing? How does it compare to, and how does it relate to physical therapy? Specifics that may be covered in this area would be range of motion exercises, transfer activities and ambulation with the use of the transfer and/or gait belt, bed positioning and body alignment, bowel and bladder retraining including sensory stimulation, and activities of daily living. All specific techniques that are taught are followed by return demonstration on the part of the individual staff members who will be responsible for carrying them out. This means nursing staff from all three shifts.

V. ACTIVITY PROGRAMING

This includes discussion of activities being presented in large groups, small groups, and the use of individual approach to patients. The activities stressed fall into eight categories.

1. *Recreational activities.*—Games, parties, movies, etc.
2. *Craft activities.*—With special emphasis on the need for masculine type crafts including wood, leather, and metal working.
3. *Religious activities.*—This means areas of interest other than routine religious services
4. *Service activities.*—In order to offer patients an opportunity to be useful, effective, and of value to others
5. *Intellectually stimulating activities.*—For those patients who feel activity of the brain is more important than activity of the brawn, this area provides the answer
6. *Remotivation and reality orientation techniques.*—These are used with the confused and withdrawn patients
7. *Community activities.*—An opportunity to return to the community for pursuing interests in sports, art, theatre, church, and clubs
8. *Effective use of volunteers.*—How to enlist, organize and direct this valuable group of people

In all of the above, active involvement of the patient is stressed rather than passive, although passive involvement is identified as being important for the patient whose function limits him to this. The specifics used must be meaningful to the patient.

VI. DISEASE ENTITIES

This presentation deals with some of the diagnostic conditions that are commonly found among the patients in long-term care facilities. The conditions discussed include arteriosclerosis, arthritis, vision and hearing problems, cardiacs, cerebral vascular accidents, fractures, especially of the hip, multiple sclerosis, and Parkinson's disease. These conditions are discussed generally as well as describing how restorative nursing and activity programming can be utilized to offer patients the ultimate in "progressive care". In this way, an attempt is made to stimulate staff to improve the status of the patient's mind as well as his body and overcome some of the effects of sensory deprivation that results from "conventional care", offered by most hospitals and long-term care facilities.

Regarding the economic aspects, in facilities that have developed a strong program, not only is there considerably less staff turnover due to increased job satisfaction, but also, administrators have voiced pleasure over the reduced costs of operation once the program is in full force.

Statistically, with only two teams functioning, the Rehabilitation Education Service staff has reached an admirable number of facilities with an ever increasing number of beds being represented and a continually changing patient population. As the program, until recently, concentrated its attention on long-term care nursing facilities, it is from these facilities that the following statistics are taken.

As of July, 1971, there were 737 licensed long-term nursing care facilities. This represented 55,977 beds. The Rehabilitation Education Service, as of the same date, had presented its educational program in 152 of these facilities, representing 12,195 beds.

The statistics regarding hospitals are not as impressive, but it should be remembered that hospitals were not interested in using the services of a rehabilitation team until 1969. As of April, 1971, the total number of licensed hospitals in Illinois was 310. This represented 90,731 beds. The Rehabilitation Education Service has had direct program contact with eight of these hospitals representing 2,323 beds.

Thus, the Rehabilitation Education Service program in its thirteen years of existence has reached 160 facilities with direct educational program content. This represents 14,518 beds. There is no way that a determination can be made as to the number of people who have received stimilus and education through the program either directly or indirectly. By the same token, there is no way an actual determination can be made of the number of patients who have benefited from the services that facilities provide as a direct result of training and consultations from the Rehabilitation Education Service.

It was not long after the Rehabilitation Education Service program began that facilities which were truly implementing the program began to see their patients' level of function improve. Unfortunately, this resulted in reduced reimbursements from Public Aid for Public Aid recipients. This had a decided detrimental effect on administration in their wanting to use the services of the team even though they agreed that what the team taught resulted in a higher level of patient care. Realizing this dilemma, the Department of Public Aid developed a program which has become known as the Rehabilitation Evaluation Committee, or approval program. This is a program that recognized those facilities that have developed a restorative nursing and activity program thereby providing services beyond the basic requirements. There are criteria which are attached in Appendix C, outlining what a facility must provide in both nursing and activities in order to receive approval. What this means to the facility is more rather than less reimbursement, as was the picture before, approval offers additional reimbursement for every Public Aid recipient, no matter how that person is involved in the program.

The approval program began in 1963 and continues to date, although it will be terminated on July 1, 1972. The evaluation committee is composed of a rehabilitation nursing consultant, an occupational therapy consultant, and the consultant physiatrist to the Department of Public Health. Also included in the on-site visit to the facility for evaluating the program are the Regional

Public Health Survey personnel and recently, many of the Mental Health aftercare personnel.

The Rehabilitation Evaluation Committee, during its evaluation, attempts to identify that a restorative nursing and activity program exists. At present, in the State of Illinois there are 181 long-term nursing care facilities with approved programs; 137 of these are approved for restorative nursing and activities; 44 of these are approved for activities only. Of these numbers, those that are approved for restorative nursing and activity programs, 106 have had consultation or direct program contact with the Rehabilitation Education Service; of the 44 homes that are approved for activities only, 24 have had either a complete Rehabilitation Education Service program or consultation from Rehabilitation Education Service. This means that out of a total of 181 approved facilities, 130 have received assistance from the Rehabilitation Education Service. (The number of approved facility beds represents a total of 17,751; of this number, 13,304 have received program developed assistance from the Rehabilitation Education Service.)

Perhaps, by way of conclusion, it should be pointed out that in revision of Standards for long-term care facilities, the services of restorative nursing and activity program are no longer voluntary or an extra; they are now considered a part of total patient care and required for the licensure of all long-term care facilities. In addition, in the partial revision of the hospital licensing Standards, an identifiable twenty-four hour, seven day a week restorative program must be provided. This progressive step, it is felt, shows the impact that the Rehabilitation Education Service has had upon the provision of health care in the State of Illinois.

Appendix A

Procedure in Securing Rehabilitation Education Service

Home obtains application forms entitled "Application for Rehabilitation Education Service" from Department of Public Health, Springfield, Illinois.

Home fills out form and returns to Supervisor, Rehabilitation Education Service.

The application is then acknowledged and a date set up for the Rehabilitation Education Service Supervisor to make an initial visit to the home. (Regional and County Health Representative invited to attend.)

INITIAL VISIT

Purpose: To explain the program in greater detail, answer questions, see facility, and find out whether the home is still interested.

Initial visit discussed with Dr. Albert Siegel, Consultant Physiatrist and the home is then accepted or denied and notified of action. (cc: Regional and County Health Office.)

If accepted—place on waiting list. Tentative date established. Home to start working on meeting with County Medical Society and R.E.S. Consultant Physiatrist.

TEAM VISIT

Purpose: Approximately one month before team enters and supervises, team that is to put on program sets up specifics of initiating Training Program with the home's key staff members. (Regional and County Representative invited to attend.)

Home Regional and County Health Offices send letter confirming all arrangements.

Initial Training Period: Four to six weeks, four days a week (8:30 a.m. or 9:00 a.m.) Classes first 2½–3 weeks, evaluate patients, and initiate Program. (All may vary with situation) (For specifics see attachments)

FOLLOW-UP VISIT

Purpose: Continued training; Help with problems in either area of Program; Exchange of ideas.

Items That Homes Are Asked to Provide

One person from their staff to supervise rehabilitation nursing. This person should be available full time while team is in the home. This person is also requested to take Rehabilitation Nursing Course.

One person from staff or community to be trained as Activity Director. This person should be available full time while team is in the home.

Materials and supplies—$50 to $100 (depending on size of home): Parallel bars, foot board, pulleys, lap boards, and storage space.

We supply patterns and activity program supplies.

Medical Permission Forms signed by attending physician.

Meeting with County Medical Society and R.E.S. Consultant Physiatrist.

Arrange for *all* staff to attend classes—place for classes: Projector, 16mm sound with large take up reel.

Set up meeting with people interested in becoming volunteers to primarily assist in activity area.

If they do not have in-service training, then they are requested to begin one.

Make individual nursing staff assignments to work with the Rehabilitation Education Service team nurse for return demonstration and practice of specific techniques.

A meeting with key staff will be arranged while the training program is being presented to discuss documentation of restorative procedures.

ROUTINE LIST OF CLASSES

(Varied With Individual Home Situation)

I. Philosophy of Restorative Care (Introduction to the Rehabilitation Education Service program).
   Film: "Proud Years."
   Discussion of Restorative Care (especially as it relates to nursing home or home for the aged situation).
II. Team Approach (Emphasis placed on all team members in the facility including maintenance, housekeeping, kitchen, laundry, administrative staff, nursing, activities, community, and family).
III. Approach and Motivation.
IV. Restorative Nursing.
V. Activity Program.
VI. 2 Classes on Disease Entities.
VII. Diagnostic Conditions (generally covered include: arteriosclerosis; arthritis; vision problems; hearing problems; cardiac; cerebral vascular accident; fractured hip; multiple sclerosis; Parkinson's).
VIII. Range of Motion Exercises.
IX. Transfer Activities and Use of Transfer and/or Gait Belt.
X. Bed Positioning and Body Alignment.
XI. Bowel and Bladder Retraining.
XII. Activities of Daily Living.
XIII. Demonstration Class in Activities.

PROCEDURE IN HOME—REHABILITATION NURSING CONSULTANT

(Classes Excluded From List)

1. Check records for kinds of information contained at time of team's entering the home; also for patient's name, diagnosis, age and present level of functioning. (Additional information secured from staff and individual patient visits.)

2. Work intensively with supervisory staff on various rehabilitation techniques.

3. Work at least one hour with each aide in the home with patients (aide assigned) teaching passive range of motion, active range of motion, active assistive range of motion, positioning, transfer, gait training in the parallel bars, gait training with walker and cane, pulley exercises. This includes working with 11–7 staff during their shift if they request it.

4. Help staff begin B. & B. retraining on selective patients.

5. Assist staff in encouraging patients in A.D.L. Begin retraining where found appropriate.

6. Help staff set up comprehensive records and give suggestions as to how to chart rehabilitation nursing techniques.

7. Give assistance to the activity program and encourage staff to do the same so that a greater understanding and appreciation for the overall team effort may be developed.

8. Assist in interpreting program to physicians when requested.
9. Assist with securing and setting up equipment for rehabilitation nursing.
10. Assist with interpretation of program to family and sometimes community groups.
11. Consult with administrator on progress of program and involve administration actively whenever possible to increase his or her understanding of the program.
12. Encourage and assist with development of procedure manuals and in-service education within the individual facility.

PROCEDURE IN HOME—OCCUPATIONAL THERAPY CONSULTANT

(Classes Excluded From List)

1. Specific instruction of activity director in various techniques with adaptations and variations for individual patients. These include crafts and recreational activities plus any other activities which can be specifically taught at this time.
2. Assist activity director in increasing knowledge of patients' medical and psychological condition and medical terminology.
3. Assist activity director in ordering and procuring supplies.
4. Assist activity director in establishing method of keeping records, daily attendance, and individual progress. Try to give an understanding of how records can be of help in planning for patients plus information to all other services of the home and attending physicians.
5. Discuss and encourage expansion of home's existing religious program (if none exists, encourage starting one).
6. Assist with planning, scheduling and carrying out activities program—variety stressed.
7. Initiating the activity program with patients involved. Include the following various types of activities: crafts, recreational, intellectual, service, and group exercises. Both group activities and individual bedside activities are demonstrated.
8. Encourage and where feasible initiate outside and community activities.
9. Meet with volunteers and assist in organizing and implementing this phase of the program. (If time is right.)
10. Assist activity director in becoming aware of her responsibilities as a member of the team. (Including staff conference, in-service, etc.)
11. Consult with administrator on progress of program and involve administration actively whenever possible to increase his or her understanding of the program.
12. Encourage whenever possible, the cooperative effort of the nursing staff to become involved and/or interested in the activity program for a more unified service to the entire patient population.

APPENDIX B

STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH

During the first two weeks of May, the Illinois Department of Public Health's Rehabilitation Education Service plans to present an eight day workshop in Restorative Nursing and Activity Programming. Agency Consultants (Public & Mental Health) who work with you and your staff, suggested we contact you.

As you know, the new standards for all Health Care Facilities outline Restorative Nursing and Activity Programming as a requirement for licensure. The information which will be offered at this workshop, when used by your staff, will help your facility come into compliance with this new ruling.

Your facility is licensed to give nursing care, so the people who would be expected to attend each of the eight day sessions would be your Director of Nursing or her assistant, your In-Service Director (if you have one) and your Activity Director. As there will be presentations of maximum benefit to you as an administrator, we ask that you be present all day Tuesday and Friday afternoon of the first week and all day Tuesday of the second week.

We are enclosing information which outlines the plan to date; speakers, topics, and times are subject to change. Please look over the material and if you are interested, fill out the questionnaire and return it to this office as soon as possible (deadline March 12). Since our enrollment will be limited to forty (40), we will register the names on the questionnaires as they are received by this office.

Upon receipt of your questionnaire, I shall plan a visit to your facility to further explain the workshop and answer any questions which you might have.

Looking forward to hearing from you, I remain,

Sincerely,

(Miss) BETTY CONNELL, R.N.,
Coordinator, Rehabilitation Education Service,
Division of Health Facilities.

[Enclosure.]

ILLINOIS DEPARTMENT OF PUBLIC HEALTH, REHABILITATION EDUCATION SERVICE, SPRINGFIELD, ILL.

QUESTIONNAIRE FOR AREA TRAINING PROGRAM

Name of nursing facility_____.
Address_____ Phone Number_____.
City_____ County_____.
Bed capacity_____ Census_____.
Administrator _____.
Type of Facility:
_____Nursing Home for Adults.
_____Extended Care Facility.
_____Home for Aged with Nursing Care.
_____Convalescent Home for Adults.
_____Other (Specify)_____.
Ownership:
_____Private.
_____Church operated.
_____Fraternal Order.
_____Other non-profit organization.
_____County.
_____City.
_____County—City.
Please check following:
_____Yes, I am still interested in the Rehabilitation Education Service Program.
_____No, I am not still interested in the Rehabilitation Education Service Program.
If you answered "yes" to above questions, please complete the following information:
Number of people who will attend the Area Training Program_____.
Names and titles of people who will attend:

Name	Title
_____	_____
_____	_____
_____	_____
_____	_____

Does your facility presently provide restorative nursing and activity programming? Yes_____. No_____.

Have any of your nursing staff attended a Rehabilitation Nursing Course? Yes_____. No_____.

If "yes", please give name of course, location, dates attended and name of person or agency conducting course_____.

Do you presently have an activity director employed in your facility? Yes_____. No_____. Number of hours worked per week_____.

If "yes", has this individual received any special training in activity programming? Yes_____. No_____.

If "yes", please give name of course, location, dates attended and name of person or agency conducting course_____

_____, *Administrator.*
Date_____.

Please return by_____to:
Miss Betty Connell, R.N.
Coordinator, Rehabilitation Education Service
Illinois Department of Public Health
Bureau of Health Facilities
535 West Jefferson Street
Springfield, Illinois 62706

PROPOSED GENERAL INFORMATION ON THE SECOND REGIONAL REHABILITATION EDUCATION SERVICE WORKSHOP

I. *Dates:* (Workshop will be eight days in length—Tuesday through Friday. May 4 through May 7, May 11 through May 14.

II. *Time:* 8:30 A.M. or 9:00 A.M. to 4:30 P.M. or 5:00 P.M.

III. *Location:* Champaign-Urbana Area. (Decision regarding the location of the workshop is still pending.)

IV. *Attire:* Participants will be asked to dress in very casual clothes (slacks, shorts, coulottes, etc.), in order to participate in return demonstration comfortably.

V. *Material To Be Covered:*

A. Philosophy of restorative care.

B. Demonstration and return demonstration in restorative techniques (range of motion exercises, transfer technique, bed positioning, bowel and bladder retraining methods, activities of daily living testing and training).

C. Disease entities (arthritis, multiple sclerosis, cardiac, blindness, fractured hip, arteriosclerosis, cerebral vascular accidents, heart disease and speech and hearing).

D. Activities (programming and skills, ordering of materials, establishing volunteer programs, etc.).

E. Documentation necessary in both areas (nursing and activities).

F. Establishing inservice training programs.

G. Utilizing consultant services.

H. Remotivation and Deconfusion.

I. Legal aspects involved in activity programming and restorative nursing.

VI. *Follow-up:* The Rehabilitation Education Service teams will spend two weeks in each participating facility to assist the staff in implementing the knowledge and skills gained at the area training program. (This will include approximately three class sessions for *all* staff in your facility.)

VII. *Recognition:* All participants completing the eight day training session will receive Illinois Department of Public Health certificates.

REHABILITATION EDUCATION SERVICE, SECOND AREA WORKSHOP IN RESTORATIVE NURSING AND ACTIVITIES

TUESDAY, MAY 4[1]

8:30 Registration and Coffee.
9:00 Welcome and Introduction, B. Connell.
9:30 Philosophy, Albert Siegel, M.D.
10:00 Film, "Proud Years."
10:40 Discussion with questions and answers.
11:15 Lunch.
12:45 Positioning.
1:45 Team Approach—Approach and Motivation, R.E.S. Staff.
2:45 Coffee.
3:00 Activities with some Demonstration.
4:30 Conclusion.

WEDNESDAY, MAY 5

8:30 Bowel and Bladder Retraining—Film, "There Is a Way." Brushing and Icing Technique.
10:15 Coffee.
10:30 Transfer Techniques.
11:30 Lunch, R.E.S. Staff.
1:00 Disease Entities.
2:15 Coffee.
3:00 Range of Motion, Pulleys.
4:30 Conclusion and Announcements.

[1]Administrators are asked to attend these sessions.

THURSDAY, MAY 6

8:30 Return Demonstration and Activity Techniques.
10:15 Coffee.
10:30 Return Demonstration and Activity Techniques.
11:30 Lunch, R.E.S. Staff.
1:00 Return Demonstration and Activity Techniques.
3:00 Coffee.
3:15 Activities of Daily Living.
4:30 Conclusion and Announcements.

FRIDAY, MAY 7

8:30 Return Demonstration and Activity Techniques.
10:00 Coffee, R.E.S. Staff.
10:30 Return Demonstration and Activity Techniques.
11:30 Lunch.
1:00 Panel Discussion:[1] "Role of the Consultant"—O.T., P.T., S.W., Diet Sp. Th., Rehab. Nurse.
3:00 Coffee.[1]
3:15 Speech and Hearing Problems,[1] D. Richards.
4:30 Conclusion.[1]

TUESDAY, MAY 11

8:30 Return Demonstration and Activity Techniques.
10:15 Coffee, R. E. S. Staff.
10:30 Return Demonstration and Activity Techniques.
11:30 Lunch.
1:00 Patient Care Planning Film, "Mrs. Reynolds Needs a Nurse."
3:00 Coffee.
3:15 Patient Evaluation, D. Ehnle.
4:30 Conclusion.

WEDNESDAY, MAY 12

8:30 In-Service (with "Black Home" assignments), B. Connell.
9:45 Coffee[1].
10:00 "Geriatric Needs,"[1] Mr. Mitchell.
11:30 Lunch.[1]
1:00 Remotivation and Deconfusion.[1]
3:00 Coffee.[1] A. Fleener.
3:30 Continue Remotivation and Deconfusion.[1]
4:30 Conclusion and Announcement.[1]

THURSDAY, MAY 13

8:30 Records and Documentation, R. E. S. Staff.
10:00 Coffee.
10:15 Presentation of In-Service Schedules, Participants.
11:30 Lunch.
1:00 Return Demonstration and Activity Techniques.
3:15 Coffee, R. E. S. Staff.
3:30 Return Demonstration and Activity Techniques.
4:30 Conclusion—Assignments.

FRIDAY, MAY 14

8:30 Legal Aspects of Restorative Programming,[1] R. Gleason.
10:00 Coffee.
10:30 Critique.
11:00 Awarding Certificates.

[1]Administrators are asked to attend these sessions.

FACULTY FOR REHABILITATION EDUCATION SERVICE WORKSHOP

Guest Speakers in order of listing on agenda :

1. Albert Siegel, M.D., Consultant Psychiatrist, Illinois Department of Public Health, Springfield, Illinois.
2. Salley Oberbeck, O.T.R., Program Director, Joint Residential Unit, Adolph Meyer, Zone Center, Decatur, Illinois
3. Don Able, R.P.T., Chief Physical Therapist, Restmore, Inc., Morton, Illinois.
4. Marcia Jurgens, A.C.S.W, Clinical Service Director, Cole County Mental Health Center, Mattoon, Illinois.
5. Barbara Butz, Nutrition Consultant, Illinois Department of Public Health, Springfield, Illinois.
6. Beverly Deaton, RN, Rehabilitation Nursing Consultant, Barry Nursing Homes, Inc., Springfield, Illinois.
7. Doris Richards, Consultant Speech Pathalogist, Illinois Department of Public Health, Springfield, Illinois.
8. Donna Ehnle, R.N., Director of Nursing, Parkhill Extended Care Facility, Chillicothe, Illinois.
9. Martha Mitchell, R.N., Psychiatric Nursing Consultant, Illinois Department of Public Health, Springfield, Illinois.
10. Aileen Fleener, Psychiatric Technician II, Peoria State Hospital, Peoria, Illinois.
11. Robert Gleason, Legal Advisor, Illinois Department of Public Health, Springfield, Illinois.

CURRICULUM VITAE

Janet B. Chermak, O.T.R.

Miss Chermak attended Milwaukee Downer College (Wisconsin) and received her B.S. degree, with a major in occupational therapy, from that school. Her M.A. is from Western Michigan University and at present she is Supervisor of the Rehabilitation Unit of the Illinois Department of Public Health.

Betty L. Connell, R.N.

Miss Connell is a graduate of Gordon Keller School of Nursing (Tampa, Florida) with extensive post-graduate work in rehabilitation nursing. She is presently the Coordinator of the Rehabilitation Education Service, Illinois Department of Public Health.

Albert R. Siegel, M.D.

After receiving his medical degree from the Chicago Medical School (Illinois), Dr. Siegel was in general practice for thirteen years. In 1962 he attended Albert Einstein Medical School (New York City) where he gained his specialty in Physical Medicine. He has served as a consultant Physiatrist for the Illinois Department of Public Health since 1965.

Roger F. Sondag, M.D.

Dr. Sondag received his Bachelor and Medical Degrees from the University of Illinois and his Masters Degree from the University of North Carolina. He has been in the field of Public Health since 1942 and presently is Chief of the Bureau of Personal and Community Health, Illinois Department of Public Health.

APPENDIX C

ILLINOIS DEPARTMENT OF PUBLIC HEALTH : CRITERIA FOR REHABILITATION NURSING AND ACTIVITY PROGRAMS IN HEALTH RELATED FACILITIES

REHABILITATION NURSING AND ACTIVITY PROGRAM

In order to qualify for special allowances from the Illinois Department of Public Aid for a rehabilitation nursing and activity program, a facility must meet all the licensing requirements of the Illinois Department of Public Health and be currently licensed.

1. STAFF

a. A manager or administrator who does not have responsibility for supervising nursing service.

b. A full-time registered nurse trained in rehabilitation nursing to supervise nursing service.

c. Sufficient number of trained nursing staff to provide adequate patient care on a 24-hour basis.

d. A staff member qualified by special training and on duty a sufficient number of hours per week to adequately direct the activity program.

e. Adequate number of dietary, laundry, maintenance, and housekeeping staff who do not have responsibility for nursing care to provide the kind of service needed by the patients served by the facility.

2. MEDICAL SUPERVISION

a. An advisory physician or a medical advisory committee to provide medical guidance in the overall administration and operation of the facility.

b. A close working relationship with a community hospital to provide services not available in the facility.

3. NURSING PROGRAM

a. Written nursing procedures to include restorative techniques for use by all nursing personnel for care of all patients accepted in the facility.

b. Written, up-to-date, patient care plan for each patient based on the individual's abilities and needs.

c. An ongoing, identifiable, restorative nursing program providing the procedures specifically identified as rehabilitative in all major areas of patient care, such as:

(1) Positioning.
(2) Transfer.
(3) Activities of Daily Living.
(4) Range of Motion Exercises.
(5) Ambulation.
(6) Bowel and Bladder Retraining.

4. ACTIVITY PROGRAM

A specific, planned, activity program of group and individual activities geared to the individual needs of the patient, and embracing a significant number of the following areas, and available for a reasonable number of hours for at least five days a week:

(1) Recreational.
(2) Diversional (Crafts).
(3) Religious.
(4) Service (for Facility or Community).
(5) Intellectual and/or Educational.
(6) Community Activities (Patients into Community).
(7) Volunteer and Auxiliary Programs.

5. EDUCATIONAL PROGRAM FOR ALL STAFF

a. An orientation program for new staff including orientation to restorative program.

b. An established, ongoing, regularly scheduled, inservice training program for all personnel.

6. RECORDS

a. Basic Records Required by Public Health (for all patients):

(1) Annual physical examination reports.
(2) Physician's written orders for all medication, treatment, diets, and activities of each patient.
(3) Physician's progress notes dated and signed by the physician.
(4) Nursing notes.
(5) Medication and treatment records properly completed and signed.

b. Restorative program (for patients receiving rehabilitation nursing and activity program services):

(1) Professional evaluation for patient care including necessary restorative care.
(2) Physician's orders for specific restorative procedures and techniques.
(3) Identifiable documentation of progress at regular intervals by all persons involved in patient's care.

7. ESSENTIAL EQUIPMENT AND FURNITURE

a. Basic—All equipment and furnishings required by the Illinois Department of Public Health available and in good order.

b. Restorative—Nursing:

(1) One acceptable set of parallel bars.

(2) At least one set of pulleys.

(3) At least one pair of adjustable crutches and/or cane of each of the major types.

(4) Various major types of walkers.

(5) Wheelchairs of an acceptable type—all of which must be equipped with satisfactory handbrakes of a style easily operated by patients. It is recommended that at least 10% of the wheelchairs of a facility have removable arms, and *all* chairs must have movable footrests.

(6) Footboards.

c. Activity:

(1) At least the floor space required by the Illinois Department of Public Health for living, dining, recreation, and craft rooms.

(2) Sufficient number of tables and chairs to serve the majority of patients in the facility.

(3) A variety of games to serve the varied interests of the patients.

(4) A variety of craft supplies.

(5) A variety of current magazines and books, radio, television and piano or organ.

Activity Program Only: In order to qualify for special allowances for an activity program only, a facility must meet all of the above criteria with the exception of the requirements for a full-time registered nurse trained in rehabilitation nursing (1-b), nursing procedures specifically identified as restorative techniques (3-a and 3-c), and special rehabilitation equipment (7-b, Nursing).

EXHIBIT I-B

AN OVERVIEW OF REHABILITATION NURSING

CARDINAL VIEWS

By Maryann Fischer

Coordinator and instructor in the Rehabilitation Nursing Course, given at the Institute of Physical Medicine and Rehabilitation at Peoria, Ill.

Twenty-four hundred years ago Hippocrates, the father of Medicine, said, "What we don't use, we lose." This is truly the heart of the philosophy of rehabilitation. Why has it taken so long for this philosophy to become a part of our total care of the patient? Why do we still see patients with one problem or another slowly deteriorate and die? Bedsores, contractures, osteoporosis, renal calculi, muscular atrophy, venous thrombosis, pneumonia, fecal impactions, loss of will and spirit, depression, and regression: these are all too familiar conditions that we see too many times in patients who need not have them. The above stated problems are what we call the adverse effects of rest. These things occur because the patient is inactive; because what we don't use, we lose.

Over the years the assumed treatment for almost anything has been, BEDREST. Beginning about the time of the second World War, the question was asked, "Why bedrest?" and, if necessary, "How long?" During the War the number of casualties exceeded the number of beds available. By sheer necessity war casualty victims were forced to evacuate their beds before the textbook said they should, to make room for the more serious and acutely affected patients. It was found through this experience that the patients who got up earlier suffered much less and had fewer complications than their counterparts who remained in bed. From this, the idea began to emerge that, indeed, there may be danger in staying in bed too long. Drs. Deitrick, Whedon, and Shorr investigated the problem further by doing controlled studies. Healthy young army volunteers were put to bed and their reactions to bedrest were studied. Irreversible skin changes began occurring within two hours, calcium and other minerals were lost from the bones, stones began forming in the kidneys and bladder, joints began to stiffen within three or four days, general weakness and muscular atrophy developed. It was found that the heart worked 30 percent harder at bedrest. An insidious apathy, dependency and depression developed. Yes, indeed, Hippocrates was right, "What we don't use, we lose."

Bed Rest May Prove Disabling

Now the question is asked, "Why do we put patients to bed and judge the quality of our nursing care by the amount of personal care given to the patient?" After a measure of this "tender loving care" we have a patient who is too weak and disabled to care for himself, so we continue to care for him until finally the adverse effects of rest remove him from our care to a better land. Let's look at the patient from a different perspective. Illness and disability have never caused a 100 percent loss of function. Regardless of what occurs, there are some that remain. Evaluation of the patient should begin immediately after the disability occurs. The questions need to be asked, "What functions are affected?", "What functions remain?", "How long is bedrest imperative?", "What functions are safe to perform and not cause further disability?". As soon as these questions are answered as accurately as possible, he must be encouraged to use whatever function remains. This philosophy gives us the first cardinal rule—"START TREATMENT EARLY." Consider a patient who has had a cerebral vascular accident. The usual result is that he will have one arm and one leg partially paralyzed and may have some language problems and perceptual problems. The arm and leg on the opposite side are *not* affected. However, if we do not encourage him to use what he has left, he will lose strength at the rate of 3.3 percent per day. If we do everything for him through his early care, we will find that he will have lost strength in the unaffected areas as well as the loss from the accident. After strength is lost it is much more difficult to restore him to the capacity of the potential he would have had if treatment had been begun early. In restorative nursing we keep in mind the adverse effects of rest from the day the disability occurs. Our nursing care includes proper and frequent positioning to prevent pressure sores and we incorporate ranges of motion into the positioning routine to help in preventing contractures. Range of motion exercises are also done to help prevent contractures and enhance circulation. We encourage the patient to assist in his positioning as soon as it is safe for him to do so. Bed activities begin when the patient can participate. We encourage him to use those remaining functions that help: to push up and down in bed, to turn from side to side, to pull to a sitting position and to do his own passive and/or active range of motion. Through these measures, we help him: to stimulate increased circulation, to put stress on his bones and thus help to maintain the minerals within the bones, to help prevent muscular atrophy, to help prevent the collection of minerals and stones in the kidneys and bladder, and to help him begin to develop a sense of independence and self-worth.

Strengthen Both Body and Mind

The first cardinal rule leads into the second, which is—ACTIVITY STRENGTHENS—INACTIVITY WEAKENS. This applies to the body and the mind. Through continual evaluation of remaining function, we set goals with and for the patient and assist him in learning independence through using what is remaining. He learns independence in early bed activities and continues in relearning a sense of balance, developing skills in activities of daily living, and to transfer himself from one place to another. He learns to stand, turn, and sit if he can do a weight bearing transfer; or, he learns to slide into the chair from the bed in a non-weight bearing transfer.

The third cardinal rule is—STRESS ABILITY, NOT DISABILITY. In this we try to encourage him in developing a positive attitude. We stress the ability to use what function he has left through helping him to relearn whatever is necessary in accomplishing his activities of daily living. During the early acute care we encourage him to wash his face, brush his teeth, and begin feeding himself. As he progresses into the convalescent care we increase his independence in activities of daily living. He will begin bathing activities, dressing activities, his own range of motion, bowel and bladder retraining, complete grooming activities, and push up exercises in preparation for transfers and gait training. During the comprehensive rehabilitation phase, we will assist him in the achievement of total independence to his maximum potential. This may include balance exercises, toilet, tub, and car transfers, gait training, and vocational training. Whenever necessary, assistive devices will be used in accomplishing independence.

Accepting Disability May Be Important

The fourth cardinal rule is—TREAT THE WHOLE PERSON. It is not enough to simply restore him to his physical capabilities, but we know that the psychological acceptance of the disability sometimes may be the determining factor in regard to his total restoration. We know that anyone who has lost any-

thing of emotional significance will go through a period of mourning in direct relationship to the degree of emotonal significance. This can be the loss of a loved one, the loss of a part or function of the body, or the loss of a loved environment. Briefly, the stages seen are as follows: shock and possibly euphoria, denial, reality, depression, anger and hostility, readjustment, and finally acceptance. This process may take a year or more to run its course and will have a direct relationship on the physical restoration. Spiritual needs must be sought out and identified in the evaluation, and whatever is needed should be provided for the patient. Helping him to resocialize begins at the time the disability occurs. We begin planning for discharge the day the patient is admitted to our care. The goals are either to return to the family and community as nearly the same as he was before, or to make him feel as needed, wanted, and useful as possible within the institutional environment. If appropriately to the situation, opportunity and encouragement are given to develop or redevelop vocational goals as early as possible. If indicated, the division of vocational rehabilitation is utilized in helping to develop then the patient can be helped to develop maximum vocational potential.

"What we don't use, we lose." Many of our patients, young and old, are losing what they could be using if we were more alert to the potential that each has, regardless of the degree or kind of disability. Many are suffering and dying from the adverse effects of rest because everything is done for the patient rather than evaluating him for his potential and assisting him in reaching his maximum ability.

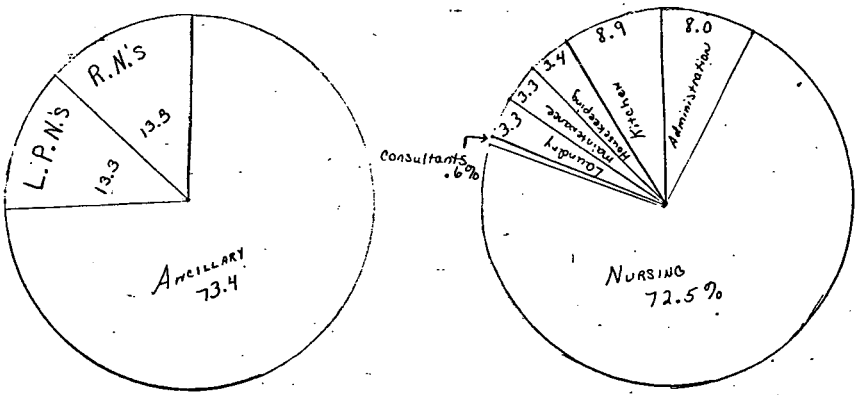
The scriptural maxim is given to us to, "Do unto others as we wish them to do unto us." What kind of care would we want if we were on the receiving end? The cardinal rules remind us of the proper perspective to take to help a fellow human being to rebuild a shattered life and to help him to live it with a sense of individual dignity and worth and maximum independence.

EXHIBIT II

WASHINGTON NURSING CENTER ACTIVITIES
SEPTEMBER 1971

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 Morning sewing Catholic Comm. 10:15 a.m. Movies Birthday	2 Popcorn Crafts Music Mr. Esser 1:30 Record playing	3 St. Marks Lutheran Church--11:00 Repairing toys for tots-1-3. Birthday	4 Story reading to Patients in Activity Rm. 10:00 a.m.
5 Visiting	6 Letter-Writing. Sing-a-long. Sewing-Games Crafts Bible Study 1:30	7 Ceramics 9:30-12:00 Hair done by Roland Manor Church 1:00	8 Morning Sewing Georgia Hartman Flannel Board Drawing 1:30	9 Popcorn Crafts Piano Bingo 1:15 Birthday	10 Washington Christian Church 11:00 Repairing toys for tots 1-3.	11 Mens Hair Cuts
12 Visiting	13 Crafts Letter writing. Sewing Games, Sing-a-Long. Bible Study 1:30 Birthday	14 Ceramics 9:30-3:00.	15 Morning Sewing. Movies.	16 Popcorn Grooming Hair done by: Beverly Manor Baptist Church 1:30	17 Washington Presbyterian Church 11:00. Repairing toys for tots.1-3.	18 Shuffleboard 10:30.
19 Visiting	20 Crafts Letter Writing. Games Sewing Sing-a-Long Bible Study 1:30.	21 Ceramics 9:30-12:00. Monthly Birthday Party. Ice Cream Social Outside 1:15.	22 Morning Sewing. Movies. Hair done by: Washington Christ Church. with E. Morris Birthday	23 Popcorn Bingo 1:15 Birthday	24 Grace Bible Church 11a.m. Mrs. Jessie Schroen - 1:30 Piano playing.	25 Mrs. Jackson & Polly Fulton Piano and Singing 10:30. Birthday.
26 Pentacostal Church 2:30 Song Service	27 Crafts Letter Writing. Games Sing-a-Long. Sewing Bible Study 1:30	28 Ceramics Piano and Singing with Wilda Miller & Joan Springer 1:30.	29 Morning Sewing. Fall ride in the country for patients. Birthday	30 Popcorn Games 1:15 Sing-a-Long.	Exercises daily at 11:00. Shopping for Patients. Coffee Break daily at 9:15. Letter Writing and Grooming. Games in North wing for Pts.	

EXHIBIT III
WASHINGTON NURSING CENTER, INC.
June 1971



NURSING DEPARTMENT
The percentage breakdown

ALL DEPARTMENTS
Hourly breakdown per day

EXHIBIT IV

[Reprinted from The Modern Hospital, May 1962]

THIS NURSING HOME KEEPS PATIENTS BUSY

New 49 bed nursing home is planned for the care and rehabilitation of long-term patients and as a center of research on nursing home planning and management.

When the 49 bed Washington Nursing Center at Washington, Ill., is opened in July of this year, somebody is certain to raise questions about some of the features of the building's design and equipment. Somebody always does.

If nobody does raise a question, Florence L. Baltz, who designed and will administer the new unit, is going to be disappointed. There are few things she likes better than the chance to expound her philosophy of nursing home administration—a philosophy that is embodied in the physical plan of the building.

For example, she placed the recreation and therapy areas in the center of activity because activity is the key to rehabilitation, which Mrs. Baltz considers the primary function of a nursing home.

The days when long-term patients could be stuffed into a dismal boardinghouse type of institution to die of loneliness and neglect are about over, she contends. The modern nursing home—or nursing care center—has a duty to provide its patients with good nursing care, good food, and active therapy to help restore them to maximum health and usefulness.

An early proponent of the "activities for daily living" program,[1] Mrs. Baltz has for years geared the nursing service in the two homes she and her husband operate toward rehabilitation and restoration. However, the physical structure of the buildings, as is true of many nursing homes, imposed severe limitations on the amount and quality of care that could be given.

To fulfill her ambition to provide all the services her patients need, Mrs. Baltz decided to build a new unit incorporating the ideas she had acquired

[1] Barton, Jane: Rehabilitation Program Is Education for Living. Mod. Hosp. 92:85 (April) 1959.

from years of experience and study of nursing home plans. Finally, she came up with a plan she considered workable and turned it over to an architect, J. T. Doyle of Decatur, Ill., to translate into steel, masonry and brick.

The one-story building, set on a 5½ acre site in a new subdivision, can be expanded to 115 beds. "Starting with a small facility," Mrs. Baltz says, "will permit us to find the areas of need as we get into operation. Then we can fit our expansion to the needs." She points out that the site selected is within 15 minutes' drive of good hospitals in Peoria.

One-story construction, she believes, is best suited to the needs of patients in wheel chairs and on crutches and also reduces the work and travel time of the staff.

Long-term patients, particularly the aged, are likely to take to their beds and, generally, retreat from the world if they are permitted to; it is just too much trouble to dress and move around even when their physical capacity permits it. In this, the patients are too often abetted by attendants who find it easier to care for patients in their beds than go through the physical and psychological struggle of getting them up.

It was to avoid this tendency to withdraw that Mrs. Baltz elected to put the recreation and therapy areas in the center of the building, directly opposite the head nurse's station. From her vantage point the nurse can see which patients go to therapy—and which ones do not.

Another reason for the central location of this unit is that outpatients who are referred for treatment can go from the admitting office to therapy without entering the patient areas.

The physical therapy room is provided with such standard equipment as steps, parallel bars, pulleys, shoulder wheel, mat and treatment table. Plumbing has been installed for portable hip and limb tanks and, if the doctors request it, a hydrotherapy tank can be installed at a later date.

The recreation area has facilities for crafts and games, which are supervised by the activities director, assisted by volunteers. It also contains an undercounter refrigerator, a two-burner electric plate, and a sink.

In the central area also is a dining room that doubles as another recreation center for patients who want to sit and read, visit or watch television. There are patients, Mrs. Baltz admits, who stubbornly resist every effort to lure them into participating in crafts and games. There is therapeutic value, however, in just getting them to associate with other patients and for this reason, while television outlets will be placed in patients' rooms, sets will be moved into the rooms only when patients are completely bedfast. Dining tables are of the single-pedestal type that seat four persons.

Beyond the dining area are the kitchen and storerooms, laundry, and a private dining room for employes.

Giving patients the companionship they need was the motive for making all but three of the patient rooms semiprivate.

The private rooms will be reserved for isolation cases or for patients who need special care. A toilet room is located between each pair of semiprivate rooms. Bathing facilities are in separate rooms, two in the east wing and one in the west. A training toilet for wheel-chair patients is to be installed in one of the bathrooms.

Because the Washington Nursing Center is to be the prototype for the chain of nursing centers projected by Americana Nursing Homes, Inc., with which she recently became associated, Mrs. Baltz is using the building as a proving ground for equipment and to test out various theories of design.

For example, she is equipping half of the patients' rooms with one-crank, variable height beds and the other half with stationary beds. The latter are between regulation and hospital bed height, and Mrs. Baltz is looking for the reactions of patients and nursing staff to the two types of bed to guide her in future purchases when the home is expanded.

Whether there is any value in putting lavatories in patients' rooms has long been a subject of controversy among nursing home owners. Mrs. Baltz thinks there is, and she has raised a few eyebrows by putting lavatories in the rooms in one wing and in the toilet areas in the other. The only way to find out which idea is best, she argues, is to try both.

Some criticism has resulted from the decision not to air-condition the building at this time, although it can be converted for air conditioning later if it seems advisable. While the nursing center is prepared to accept long-term patients from the age 16 up, and to give short-term convalescent care, most of the patients will be in the upper age group. It has been Mrs. Baltz' experience that old people are

never warm enough. "Even on the hottest days they still want sweaters," she explains. "Maybe the staff would be happier with air conditioning, but we are most interested in the patients' comfort. Farther south, of course, air conditioning is necessary, but in our climate we don't think it is."

Several new pieces of equipment designed for handicapped and geriatric patients that have appeared on the market both in the United States and Europe are now being tested.

One of these is a cast iron and plastic bath tub developed in Sweden. The tub is 7 feet long and about 28 inches high. The sides can be lowered so ambulatory and wheel-chair patients can get into it without having to climb, or be lifted, over the side—an experience that is terrifying to patients and exhausting to nurses. Even bedridden patients can be brought into the bathing room on carts and easily transferred to the tub. Once the patient is safely in the tub, the sides are raised and the water is turned on. When he is ready to emerge, the procedure is reversed. A lever locks the sides of the tub so an absent-minded attendant can't flood the bathroom by letting down the sides before the water has been drained out. This equipment has proved immensely successful, Mrs. Baltz reports. The patients love it and the nurses can give two baths in the time it usually takes to bathe one patient.

The resourceful Scandinavians have also made some innovations in bed design which have aroused Mrs. Baltz's interest. One bed she is studying is stationary and of standard height. Instead of cranks, handles are used to elevate foot and back rests.

Other equipment being tested includes geriatric chairs proportioned as to height and depth for the comfort of elderly arthritic patients and provided with sturdy arms that will support their weight as they lever themselves to their feet.

Experience gained at the Washington Nursing Center in all phases of operation, management, nursing procedures, and physical planning is to be applied to the other homes, some of which are under construction, in the American group.

Mrs. Baltz is satisfied that the Washington center will enable her to do the job she wants to do.

"Maybe we didn't get just everything we wanted," she says, "but the essentials are here to provide the best of rehabilitation and skilled nursing care."

EXHIBIT V

[Reprinted from Modern Nursing Home Administrator, March/April 1967]

EVALUATION UNCOVERS CLUES TO BETTER CARE

On its weekly rounds, Washington Nursing Center's team of therapists and nurses studies each patient's problems and progress so the staff can establish a plan for his care that will help him along the road to rehabiliation.

(By Jane Barton)

Flourishing his cane to the hazard of the passers-by, Mr. A made his way down the corridor of Washington Nursing Center, Washington, Ill., with a rolling, sailor's gait, legs spread wide apart. He moved with surprising speed.

Alarmed by his burst of energy, Johanna Orth, the physical therapy consultant, hung onto his gait belt, while other members of Washington Center's patient's evaluation team cheered him on and congratulated Mr. A and the rehabilitation-minded nursing staff on his achievement.

Administrator Hazel Beenders pridefully observed: "Rehab has really rehabbed Mr. A. His family just can't believe it." Florence L. Baltz, R.N., president of Washington Center, noted with satisfaction that when Mr. A had been told some time before that he no longer needed a wheel chair and would henceforth be expected to walk with just a cane, he wasn't very happy about it. In fact, he had complained that "no one was doing anything for him." But all that was now forgotten, and Mr. A was talking about going home.

Mr. A is one of five patients studied by the evaluation team recently on its weekly round of visits to selected individuals in order to establish a total plan for their nursing care. The patients selected for the team's study represent a cross section of the diagnoses one expects to find in a skilled care nursing

home: cancer, diabetes, cardiovascular accidents, fractures, multiple sclerosis, and heart disease, with all their attendant disabling effects. A different group is seen each week, so the team manages to visit all patients at designated intervals.

The other four patients studied at this particular session did not put on quite as spectacular a show of improvement as Mr. A did, but each in his own way demonstrated that he was moving a little farther along the road to rehabilitation.

In the case of a recently admitted woman patient, still very ill, the improvement which earned the approval of the team was her ability to turn herself over on her left side unaided and remain there, even though it hurt. This accomplishment would help promote the healing of an old decubitus ulcer which had developed on the patient's right side, and was regarded by the evaluators as a "good job of patient teaching" by nurses and aides who had worked hard to make her understand the importance of helping herself.

The patient evaluation program is an outgrowth of the conviction long held by Mrs. Baltz and her associates that every patient in a nursing home has some goal he wants to reach, and that the nursing home staff has an obligation to help him reach that goal—and then the next one, and the one after that as far as his condition permits.

Rehabilitation is an article of faith at Washington Nursing Center. Mrs. Baltz pioneered in the pilot Rehabilitation Education Service program conducted 10 years ago by the Illinois Public Aid Commission in cooperation with the U.S. Office of Vocational Rehabilitation, the Forest Park Foundation, and the Peoria Institute of Physical Medicine and Rehabilitation. During the three-year project, nurses and aides in nursing homes were taught routine rehabilitation procedures so they, in turn, can retrain patients in the activities of daily living as a first step in restoring them to their maximum ability.

Mrs. Baltz has preached and practiced the gospel of rehabilitative nursing ever since. "Everyone here is oriented to rehabilitation—and it filters down to janitors. All employes are taught not to do anything for a patient that he can do for himself," she says.

Even if the patient's maximum capability turns out to be minimal, the staff's efforts to restore whatever function remains can make an enormous difference in the patient's morale and behavior. "We know that rehabilitation nursing has cut down on the amount of sedatives the patients require and the amount of linen they use," Mrs. Baltz points out. "Activity and sociability make them tidier."

The purpose of the nursing care evaluation team's visit is to assess the patient's condition and discover what progress he has made since he was last evaluated, or, in the case of a recent arrival, what has happened since his admission. It can then decide what short-range and long-range goals he can be expected to achieve and how to plan his care properly in accordance with the necessary physician's written orders.

The program is directed and coordinated by Erma Borchers, R.N., director of nursing, and the team includes representatives from all departments involved in caring for patients: the administrator, a charge nurse, activity director, rehabilitation nurses and aides, the consultant physical and occupational therapists, and the consultant dietitian. The three consultants come to Washington Nursing Center at regularly scheduled times to work with patients and staff members; the weekly rounds are planned so they can participate and contribute their special skills. Whenever possible, a physician is included in the rounds, and the families of patients being studied may also attend.

During a visit with the patient, the team members skillfully extract the information they need by conversation, examining the affected areas of his body, and getting him to show them what he can or can't do.

The tone of the conversation is tuned to the needs and temperaments of the individuals: cheerful and bantering with those who respond to it, gentle and soothing with sick and frightened patients, always friendly and encouraging.

The questions encompass a broad range of subjects: What does the patient do during the day? Why doesn't he join in the many and varied group activities available at the center? What does he like to eat, and why doesn't he eat more? Is he interested in politics? Perhaps he would enjoy the group discussions. Can he feed himself?

Can he chew his food, or does he have to eat ground meat and strained vegetables? Wouldn't he be more comfortable if he wore his dentures? Do they fit properly? How is his eyesight?

The answers to the questions give valuable clues to the patient's state of mind, as well as his state of health.

Mr. A, for example, replied to the question about what he did all day with: "Just sitting around. At home, I can visit and hunt and fish and play my violin." He complained that he couldn't see with his glasses.

When the glasses were fished out of the drawer where he had discarded them, and tried on him, it was obvious that he certainly couldn't see with them; he couldn't even keep them on. It had never occurred to him to mention this to anyone before.

New glasses for Mr. A were put on the list of things to be done for him, and Mrs. Borchers assured him things would be much better when he got the new ones.

Mention of the violin prompted Mrs. Borchers to suggest that his family might bring it to the center so he could practice but Mr. A objected that he would never be able to close his fingers on the violin.

"Yes, you will. You've just got to work on those hands. Look how much you've done already."

As the team departed for the next visit, Mr. A was observed to be opening and closing the fingers of his left hand with more zeal than he had shown before.

The weekly rounds also disclose problems with equipment and procedures used by the staff in caring for patients.

In their nursing care evaluation of one unusually tall patient, the rehabilitation nurses discovered that the footboard used to support his feet was not suitable, and recommended that a different type be used. They noted that burns on his feet were healing well, and agreed that the progress should be reported to the patient's physician to ensure the continuity of the care he had been receiving.

In another instance, Mrs. Baltz noticed that Mr. B, who had been given a new wheel chair, was using an old one. What had happened to his nice new chair, she wanted to know. "It run like a sled on dry land so they took it out of service," the patient replied briskly. Mrs. Beenders made a note on the pad she carried with her on the rounds for just such purposes.

She also made note of the fact that Mr. B was to have extra nourishment before bed-time to help build up his weight. It took persistent questioning by the dietitian consultant to get Mr. B to admit that what he really likes is bread and milk and agree that he would ask for a bowl before he went to bed.

Before the visit ended, Mr. B volunteered the information that he "sure liked that mush and milk we had for supper the other night." He added: "Tell you what—you ought to make an extra batch and give us fried mush for breakfast." This culinary tip was added to the list.

Following the visits, the team retired to the staff dining room to discuss the patients, study their past records, and decide how to plan for their future.

Each member of the team had some idea or recommendation to contribute to the general knowledge. Mrs. Orth explained that Mr. A's peculiar gait was characteristic of patients with a poor sense of balance—"the broader the base, the better they can walk." She recommended that since he could now walk unaided, his cane should be unobstrusively removed before he hit somebody with it.

As each patient was discussed, Phyllis Bartlow, the occupational therapy consultant, entered notes on an evaluation form. The notes are written in different colored ink each time a patient is evaluated, with the date of the evaluation. Blue ink was used for the first entries on the accompanying form, green for the second, red for the third. The date of the next visit agreed upon by the staff is entered on the record, and services as a tickler file.

The evaluations of the patients and the prognoses of the staff members are practical and realistic, as are the goals they set for them. Discussing Mr. A, for example, Mrs. Bartlow asked: "Are we just being sentimental when we talk about sending him home?"

The team agreed that it would not be wise to encourage him too much at present until it could be determined whether his family would even be able to take care of him. Mrs. Orth pointed out that perhaps Mr. A wasn't quite as anxious to go home as he seemed to be. "When we took his wheel chair away, he said, 'Now, I suppose you'll get rid of me'."

Mr. B, who had shown great improvement, was judged a good candidate for independent living or "a sheltered care home if that doesn't work out." The immediate goal for him was to get him involved in activities and socializing, and also

to see to it that he didn't backslide from his recent conversion to the status of nonsmoker.

In their evaluations, the team members referred frequently to the admission questionnaires which had been filled out by the patient or his relatives.

This lengthy and detailed questionnaire is planned to provide information on the social, emotional and physical aspects of the patient's life. It was developed by the Kramer Foundation in Palatine, Ill., and is being tested in eight nursing homes in Illinois with the support of the Illinois Department of Public Health.

The answers to the questions offer useful insights into the patients' past and present condition and behavior, Mrs. Baltz says, and help the team do a better job of planning for their care. She added: "It's interesting, too, to see what they refuse to answer. Sometimes that tells us a lot."

Washington Nursing Center's evaluation program has attracted much attention since it was started last year. Nurses and caseworkers from Illinois Public Aid Department have made rounds with the evaluators. Administrators and R.N.s from other nursing homes have also attended the sessions.

One visitor who was invited to participate asked if the descent of such an entourage might not be overpowering to the patients, particularly when strangers turn up.

Mrs. Baltz' answers was: "They love all that attention. The only problem is that when we interview one patient in a two-bed room, the other one sometimes feels neglected. He wants to be visited, too. Since we started the program, we've had patients ask why the team never visits them. Of course, they have been visited, maybe just the week before."

The evaluation program thus carries a fringe benefit in addition to its basic purpose. It makes the patients feel important.

EXHIBIT VI

WASHINGTON NURSING CENTER APARTMENT,
1200 New Castle Road, Washington, Ill.

Mrs. Florence L. Baltz, President of Washington Nursing Center, Inc., announces the construction of the Washington Nursing Center Apartments which is an 8 unit apartment building adjacent to the Center on New Castle Road, Washington, Illinois. Apartments will be available for occupancy on September 1, 1970.

Each unit will have 1 bedroom, bath with non-skid tub and shower, utility room, kitchen, living room, 2 closets, and individual private entrance with covered patio.

Coin operated washers and dryers will be on the premises and a multi-purpose room for family gatherings and community activities will be located in the middle of the building.

An emergency call system from each unit will be directly connected to the nurse's station at the Nursing Center and operated by merely lifting the receiver. This will afford security 24 hours a day.

The units are ground level with no steps. Heat and air-conditioning furnished; also, stove, refrigerator, carpeting, and drapes furnished. All utilities except telephone included in monthly fee. No Real Estate Taxes to pay.

A nurse will spend one hour a week on premises to check blood pressures and give weekly injection as ordered by the resident's physician. More frequent nursing care will be an extra charge.

Enjoy the freedom of your own home with no worries, and all utilities except telephone furnished for a monthly fee. Rates are available upon inquiry.

EXHIBIT VII

STATE OF ILLINOIS,
DEPARTMENT OF PUBLIC HEALTH,
Springfield, June 26, 1967.

MRS. FLORENCE BALTZ,
Washington Hilton, Columbia Rd. NW.,
Washington, D.C.

DEAR MRS. BALTZ: Mrs. Ahrenkiel has told me of your inquiry.

On June 15 with almost a year's experience, 1,280 plus transfers of information about patients went with the patient to provide information as he moved between agencies and institutions. This must have been a delight to the nurse receiving the patient.

We are now getting ready to write the first annual report. There should be a good degree of statistical accuracy as we have used scanning forms and a computer to tabulate data. The Coordinating Committee (representatives of sheltered care homes, homes for aged, nursing homes, extended care facilities, hospitals, sanitariums, visiting nurse associations, and health departments) met and voted to continue the study for a second year. The nurse, an employee of the Illinois Department of Public Health, is loaned to the Visiting Nurse Association of Sangamon County for this two years' project. The other expenses (secretary, equipment, supplies, etc.) are met by cooperating agencies—in other words, ⅔ of budget State, ⅓ local funds. Two counties are cooperating in the project.

The enclosed materials are very sketchy but may help you interpret the project. I am highly enthusiastic, so much indirect good has come in connection with it:

Better understanding between agencies and facilities.

An enhanced image of nursing homes and extended care facilities in mind of physicians and nurses.

Better nursing care plans in all facilities.

Better information is being transferred now than ten months ago.

Increased rapport between nurses and doctors in planning with patient and family.

Improved medical understanding of differing roles of various types of institutions and home health services.

Better information being transferred between different departments in same hospital.

Yours sincerely,

MARGARET RANCK, R.N.,
Consultant Nurse.

JANUARY 18, 1967.

REPORT NO. 3

SANGAMON—MENARD COMMUNITY TRANSFER PROJECT

The Transfer Project is now six months old. I do hope the statistical report of our activities will give you a good picture of our progress.

Transfer information goes with most patients transferring from one agency or institution to another. But more important, the quality of information is improving tremendously. The nurses in various agencies or institutions tell me it is a joy to receive the transfer information with the patient—not a few days or a week later. The quality of nursing care plans have also improved. This not just so much paper work but rather definite preparation for continuity of care. This is not 413–1 being discharged, but rather Mr. Jones, age 66, going home with a new colostomy and in need of follow-up nursing care.

Plans are now being made for more in-service ward conferences in both hospitals—including all levels of personnel as much as possible.

We hope to be of some help with the proper utilization of hospital beds. We like to think of each step as a step closer to the patient's own home—a return to his own normal way of living.

MRS. JULIA CIHAK, R.N.,
Coordinator, Sangamon-Menard Community Transfer Project.

EXHIBIT VIII

AN AUTOMATED SYSTEM FOR THE REGULATION AND MEDICAL REVIEW OF LONG-TERM CARE FACILITIES AND PATIENTS

INTRODUCTION

The crisis in the health care delivery field is more widespread than simply the spiraling costs and lack of competent personnel. It has become evident through the nursing home scandals of recent years that society has turned over the sickest, the most helpless, and the most vulnerable patient group in the medical care system, to the most loosely controlled and least responsible faction of that system. (*1*) The problem has become so terrible that the President has issued an edict to Federal Health Agencies to clean up the nursing home industry. (2)

As a response to the problems of nursing home regulation and licensing, the Illinois Department of Public Health has developed an automated system to assist in more effectively meeting its responsibilities. The system is intended as an efficient mechanism that can be used for regulating both the adequate delivery of health services and the safety of patients in long-term care facilities.

PRESENT SITUATION AND PROCEDURES FOR REGULATION AND REVIEW

In the past, using a traditional, subjective public health, hand-scored system, long-term care facilities were inspected during one announced inspection each year. This has proved to be quite inadequate for the successful enforcement of the State's licensing standards or the review of medical programs. In addition, many facilities were not inspected prior to the expiration of their license, allowing them to remain in operation with an expired license as well as unevaluated programs of care.

The Department of Public Health accomplishes for the Illinois Department of Public Aid the federal requirement that there be a medical review of the care provided to each patient in a skilled or intermediate nursing home. (*3*) These evaluations of patient needs and care provided were made at least annually in all licensed long-term care facilities containing Public Aid recipients and certified under the Medicaid program to provide skilled or intermediate care. The medical review teams were composed of physicians, registered nurses, and other health personnel as deemed appropriate. After medical review, specific recommendations were forwarded to the Department of Public Aid. These recommendations include information regarding the care provided each recipient as well as professional assessment as to whether the facility could meet the health needs while promoting the maximum physical well being of all patients in the facility.

This medical review program proved to be totally ineffective because of the length of time between a Public Aid evaluation for care and the subsequent Public Health professional review. Usually, complete changes in the patients' conditions occurred, thus nullifying a meaningful comparison of the two evaluations.

The nursing home crisis does not exist only in Illinois. It is a startling fact that 80% of the nursing homes that receive public tax dollars do not meet even minimum Federal standards. (*4*) The problem has been studied, analyzed, and documented; but it has been only recently that major national publicity has focused the need for positive action to improve the regulation and review of nursing homes.

THE PROBLEMS OF PREVIOUS REGULATORY PROCEDURES

The major difficulties in Illinois with the unstructured regulatory procedures were identified as follows.

There was a totally inadequate system of inspecting and licensing facilities. Each facility underwent only one inspection a year, and these were announced prior to the survey. The questionnaire utilized was incomplete; and because it was subjective, it was difficult to determine compliance with the standards. In this regard, surveyors had significant difficulty in specifying the degree of compliance with reliability or precision.

The scheduling of facilities for inspections was haphazard; and at times, homes in compliance were inspected repeatedly instead of those not providing adequate care. These difficulties were further exacerbated because there was no objective way to assign a meaningful, overall evaluation rating to the more than 1,100 long-term care facilities in the State.

Manual documentation and processing of forms created severe limitations on the quality and timeliness with which procedures could be accomplished. Time-consuming documentation of the inspection forms from the field, letters to non-complying facilities, and patient medical review memos to the Department of Public Aid, were some of the complexities which paralyzed central office operations. Manual operation and reporting led to illegible inspection and review findings in many instances. The various types of reports and documents had to be kept in manual files and resulted in tedious and incorrect filing procedures. It is not difficult to understand why there was almost a total lack of accessible data for timely retrieval and evaluation.

It became painfully evident that a valid, precise, and real-time information system was the necessary element of any regulatory procedure. It was also obvious that there was an inability to gather pertinent ownership data. Information was not available concerning ownership of whole or part interest in multiple facilities. This is extremely important in determining conflict of interest as well as prosecution of individuals not in compliance with State law. In addition, there was a lack of complete and updated staffing information of nursing homes. The individual's license status, training, present and past positions, and current responsibilities, as well as the staffing patterns of nursing home personnel, was unknown.

Incomplete construction data prohibited detailed checks against minimum standards and nullified any planning for the future needs of nursing home beds in Illinois. To make matters worse, the State was unable to identify the exact numbers and location of State-supported or aided patients in long-term care facilities. Succinctly stated, the State had an embarrassing minimal statistical capability. This capability is extremely important to any meaningful reform, since the gathering of cost data is crucial for future placement of patients and subsequent rate negotiations with the providers of care.

As if these elements were not difficult enough to deal with, the uncoordinated relationships of the involved State agencies added significantly to the problems. The redundant activities of State agencies, specifically the Departments of Public Health, Public Aid, Mental Health, and Registration and Education, lead to a number of obvious deficiencies. There were multiple unusable data processing files for patients and facilities kept by each department. The lack of coordination and inefficient use of agency personnel was widespread and defended. The duplication of forms and procedures used to evaluate the need for care was not only ineffectual, but contributed significantly to situations in which patients received less than optimal care.

The medical review program, which was created to insure quality control of care provided to the patients in long-term care facilities, was sorely inadequate. In many instances, the evaluation of the care required for patients showed time lags of from three to nine months between the initial Public Aid evaluation and the completed Public Health medical review. This medical review was accomplished by nurses, and only infrequently were physicians utilized. This occurred even though physician visits were required in cases where patients were transferred from one level of care to another; e.g., skilled to intermediate care. Finally, whenever discrepancies occurred between the care provided and the level of reimbursement, there was a lack of any formal procedure to make meaningful and rapid corrections.

NEW APPROACHES TO REGULATIONS AND REVIEW

When the Illinois Department of Public Health began to investigate means of improving the regulation and medical review of nursing homes, the many difficulties and limitations described were too obvious to be ignored. Of course, additional inspection personnel and more stringent enforcement of standards were necessary; but these alone would not substantially improve either the compilation and retrieval of information or the regulatory and review activities.

It was decided that a flexible fully-automated system, would be required to accomplish the reform. The system to be utilized had to be capable of storing and analyzing inspection findings, facility data, personnel data, ownership data, and additionally process and issue licenses.

Although the project was primarily under the auspices of the Department of Public Health, it required the total commitment of the other two State agencies having responsibilities for patients in long-term care facilities. The Departments of Public Aid and Mental Health interfaced in many areas such as; common sources of patient and facility information, requirements for statistical analysis and program planning, and availability of beds for proper patient placement. The success of the project depended in large measure on the cooperation between all involved agencies.

A DESCRIPTION OF THE AUTOMATED REGULATORY PROGRAM

Technical Aspects. Data processing for the project is accomplished at the Illinois Data Center, Management Information Division of the Department of Finance. An IBM 360/ Model 65 and a 370/Model 155 are the computer equipment utilized. The primary data management software system is the information Management System (IMS), Version II, an IBM Corporation program product. All programs and procedures used are consistent with the State of Illinois' Total Health Information System. (5) The software package provides an easy method for the construction and management of the facility and patient data bases. It easily accommodates hierarchical data structures, on-line and batch processing.

Optical scanning techniques provided the most efficient and rapid means for the collection and inputting of data to the central files. The scanning is accomplished using the Input-3 scanner, produced by Recognition Equipment, Inc. The Input-3 accepts both hand-printed numeric characters as well as a variety of machine-printed alphanumeric characters.

Although the present system is designed for batch system loading, it is anticipated that on-line teleprocessing will be implemented during the second phase. In addition, logical data dependencies between the facility and patient data bases will be developed, fully utilizing the capabilities of Information Management System II.

Centralization of the Data Base. The data bases for long-term care facilities and patients required flexibility, and included the various data elements used by all State agencies involved with nursing homes.

Facility Inspection. The objective in redesigning the present inspection procedure to be fully automated was to provide the Department of Public Health with the mechanism to perform meaningful inspections during the year. A concept of phased levels of inspection was required to meet that objective. A Phase I inspection examines compliance with broad, generalized areas of standards for facilities. The set of questions refers to specific divisions of the Long-Term Care Facility.

Minimum Standards, Rules and Regulations.(6) These questions were chosen as the key or representative condition which accurately reflect a segment of the regulations. With the use of key questions, an inspector can survey rapidly and complete a reasonably accurate check of a facility without going into the time-consuming details of the standards. This Phase I inspection, which is unannounced, can be accomplished within one-half working day. The exam is, in fact, a quality control procedure; and it is utilized widely in all fields of inspection activities outside of health services.

The Phase II inspection, which is a fully detailed survey, covers all the State's standards for long-term care facilities. This survey additionally evaluates each level of care; i.e., skilled, intermediate, and sheltered, applicable to the individual facility. A complete Phase II inspection will always be done as part of the yearly announced inspection prior to relicensure or for facilities requesting initial licensure. There are two other types of Phase II inspections. A partial Phase II inspection allows for survey of specific sections of the standards, and occurs usually thirty days later, when there were deficiencies uncovered during the Phase I or the Phase II annual licensure inspection. A partial Phase II inspection may also be conducted concurrently with a Phase I survey. This occurs when the surveyor decides to make a detailed evaluation of a specific area of the standards when the nursing home is in substantial noncompliance.

The scheduling of the various phases is done automatically by computer. Optimal utilization of field personnel, with consideration of location and travel, will allow for efficient activity in any monthly period. The schedule is produced each month and is programmed to coordinate and analyze regional office staffing patterns, workload, travel time, facility size, as well as many other factors. The scheduling procedure determines the intervals of surveys for each facility by evaluating compliance during previous inspections. The length of time required to complete a Phase II inspection, based on previous experience, is automatically evaluated by the computer scheduler. The updated facility profile for each institution that is scheduled to undergo a survey is forwarded to the regional office. In this manner, the surveyors are aware of previous survey findings and conditions. This information is extremely important in accomplishing a meaningful evaluation.

The facility data base contains the following information segments; (1) facility identification, (2) inspection information, (3) medical reviews, (4) ownership, (5) staffing, (6) construction, (7) enforcement, and (8) licensure. The facility data base was created from data accumulated from the individual facility records of the Public Health regional offices. As can be expected, the preliminary information was incomplete; but it provided a sufficient data base for initial implementation of the program. Included in the initial base was data on proposed facilities and those under construction. Permanent identification numbers were assigned to each facility to allow for unique storage and retrieval of all data by the different departments. The resultant file became a single reference source for all facility data. It was now in a usable form for planning, statistical analysis, studies of bed utilization, determination of anticipated requirements for beds and facilities in any particular service area, and finally, for implementing meaningful regulatory procedures.

The patient data base contains complete identification of patients for which the State is responsible. Included is a limited amount of data on private patients for statistical analysis. The medical and evaluation data serves as the single source of patient information for all agencies, and is utilized prior to any further

evaluations. This is necessary in order to make a meaningful comparison between the program evaluations of the fiscal agent, Public Aid, and the medical reviews (quality control) of Public Health nurses and physicians. The retrieval of a specific patient record, the records of all patients within a specific facility or in a specific geographic location, and comparative cost data for patients in different facilities and regions, is now possible.

Collection and maintenance of the patient data is the responsibility of all the involved State agencies. The result is a reduction in duplicated activities within and across agencies, since only one patient record is updated with each entry regardless of the agency entering data. With this method, patients within the data processing files of both Public Aid and Mental Health were identified, eliminating the inefficient redundancy that had occurred previously.

The facility inspection questionnaire required a completely new design. A single, optical scanning form was needed for recording the surveyor's evaluation. The questionnaire itself had to be reusable and encompass, in an understandable manner, all inspection phases and variations. The questions for inspection are ring bound in a permanent booklet. The optical scanning form is inserted and removed at the completion of the exam.

The Phase I questions are readily identified. All inspection questions are numbered sequentially to correspond to the special answer sheet. Simultaneously, the questions in the booklet are numbered with the eight-digit number that corresponds to the specific condition in the Regulations. This standard number allows for reference directly to the division, section, paragraph, and subparagraph under evaluation.

The questions to be evaluated by the surveyor are terse, one or two line, keyword statements. A dotted line on the question page extends from the question to the location for the answer on the optical scanning answer form.

The answer form has columns with eight answer positions from top to bottom. The pages of the permanent questionnaire booklet have been cut so that the question pages diminish in size as they are turned. In this way, each succeeding smaller page uncovers a new answer column. The procedure is repeated for lining up questions with answers on each page.

At the bottom of the question page is the legal wording of each standard from which the questions at the top were taken. The surveyor has direct access to the written standards while he undertakes his inspection. This has proven to be a significant help in training personnel and also affecting a more uniform interpretation of regulations.

The optical scanning answer form has 270 positions for the recording of information. Thirty are for identifying information of the facility and surveyor. The remaining 240 are for the answers to the inspection questions. The answers can be zero (0) to five (5) which allows for expressing the degree of compliance to each question. Each number used has a specific meaning, with zero (0) denoting total compliance with the standard (an absolute yes answer); one (1) and two (2) representing qualified yes answers; three (3) and four (4) representing qualified noncompliance; and a five (5) indicating total noncompliance with the standards (an absolute no answer). In this manner, surveyors are no longer limited to just yes and no answers with some subjective comments. Numerical evaluation allows for the judgment to be more objective. Meaningful comparisons as well as reliable evaluation can now be made.

A rating of three, four, or five for any condition requires an additional terse comment on an exit interview form used to inform the facility's administrator. This is done in order to give the administrator some immediate results of the survey, and is followed at a later date with a more complete record of inspection findings.

The completed optical scanning answer form is forwarded for scanning to the Department of Public Health's Division of Data Processing. The facility inspection information both updates and adds to the data base. Each standard has an assigned weighting factor which is multiplied by the degree of compliance reported. An analysis and evaluation program then computes an overall rating for the facility. In this way, the facility's rating reflects both the surveyor's objective evaluation and the relative importance of that condition. After analysis, the program is designed to automatically recommend, or deny, licensure for each specific level of care in the facility.

The computer automatically generates a memorandum to the facility. This printout identifies all specific deficiencies. It also informs the administrator, depending upon the degree of noncompliance and weighted importance of the areas

involved, which situations must be corrected. Included is the specific time period in which corrections must be made. After the period specified in the memorandum has lapsed, a partial Phase II inspection will be scheduled by the computer program. In addition, a plan and schedule for correction of deficiencies must be submitted by the facility. Continuing deficiencies will be documented in detail for the facility so that chronic problem areas, in themselves not serious enough for loss of license, will be made evident.

Medical Review. The Public Health medical review procedures represent quality control of the care provided for Public Aid patients within nursing homes. The review is a Federal requirement for the evaluation of Medicaid patients receiving skilled or intermediate I and II care. This must be accomplished at least once annually for each patient. A Public Health nurse reviews the care required by each Public Aid patient. This review also includes both the quality and availability of services. In addition, a consulting physician will be required to personally investigate a minimum of ten percent (10%) of Medicaid patients within the facility.

Medical reviews are scheduled automatically as part of the same program used to schedule facility inspections. These reviews, however, are scheduled every three months. A list and description of patients for which the State purchases care is provided to the Department of Public Health. A randomly selected number of non-Public Aid patients are also included for review. The list includes all patients to be reviewed in a specific month in a particular facility. Ten percent (10%) of the patients are automatically and randomly selected from the patient data base to receive an on-site physician review. The list indicates all new recipients for initial review as well as those not evaluated within the previous ten months.

Rather than evaluate 100% of the patients in a facility only once each year, a sampling technique is utilized. Approximately 30% of the Public Aid patients in each facility are reviewed every three months. In scheduling patients for review, the computer program assumes that a nurse can do twenty medical reviews during a normal working day, including travel time.

Since four reviews are accomplished each year with 30% at each visit, all Public Aid patients in a facility will be seen during the year. The scheduling algorithm insures that different patients are scheduled during each quarterly visit. This procedure allows for evaluation of programs at least four times a year and overcomes the problems of doing a review of all patients each time. Obviously, any facility not providing adequate care will be noted automatically; and the computer will call attention to the need for more thorough and immediate investigation by the Department of Public Aid.

Accompanying the list of patients scheduled for review is the most recent copy of the form containing only the detailed descriptive information on every Public Aid patient. The Public Aid caseworker[s] evaluation is omitted to allow the Public Health nurse to make an unbiased review. The form is designated as the Illinois 184 and is indicative of the uniform approach for the three departments. Mental Health and Public Aid patients in nursing homes are indistinguishable except by special code designation. The nurse or physician evaluating the care for the patient verifies and updates the medical portion of the form. At the same time, an accurate and complete review of the need for care is undertaken.

The primary objective of these professionals is to identify the specific needs of each patient and determine the degree to which these needs are met by the programs in the facility. Once this is accomplished, the validity of charges for programs provided by the facility is evaluated. This procedure insures that the State receives for its patients the care that is purchased.

The medical review questionnaire closely resembles the facility inspection questionnaire. The pages are also of diminishing size with the questions arranged in the same manner as described for the facility inspection. In this questionnaire, the optical scanning answer sheet is actually the Illinois 184 evaluation form.

Each question is fully amplified with special conditions and exceptions detailed at the bottom of the page. As previously described, the questionnaire is permanent, with the answer form detachable.

Completed answer forms are optically scanned with automatic insertion into the patient data base. The Public Health evaluations are compared in the data base with the evaluations prepared by the Public Aid caseworker prior to, or immediately after, placement of the patient in the nursing home. A memorandum is automatically generated listing any discrepancies uncovered between the caseworker's evaluation and the medical review. All differences in levels of care

between that evaluated by the caseworker and the Public Health review team are separately documented. The computer generates the memorandum to notify the Department of Public Aid of the need for appropriate action. Public Aid, as the fiscal agent of the State, can then adjust any payment schedules as deemed necessary.

Notification to Public Aid is generated by the computer within two weeks of Public Health's completed medical review. This significantly decreases the interval between evaluation and review of patient care. Paperwork demands on the nurses, physicians, and central administrative staff is greatly diminished.

An additional procedure, made possible by having a single source of patient data for all State agencies, is a direct authorization and billing system. This system allows for a marked improvement in the State's ability to determine patient eligibility and authorization of payment. It also provides an automated procedure to reimburse the facilities for care provided to patients. These procedures have significant impact on controlling abuses of overpayment for Public Aid patients in long-term care facilities.

CONCLUSION

To more adequately assure the delivery of health and social services to patients in long-term care facilities, an automated facility regulatory and medical review system has been developed. The system accomplishes the monitoring of the delivery of these services through a totally computerized evaluation and review process. The system either reduces or, in some instances, completely eliminates, the need for manual documentation and processing. It markedly reduces the redundancy of operations among several State agencies. A new approach to the Federally required medical review program resulted in the development of a single and complete source of both patient and facility information. Since there will always be limited resources and personnel for regulation and review of nursing facilities, an automated, multiphased, computerized process provides for considerably greater efficiencies. Using this system, personnel are far more able to regulate care provided to the elderly in nursing homes than has ever previously been accomplished.

REFERENCES

1. Congressman David Pryor of Arkansas from a speech made to the U.S. House of Representatives, April 3, 1970.
2. Presidential statement made in Nashau, New Hampshire, on August 6, 1971: "Qualities of Care in Nursing Homes".
3. Federal Register—Vol. 36, No. 32, Feb. 17, 1971, for skilled Nursing Homes; and Vol. 35, No. 112, June 10, 1970, for Intermediate Care Facilities.
4. Old Age: The Last Segregation, Ralph Nader's study group report on nursing homes; Claire Townsend, Project Director, Grossman Publishers, N.Y., 1971.
5. Design Concept Report for the State of Illinois' Total Health Information System, the Illinois Department of Public Health, March 15, 1969.
6. State of Illinois, Department of Public Health, Minimum Standards, Rules, and Regulations for Long-Term Care Facilities, issued September 1, 1971.

[ADDITIONAL INFORMATION SUBMITTED BY FLORENCE L. BLATZ, SUBSEQUENT TO HEARING]

Mr. Chairman and members of the Sub-Committee: I would like to submit an additional positive, working program from Illinois to be printed in the record.

The described program is being carried on at the Monmouth Nursing Home, a 28 bed proprietary facility in a town of 10,570 population in Mid-Western Illinois. Mrs. Dorothy Morefield is Administrator.

This type program could be successful in other small communities if Federal and State agencies and others would approve and recognize facilities other than only non-proprietary. My real deep concern has been that when programs for the aging are discussed they are mainly for larger cities or metropolitan areas. The aging and long term disabled person in small communities are entitled to the same consideration.

The smaller community nursing homes have staffs qualified to offer several services, such as training homeworkers, various home health services and meals for the homebound. The latter is explained in the enclosed statement.

As you will notice in the last paragraph of the statement, this project has been so successful that it needs help to enlarge the project to better serve that community.

The meals for homebound person is just one successful project that proprietary nursing homes can carry on in many small communities to assist people to stay in their own homes longer and without a doubt at a lower cost than building more beds and facilities and placing people into a large group care environment.

[Attachment.]

MONMOUTH NURSING HOME

[Dorothy Morefield, Administrator]

For many years, the Monmouth Nursing Home has been aware of the nutritional needs of the elderly. The inability or lack of interest in proper food preparation leads to both mental and physical breakdown. We were also aware of the fact that many people alone had lost contact with the outside world, that many went for days at a time without anyone checking their physical well being. Since we have always believed in community service, we hit upon a two-fold idea—hot meals once a day and an automatic check on the recipients.

The hot meal program is not new, but it is unique for a nursing home. But why not? Certainly we understand diets and the nutritional needs of the elderly as well as anyone.

Our first approach was to ask permission from the department of public health. They were most receptive to the idea and gave a big boost in contacts to make in setting up such a program. We spent a day in a nearby city where there was such a program. Our state nurse accompanied us to visit with the volunteer delivery service, with the two women who spearheaded the project, through the food line at the hospital and a visit with the administrator of the hospital. All of these people were most enthusiastic and of great assistance to us. We came home determined to have such a service.

The next week, we were asked by the A.M.A. Auxilliary and the council of churches if we knew of something they might help with. Here was our community involvement! The physicians cooperated by being most anxious to give patient referral. Volunteer delivery service was undertaken by the council of churches. Every church in Monmouth took one full month's turn at delivering meals, and a check was made to see if all was well.

Public Aid considered this a fine boost for some of their people, and we had their blessing.

We hit upon the idea of insulated ice chests for delivering the meals. These keep the food hot and were light for easy handling. Food was served on attractive disposable dishes, and in no time at all we had more than we could supply.

Our program was started in August of 1969. We have people who started with us, and those who only need for a while to recuperate from a hospital stay.

We have outgrown the program because we are a small home, and we are trying hard to find help from an institution in carrying on our fine project. We have just skimmed the surface of what needs to be done, and this all takes time. I am afraid we have become so money oriented that we have forgotten the warmth of a helping hand.

ITEM 3. RANDOLPH HILLS NURSING HOME DAY CARE SCHEDULE OF EVENTS—SUBMITTED BY HARVEY R. WERTLIEB, ADMINISTRATOR

Monday:
10:30 Brunch.
12:30 Crafts workshop.
3:30 Dinner.

Tuesday:
10:30 Brunch.
12:00 Discussion group.
1:30 Bingo.
3:30 Dinner.

Wednesday:
10:30 Brunch.
12:30 Crafts workshop.
3:30 Dinner.

Thursday:
10:30 Brunch.
12:00 Bible class.
1:30 Activity hour (sing-a-longs, movies, games).
3:30 Dinner.

Friday:
10:30 Brunch.
12:30 Crafts workshop.
3:30 Dinner.

The present cost structure is listed below.

DAY CARE—SCHEDULE

12 Noon—3 p.m.—$6.00 per day; Monday–Friday, Arts & Crafts Workshop; Tuesday–Wednesday–Thursday, Activities: 10 a.m.–3 p.m.—including brunch, $8; or 12 Noon–5 p.m.—including dinner, $8; or 9 or 10 a.m.–5 p.m.—including brunch and dinner, $12.

(5 days per week 10–3 or 1–5---------- $60 per week)
(5 days per week 12–3---------- $30 per week)

ITEM 4. STATEMENT ON INVOLVING THE CONSUMER PRESENTED BY MARSHALL N. HORSMAN, ADMINISTRATOR, BEAUMONT CONVALESCENT HOSPITAL, BEAUMONT, CALIF.

One of the most difficult problems facing the nursing home field is the involvement of the consumer-to-be. With consumer groups assuming a vastly expanded and very necessary importance nationally, nursing homes face an uphill struggle in this area.

Again, I want to report on one area where progress is being made and where lessons were learned that might be valuable in other areas. And again I am referring to Los Angeles County and the Los Angeles County Council of Nursing Home Association (LACCNHA).

For many years the various Association Chapters in Los Angeles County attempted to contact senior citizens groups offering to send speakers to meetings to answer questions or discuss nursing homes, inviting groups to visit facilities and even offering space in facilities for meetings. There were virtually zero responses to all of these efforts.

After discussion by both the Education Committee and the Board of Directors of LACCNHA a decision was made to formally establish a Senior Citizens Advisory Council. A date was set for a luncheon meeting and a very official invitation was sent to executive staff members and presidents of the following organizations: Department of Senior Citizens Affairs, County of Los Angeles; The Mayor's Advisory Committee for Senior Citizens, City of Los Angeles; California League of Senior Citizens, Association of California Consumers and several other organizations that provided services to the aged *well.*

At the first meeting virtually all those attending were staff members. Very few elected officers came although the overall response by organization was almost 100%. It was in these preliminary discussions with staff that we were able to learn the very deep psychological block the elderly well have to facing up to becoming the elderly ill. The extent to which these fears go might be illustrated by the fact that one of the organizations which conducts monthly trips had to cancel one scheduled for Death Valley for lack of registrations.

Since the initial meeting, progress has been made. More elected representatives are attending meetings. Discussions are being held on proposed national health insurance plans, health maintenance organizations, H.R. 1 and other matters of specific interest to the elderly. Visiting nursing homes has been de-emphasized for the time being, but several picnics have been planned in parks near nursing homes where patients from the nursing home who are able can join the senior citizens on a social basis.

We recognize that these are just beginning but we anticipate the time when professional nursing home administrators can share problems and policies with this consumer section of our society.

FORM USED TO EVALUATE SERVICE TO PATIENTS, FORMER PATIENTS, OR RELATIVES OF PATIENTS BY THE BEAUMONT CONVALESCENT HOSPITAL

So that we may provide better service, would you take a few moments right now to complete this brief questionnaire?

I am a _____,
(current, or former patient, or relative of a patient)

and was a patient for about _____.
(days) (weeks) (months)

How do we rate?	Excellent	Good	Average	Fair	Poor
(1) Nursing Care	_____	_____	_____	_____	_____
(2) Food Service	_____	_____	_____	_____	_____
(3) Housekeeping	_____	_____	_____	_____	_____
(4) Business Office	_____	_____	_____	_____	_____
(5) Your doctor	_____	_____	_____	_____	_____

In what areas do you think we should improve? _____.

What impressed you most about our hospital? _____.

How did you learn of our hosptial or why did you decide to come here?

_____
(doctor, friend, yellow pages, reputation, recommended by friend)

Additional comments _____.

Your name _____
(leave blank if you wish)

Thank you very much,

MARSHALL N. HORSMAN,
Administrator.

"PLAYING THE ROLE OF THE PATIENT"

ONE APPROACH TOWARD REHABILITATION . . . BY SENSITIZING STAFF TO PATIENT PROBLEMS

(By Marshall N. Horsman)

When a normally healthy individual becomes a patient, a number of psychological and emotional problems tend to enter the picture in addition to the physical complaint. These emotional problems can seriously impede the well being and success of medical treatment given by the physician and nursing staff.

APPREHENSIVE PATIENTS

Many elderly patients entering a Nursing Home are extremely apprehensive, confused and sometimes angry. They have been suffering from one or more diseases probably for a considerable length of time, and no doubt have been in and out of hospitals a number of times. Most of their life savings have already been spent in a futile effort to regain their health, and now they must accept public assistance to help with the cost of care. They have been separated from their home, personal possessions, family pets, gardens, neighbors, relatives and other loved ones, and possibly their spouse has already passed on to leave them alone.

GOLDEN YEARS?

During their active years, they may have been employed in a satisfying career which brought meaning and fulfillment, and in leisure time, they would contemplate future retirement and the "golden years" when they could travel and do all the many things they wanted to do. But those dreams are all shattered and broken now. Unless this person has an unusual personality with a strong will to live and a philosophy of life that cannot easily be shaken, the patient may enter the Nursing Home with feelings of hopelessness, bitterness, distrust and rejection, unloved and unwanted. He may have a hearing loss, failing eyesight, false teeth and a few personal items.

NEEDLESS LOSS OF HOPE

As a patient in the acute hospital he probably saw his doctor nearly every day, and with a large staff of R.N.'s and many types of life saving medical equipment, he had some hope that something was being done for him and he would soon go home. But now he is being transferred to a Nursing Home.

CONFUSED THOUGHTS

"Why am I going to a Nursing Home?" He becomes bewildered, and continues to ponder . . . "Isn't that where they send old people to die?" "I read where a Nursing Home burned down and 20 patients couldn't get out in time and died in the flames." "And it seems I've heard other stories of how they mistreat you, and if you don't obey them, they tie you up." "Several years ago I visited a neighbor in a small Nursing Home, and it was so depressing, and awful smelling I couldn't wait to get out of there." "I must be a goner for sure." "Why can't I just go home and die." These may be some of the confused thoughts going through the patients mind.

PREPARATION VITAL

How important it is for the physician, nursing staff at the hospital and family to prepare the patient for transfer by explaining that he still needs skilled nursing care, treatments, medication and rehabilitation that can best be given in a modern Convalescent Hospital or Nursing Home, unlike the old nursing homes of years ago.

Too often the patient feels his doctor has given him up, his family has their own lives and are too busy to come see him, and now he is all alone with no one to fight his battle for him but himself, and he is at the point of giving up.

COMPASSIONATE CARE

How important it is that the progressive convalescent hospital or nursing home have an educated and highly motivated administrator with compassion who has carefully chosen and trained each staff member, so that every patient will be greeted with a friendly, reassuring smile and words of encouragement, followed with professional care that the patient needs.

NEEDS FULFILLED

Every need of the patient must be considered. His clothes and personal articles must be carefully put away, valuables taken to the office for safekeeping. The cook should visit him and discuss his likes and dislikes within the diet the doctor orders.

VOLUNTARY "PATIENTS"

In an effort to get closer to a solution to these problems, a plan was started at Beaumont Convalescent Hospital whereby each staff member would voluntarily become a patient for 24 hours. Three members of the nursing staff were chosen to be the control team to plan and schedule the role playing project. As vacant beds were available, a staff member would volunteer to be admitted. Prior to admission the control team would work up a fictitious diagnosis, and develop a nursing care plan.

ADMITTING DAY

On admitting day, the new "patient" would arrive by car and be brought in by wheel chair to her room. She would be helped into the usual gown, which is open in the back and then be put to bed. She would be greeted by the administrator and the director of nurses and introductions would be made to others in the room. She would then be made comfortable, and the ward clerk filled out the admitting forms and started a chart.

The nursing care plan was reviewed by the charge nurse and baths scheduled, medications (placebos and sterile water used in place of real medicine), treatments, physical therapy, diet, etc.

EVALUATION FORMS

Each "patient" was provided an evaluation form which was devised by the control team, consisting of six pages of questions, covering areas of admission, physical environment, food service, personal care, housekeeping, and a sum-

mary of the reactions of the nurse who had become a patient for a day. These evaluation forms, when completed, were then analyzed and discussed by the control team, information tabulated and reviewed by the administrator and director of nurses, and results discussed freely at staff meetings. The end result was a much more sensitized staff, alert to the problems of the patient, because they have been patients themselves and have observed the manner in which care is given . . . having seen the sights, the sounds, the smells, the attitudes of fellow staff. He was shown how to use the button to call a nurse. Hospital rules were explained, particularly those regarding smoking, visiting hours, etc. He was oriented about the activity program, reading material, arts, crafts, movies, bingo games, etc. If he wishes, friends and relatives are notified of his new address. We attempted to do everything possible to help the patient become oriented to his new surroundings, and take care of any personal unfinished business. By helping to remove anxiety, and then provide a setting of friendly, and efficient nursing care, we can get on with the job of rehabilitation. Of course, the patient must have the will and the desire to get better, or we will not see much success.

HUMAN DIGNITY

An important aspect of care is the preservation of the patient's pride, self-esteem and privacy. How tragic when the patient is cared for by a calloused nurse, insensitive to the fears, anxieties and loss of pride the patient may suffer. Such a nurse may feel rushed when giving daily baths, and may not take the extra care to see that privacy is protected during each step of the procedure. The bath blanket may not completely surround him, the curtain may not be pulled all the way, the door may have been left ajar. If the patient is unable to get to the bathroom alone, he must rely on the nurse to help, or he may need the bedpan. If the nurse is not alert to his light or his call, maybe he can hold it for a few minutes, but what if a few minutes is prolonged and turns into endless torture and he can't hold it? What happens then? Is the nurse compassionate and apologetic when the soiled linen must be changed and the patient and bed cleaned up, or is the nurse defensive and hostile toward the patient, for "messing up the bed and causing me a lot of trouble"? Such a situation, if continued unchecked, may very likely lead the patient to become frustrated and give up and allow himself to become totally incontinent.

FORM USED IN THE EVALUATION OF ROLE PLAYING AS A PATIENT

Identify Your Role:

1. Were you strictly a bed patient? _____ Yes _____ No
2. Were you allowed wheelchair privileges? _____ Yes _____ No
3. Were you restrained? _____ Yes _____ No _____ short periods _____ chair only _____ all the time.

Admission:

1. Was your temperature and blood pressure taken?_____
2. Did the staff introduce themselves and help to make you feel comfortable?
3. Were they pleasant and helpful? _____
4. Were you introduced to your roommates? _____
5. Were you given a pitcher of fresh water and other items from the hospital supply? _____
6. Were the hospital policies explained to you?

_____ Meal time
_____ Dr.'s visits, frequency
_____ Baths
_____ T.V. Room
_____ Recreational Activities
_____ Visiting hours

Physical Environment:

1. Was your bed comfortable? _____
2. Were your personal belongings handy and within reach? _____
3. How did the noises and voices of other patients affect you? _____
4. Did you have adequate fresh water? _____

5. Do you feel it was passed often enough? _____
6. How did you feel having side rails up at night? _____
_____
7. Did you feel you were awakened too early in the morning? _____
8. How did you react to the early morning activities—say 5:00 a.m.? _____
_____
9. Were you checked during the day, evening, and night for a wet bed? _____
10. Were there any offensive odors noticed? _____
11. Was the lighting sufficient for your needs? If not, please explain.
_____
12. Were you at any time physically uncomfortable? _____
_____ Temperature too hot
_____ Temperature too cold
_____ Clothing too restrictive
_____ Bedding too tight
_____ Wt. of bedding too heavy
_____ Diapers rough
_____ Pillows too firm or too big

Food and Food Service:

1. Did you enjoy meals? If not, why? _____
_____
2. Were you given any food that you thought wasn't fresh?
_____
3. Was the food served hot? _____
4. Were you prepared for mealtime—head of bed raised? _____
_____ Bedpan offered
_____ Hands washed if bedpan used
_____ Tray convenient height on overbed table to enjoy
_____ Assistance given if needed _____ meat cut, pancake prepared, beverage poured into cup, sugared if desired.
5. Did any kitchen personnel contact you to learn your likes and dislikes with the physicians diet order? _____
6. Did you feel the meals were served too close together or too far apart?
_____
7. Were you hungry before bedtime? _____
8. Was it necessary for you to be fed? If so, how did you enjoy the procedure? Please comment _____
_____
9. Were the portions large enough? Too large? _____

Personal Care:

1. Describe your bath in detail. _____
_____
_____
_____
_____
2. Was the aide gentle? _____
3. How did it feel to be pushed down the hallway undressed with only a sheet around you? _____
4. Did the aide brush your teeth? _____
5. Did the aide brush your hair? _____
6. How did the shower feel? Was the water too forceful? How was the temperature? _____
7. Did you have any reaction to the hospital soap? _____
8. How did you react to male nurse aides coming into your room to do personal things for you? _____
9. How did you feel about sharing a room and toilet with strangers? _____
_____
10. Did you use your signal light? _____ Was it answered promptly? _____
11. Were your nails cut if necessary? _____
12. Were you offered a washcloth in the a.m.? _____
13. If a man, were you shaved? _____

If confined to a wheelchair:

1. Did you tire of the wheelchair? _____ Where? Arms _____ Legs _____ Buttocks _____ Back _____

2. Was it difficult to let personnel know of your personal needs? _____
3. Did you feel you were sometimes deserted when you needed help most? _____

Housekeeping:

1. Was your bed clean? _____
2. Was your night stand and over-bed table clean? _____
3. When you were bathed, did you feel the tub or shower chair was clean? _____
4. Did you see or smell urine or B.M. or food on the floor? Was it cleaned up within a reasonable time? _____
5. How did you feel with your bedpan or urinal on your overbed table? _____
6. Was the bathroom clean? Did it smell like urine or B.M.? _____
7. Were you willing to use the bathroom? Was it clean enough? _____
8. Do you think the beds and night stands should be pulled out and moped behind? How often? _____
9. Do you think the laundry is clean enough that is done at our own facilities? _____

Miscl:

1. What kind of bath did you have? _____
2. Were you warm enough while you were being brought to and being bathed? _____
3. Were you restrained? How did it feel? _____
   _____ Wrist restraint _____ waist restraint
   Were they _____ too loose _____ too tight?
4. Did you wear a dressing? Was it changed often enough? _____
5. Was care taken if you wore a cathator when you were turned and gotten up? _____
6. Were you given physical therapy? What was done? _____

Summary:

Do you feel you are more sensitive to patients and patient needs having completed this role playing?_____
_____

Can you put yourself in the patient's position and better understand their reactions and behavior in their situation?_____
_____

Make comments and summarize what you personally have learned by this experience. _____
_____
_____
_____
_____
_____
_____

Do you think it would be beneficial to repeat this in 6 months?_____
_____
_____

List suggested improvements in the following departments: Housekeeping. Kitchen, and Nursing.
_____
_____
_____
_____

Would you be willing to be a patient or would you like a member of your family to be a patient here?_____
_____
_____

Special Procedures:

1. Whirlpool bath_____
2. Levine tube_____
3. Suction _____
4. Oxygen therapy_____
5. Bitter medicine_____

Evaluations of Activities and Recreation:
_____
_____
_____

Rehabilitation Activities:

Any Additional Comments or Suggestions: ---

ITEM 5. PREPARED STATEMENT OF STANLEY P. WILCOX, PRESIDENT, CEDARS, INC., CHARLOTTESVILLE, VA.

The Towers—continuing care facility is a private tax-bearing institution owned and operated by Central Virginia Health Facilities. A Virginia corporation, the building divides into the following functional areas:

Towers—grd.: Pharmacy, medical records, laboratory.

Towers—1: Admissions—transportation, rehabilitation—speech & hearing, rehabilitation—physical therapy, rehabilitation—occupational therapy, rehabilitation—activities of daily living, patient dining area, gift shop, beauty shop, chapel.

Towers—2: Connection to medical offices, full diagnostic X-ray department, 18 private rooms—orthopedics, 24 semi-private beds—orthopedics.

Towers—3: 22 private rooms—internal medicine, 32 semi-private beds—internal medicine.

Towers—4: 22 private rooms—general admission, 32 semi-private beds—general admission.

Towers—5: 30 Private studio rooms—physchiatry.

The posture of this new facility is one of a sub-acute general hospital which does not conflict but supports the two acute hospitals in the city by supplying complementing services at significantly less cost per day.

Central Virginia Health has an "affiliation agreement" with the University of Virginia and formal "transfer agreement" with the Cedars-Arlington House, the Cedars-Barracks Road and the Orange County Nursing Home.

B. Regional Medical Application

1. *Magnitude of the problem to be resolved.*

Congressional legislators and the Administration are talking to themselves and the press about the crisis in health care, but where is the crisis? Acute hospitals are doing well and expanding, so where is the crisis? Doctors are busier than ever, so where is the crisis? The crisis is in the total cost of individual illness to be met by the individual taxpayer. The crisis includes the premium dollars the public must pay for third party protection or Medicare protection in a poorly structured health delivery system.

When national health insurance comes, it will have to address itself to this basic problem. Health organizations must re-orient their thinking to the delivery of services in a suitable and matching environment * * * be it the home, supervised residential living or the ICU of an acute general hospital. "Services related to environment" is the problem that must be resolved.

We in Region 10 are fortunate in that we have many of the piece-parts required to structure a comprehensive health plan. The Towers—CCF needs to be used by the medical community if the cost per illness is to be controlled and if the higher cost acute beds in the region are to be used effectively.

2. *Services to be offered in support of other institutions*

At the outset we must say that the Towers—CCF has been designed and built specifically to be a support to the University of Virginia Hospital and insofar as possible to be an integral part of the University's medical center. This however does not mean that proper use by either Blue Ridge Sanatorium or Martha Jefferson Hospital physicians is not welcomed. As Blue Ridge developes more and more toward an acute respiratory facility and Martha Jefferson grows in acute services, continuing care support becomes more meaningful.

Direct supporting services for the above mentioned facilities of course means on-going therapies including speech pathology and activities of daily living therapy. Our hubbard tank unit will directly support orthopedics, neurologic

and plastic surgery cases from any acute institution. Our renal dialysis unit will afford advanced training in the mechanics and use of these machines for acute patients on their way to a home setting. A periphery service is transportation, at no additional charge, between the CCF and other institutions as the need arises.

3. *Out-reach programs to the community*

The delivery of health care to the community has gradually and finally taken on a new look. The old European idea of the "infirmary" and "lying-in-hospital" is changing towards what can be done to keep the prospective patient out of that hospital bed. Preventive type medicine to work must include established institutions being interested in clinical out-patient services both to forestall a direct patient admission and as a follow thru on post discharge cases.

Community involvement then is out-patient services in nature. Our X-ray unit will service the out-patient clinic, the children and youth center and the clinical demands of the orthopedic-orthotics center.

Both our laboratory and X-ray units will work with the new multi-phasic screening service in the Towers Office Building. This service has a relationship with business employment physicals, pre-admission physicals, etc. and appears to be not only preventive in nature but predictive in nature.

4. *Applications of regional training support*

The continuing care facility is heavily involved and committed to the training needs in this region; in fact, the affiliation with the University of Virginia revolves around the ability of the CCF to be a significant teaching experience for both their medical students and students in the school of nursing. Resident physicians with specialties in orthopedics, internal medicine, neurology and neuro-surgery will be part of a rotating assignment plan affording the student a 45 day experience in this type and level of care.

5. *Consumer participation*

Sensitivity to consumer needs and areas of concern can best be handled by the envolvement of non-connected public spirited citizens whose level of understanding is adequate for objective evaluation. The patient and his needs are the key to public acceptance. The ability of that patient to enter the health field at various levels due to the availability of *consumer oriented* services should visibly enhance consumer acceptance of this project. The hospital will have a seven member "Towers Advisory Board" made up completely on non-medical and non-involved consumers whose recommendations to the corporate board will be of first importance.

C. *Scope of Operations*

1. *Sub-acute rehabilitative in-patient services*

With our direct physical connection to the prosthetics and orthotics departments we have every reason to believe that our second floor will become the orthopedic center for central and western Virginia.

On the third and fourth floors with our emphasis on stroke and arthritis and our support for these diseases in speech, occupational therapy and the physical therapies. These beds should be in effective use towards physical habilitation and rehabilitation.

Our fifth floor will be entirely directed towards mental rehabilitation and the community psychiatric therapies surrounding the mental restorative processes.

In summary, our services are broadly restorative but specifically applied thru medical and para-medical evaluation and follow through.

2. *Training for residents and nurses*

As indicated in B–4 above, of nearly equal importance to the applied patient rehab program is the development of significant training experience for residents in these related specialties and as a training field for the University of Virginia School of Nursing. This will not be designed to be training by observation but training by doing * * * by being a part of evaluation teams, progress reviews and bedside applications, our function does not directly include the administrative development of these students but rather their detailed application of health improvement techniques to the individual patient.

3. *Clinical out-patient services*

In various ways and to different degrees we will be involved with the prevention and possibly the predication of disease, a multiphasic screening project in

the connecting medical office building will use both our hospital laboratory and X-ray departments.

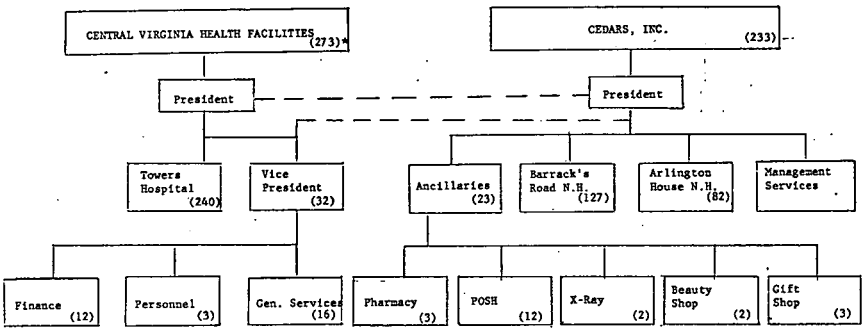
Our therapy department will receive home based patients either post-discharge or direct referrals.

The adjacent family clinic headquarters and children and youth center each will require out-patient use of our in-house Lab and X-ray sections.

D. *Summary*

Our need and function is clear and our proper position in Region 10 is clear:

1. Meaningful rehabilitative care
2. Significant cost control per illness
3. A learning experience for student nurses and resident physicians



* Number in each block denotes number of personnel

ITEM 6. THE UNIT DOSE SYSTEM, SUBMITTED BY KENNETH D. RELYEA, R.Ph.

THIS UNIT DOSE SYSTEM SAVES NURSING TIME AND LABOR

(By Kenneth D. Relyea, R.Ph.)

[Reprinted from Modern Nursing Home, January 1970]

Six years ago, I walked into a nursing home for the first time to discuss pharmacy service with its administrator. I knew very little about nursing homes but immediately discovered the administrator knew something about pharmacy—and he wasn't happy, because he said he rarely saw a pharmacist.

He talked about the inordinate amount of time his nurses had to spend each day preparing for medication rounds—time taken away from patient contact. He showed me carton after carton of partially used patient prescriptions which had to be disposed of because the medication had been discontinued. The family's money and yours and mine as taxpayers, was being wasted.

He showed me more than 500 bottles of medication at the nursing stations from which the nursing staff had to select each patient's daily doses, and said he was concerned about the likelihood of drug error. The director of nursing confirmed everything he said and added several observations of her own.

Our investigation of nursing home medication records revealed that a single patient frequently takes five or six different drugs, many of which are administered several times a day. Accordingly, in a 100 bed home, the nursing staff must select the patient's medication from as many as 500 or 600 different drug bottles, then pour the individual dose into a dispensing container. At this point, the drug's identity is lost. Based on an average of eight doses per patient per day, the nursing staff of a 100 bed home goes through this procedure approximately 24,000 times in one month.

In addition to the substantial nursing time required for this duty and the attendant likelihood of medication error, other factors have a direct bearing on the efficient delivery of medication to the nursing home patient. Some of these

factors are: (1) personnel turnover, (2) additions and subtractions from inventory, (3) medication ordering procedure, (4) more than one supplier of pharmacy service, (5) medication "shrinkage," (6) overloaded storage facilities, and (7) frequent interruption of the staff for other nursing duties.

The system we developed to remedy these problems is an adaptation of the unit-dose packaging concept developed by large hospitals and pharmaceutical companies. However, it expands on the concept by providing to the pharmacist the capability for the systematic preparation of patient medications at the pharmacy, and for safe and efficient transportation and delivery of the medications to the patient's bedside.

The primary feature of this system is the daily preparation by the pharmacist of the nurses' medication trays according to instructions on the physician's prescription. This procedure saves the daily nursing time required to sort, count and pour medications, which can amount to five or more hours per 100 patients per day.

The key element of the system is the patient profile card. One card is made up for each patient; it contains all prescription information on every drug the patient is receiving. It must be referred to every time a medication is ordered or stopped. This card provides the pharmacist with an immediate and on-going recapitulation of each patient's total medication regimen and makes it possible for him to detect any physical or pharmacologic incompatibilities.

From the patient profile cards, distribution planning boards are prepared by the pharmacist, on which he plots the patient locations in the home, the drug names, and dosage times. Using the boards as a model, he prepares the nurses' medication trays for a 24 hour period. The nursing trays—labeled by time and including patient names—are prepared with drugs packaged in unit dose containers.

When all the patient medications for the 24 hour period are prepared, the nursing trays are placed in a locked cabinet and delivered to the appropriate nursing station. Then when the nurse is ready to distribute medications, she simply unlocks the cabinet, removes the prepared trays, inserts her medication cards in each tray (thereby double-checking the pharmacist's work), and proceeds to the patients. The confusing and time-consuming task of handling drugs at the nursing stations is eliminated.

At the bedside, the unit dose container is removed from the medication tray, the identification label is peeled off, and the drug is administered to the patient directly from the cup. The medication need not be touched; moreover, positive identification of the drug is maintained until it is consumed. The same procedure is repeated for the next dosage period.

When each day's filled cabinet is delivered to the nursing station, the empty cabinet from the previous day is returned to the pharmacy for reservicing. The pharmacist has 24 hours to prepare all the medications required, so his work load is regulated on a daily basis. In order for the system to work efficiently, however, at least 90 per cent of the pharmacy services must be provided by one supplier.

ITEM 7. PREPARED STATEMENT OF PAUL DE PREAUX, PRESIDENT, CONNECTICUT ASSOCIATION OF NON-PROFIT HOMES FOR THE AGING; ADMINISTRATOR, AVERY CONVALESCENT CENTER, HARTFORD, CONN.

We propose that three or four universities or colleges with an active gerontological department be selected to participate in a pilot program of the "Village Concept" of care.

These pilot programs could be funded by the Department of Health, Education, and Welfare, since it involves not only comprehensive care of older persons, but additionally would serve as a base for research and training in the important academic area of social gerontology. However, interested foundations, institutions or corporations especially equipped and adequately financed could conduct this program for the benefit of each area of the country.

The "Village Concept" referred to should be composed of the following:

1. Apartments—100:
   Completely independent living for those still able to care for themselves.
2. Congregate Living—100:
   Hotel-type living for those who no longer can or wish to cook or keep house for themselves or who do not wish to live alone.

3. Intermediate Care Facilities—100:
   For those persons who are semi-independent and require nursing supervision or surveillance beyond Visiting Nurse care.
4. Nursing Home—Convalescent Hospital—120:
   Intensive nursing care unit for those requiring 24 hour nursing care with emphasis on rehabilitation of the individual.
5. Campus Community Center:
   This is the area of administration and community involvement. It should be staffed with administrators, social workers, dieticians, doctors, dentists, physical therapists, recreational directors, occupational therapists and all other para-medical personnel who would serve the other four facilities and older persons in the adjacent community.

This concept is based on the "total care" of the resident or patient and the "Village" would be a two-way street of concern. The pilot programs could prove that age is not an insurmountable obstacle to rehabilitation and that the older persons could move in both directions.

The entire "Village" could be utilized in this setting as a training and research center. The various units of the "Village" would provide a site for a coordinated program in research and training in gerontology. Existing colleges, schools, and academic departments would be able to augment their specialized educational research interests as indicated below:

Academic unit	*Educational activity*
Psychology	Research, clinical experience, and graduate training.
Sociology	Research and graduate program in Social Gerontology.
Social Work	Practicum and case work experience.
Nursing	Clinical experience and degree work in Nursing Home Administration.
Home Economics	Research and training in Housing, Foods, Clothing, Institutional Administration and Dietetics.
Physical Therapy	Training, internships, and field experience.
Recreation	Experimental programming, training, internship.
Business Administration	Degree programs in Long Term Care Administration and Housing Administration.
Continuing Education	Non-credit courses for elderly residents plus training for all campus professionals in Gerontological Specialties.
Medicine	Clinical experience.
Dentistry	Clinical experience.
Life Sciences and Biology	Specialized research.
Hospital Administration	Training, internships, and field experience.

Greater emphasis could be placed on preventive medicine. Determinations could be made as to the actual extent of preventive health care services necessary to maintain the older person rather than expending so much funds on curative services. It is estimated at the present time that less than $2.00 is spent per capita on preventive medicine whereas almost $135.00 is expended on curative medicine. This gap must be closed since recent studies have indicated that preventive medicine can cut hospital residence time from 25% to 50%.

It is believed that this program could assist the Federal Government in many areas of care for older persons: standards; knowledge of medical, social, psychiatric, religious, nutritional needs, etc.

In addition to the care of older persons, one other area might be explored. Students often do not wish to speak with members of the "Establishment" but they consider the older, retired persons the opposite end of the spectrum. They feel that they are *also* disenfranchised by the "Establishment". If a meaningful dialogue could be engendered between these two groups, it could have many excellent effects: on the one hand the maturity, wisdom, and experience of the elders and on the other the youthful, exuberant idealism of the young. What greater need have we today than communication?

This could be an immeasurable bonus of the concept, especially if some of the older persons began to take advantage of the opportunity to attend noncredit courses and mixed intellectually with the young.

Life supportive services should be provided when needed to assist older persons living independently in the community, however, this can be done most efficiently from the "Village".

In many discussions with older persons over the past few years, we have discovered many unanswered needs, not the least of which is housing. The vast majority of persons with whom we've spoken have endorsed the "Village" concept. They realize that often "housing" is considered "apartments" and "apartments" are really only one facet of the total need.

The older persons and we believe that the "Village" is the most feasible, utilitarian and logical answer to this multiplicity of needs engendered by the ever-increasing numbers of older persons. It has basis in action, for many of the Scandinavian countries have utilized similar facilities for years and have proven its efficacy.

Present governmental housing programs delineate various structures to answer separate premises of physical need. It is now time that the multiplicity of needs be combined and attacked collectively in the "Village." There must be a consolidation and coordination of planning to adequately effectuate the answering of the needs of the whole man—physical, social, medical, psychological and mental. We believe further that the primary requisite of the Village is that it be under one administration and in one locality. This imparts a permanence of residence to the older person for no longer would he be moved from town to town and environment to environment to obtain the type of care appropriate to his physical capabilities. Except for admission to a general hospital he never need leave his home and friends for totality of service is inherent to the Village. It would provide the residents with all the care and services required as a need arises. Further, it would retain the human element, the one item which is now missing from federal programs for the older person has become a statistic to be moved willy, nilly to fulfill utilization review blocks.

This "Village" concept is predicated on the knowledge that there are five areas of need involved in the care of older persons.

1. Apartments:
   Completely independent living for those still able to care for themselves.
2. Congregate living:
   Hotel-type living for those who no longer can or wish to cook or keep house for themselves or who do not wish to live alone.
3. Intermediate Care Facilities:
   For those persons who are semi-dependent and require nursing supervision or surveillance beyond Visiting Nurse care.
4. Nursing Home—Convalescent Hospital:
   Intensive nursing care unit for those requiring 24 hour nursing care with emphasis on rehabilitation of the individual.
5. Village Center:
   This is the area of administration, ancillary services and community involvement. It should be staffed with administrators, dieticians, social workers, doctors, dentists, physical therapists, occupational therapists and other para-medical personnel who would serve, not only the residents in the "Village" but older persons in the adjacent community.

One of its primary functions should be the clinic approach to preventive medicine for both village and community residents. One of the greatest faults at present, is the lack of a comprehensive preventive health care delivery system.

Further, it must be the area of community involvement, in fact the hub of the wheel which reaches out to all older persons in the immediate geographical locale. It is also imperative that younger members of the community become involved in the life of the "Village", otherwise it can become an "isolation area". If it becomes this, then it becomes an island of care in a community that doesn't care.

We can foresee no reason why government, under present programs, cannot endorse and support this concept.

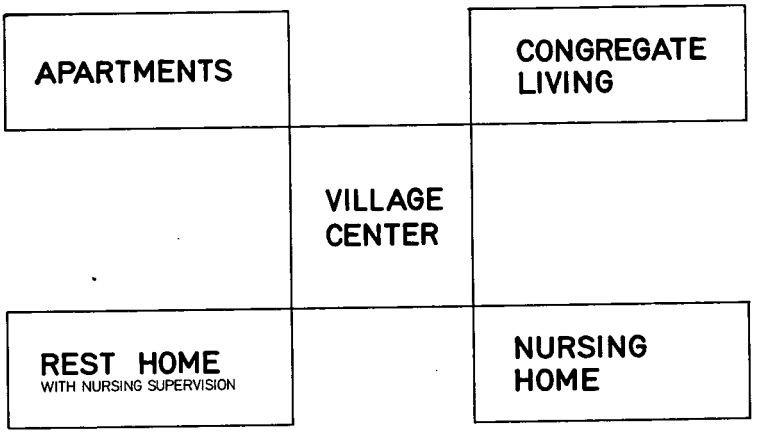
Grants could be made on a 50–50 or 75–25 basis for construction of such "Villages" to non-profit organizations and FHA insured mortgages should be made available to proprietary groups for construction of same. We believe government should stand clear of construction itself. It should set the standards, but allow the local organizations to plan and construct the "Village" itself. One of the attractive features of the Village is that it need not be large. In fact, it should be of the size and style of the community it serves but should be expandable in case needs increase.

However, each must be a complete entity in itself for only in this way can we truly serve the total needs of the older persons and return to them the dignity and individuality which is their right.

The most devasting indictments I have ever encountered re: this unintentional dehumanization of the individual was in Washington, D.C.

I was asked by an administrator while visiting a nursing home to converse with an aged lady who was described to me as a "hermit." She refused to leave her room, make friends or engage in the recreational or religious activities available. After speaking with her awhile and after the usual conversation, I asked her why she never left her room or tried to make "friends". Her answer was an indictment of an entire program of care for the elderly. She said, "Son, when I get better, they will have to transfer me to another home. I'm now 84 years old and I'm too old to lose any more friends. I couldn't stand it."

If any statement pleads more for the "Village" concept of care than this, I know it not!



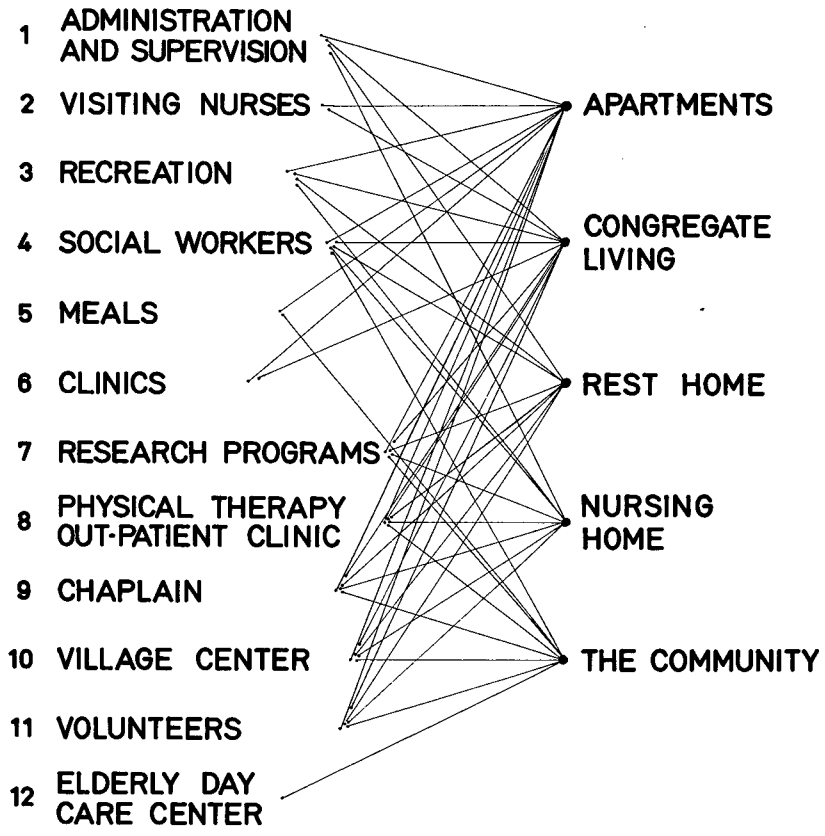
1 APARTMENTS_
COMPLETELY INDEPENDENT LIVING FOR THOSE STILL ABLE TO CARE FOR THEMSELVES.

2 CONGREGATE LIVING_
HOTEL TYPE LIVING FOR THOSE WHO NO LONGER CAN OR WISH TO COOK OR KEEP HOUSE FOR THEMSELVES OR WHO DO NOT WISH TO LIVE ALONE.

3 INTERMEDIATE CARE FACILITIES_
FOR THOSE PERSONS WHO ARE SEMI-DEPENDENT AND REQUIRE NURSING SUPERVISION OR SURVEILLANCE BEYOND VISITING NURSE CARE.

4 NURSING HOMES_ CONVALESCENT HOSPITALS_
INTENSIVE NURSING CARE UNITS FOR THOSE REQUIRING 24HOUR NURSING CARE WITH EMPHASIS ON REHABILITATION OF THE INDIVIDUAL.

5 VILLAGE CENTER –
THE AREA OF COMMUNITY INVOLVEMENT AND SERVICE. THE INVOLVEMENT OF THE COMMUNITY WITH THE LIFE IN THE VILLAGE AND THE RECIPROCAL INVOLVEMENT OF THE VILLAGE IN THE COMMUNITY. BASICALLY AN OUTREACH PROGRAM.



Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURE FROM J. RAYMOND GLADUE, M.D., PRESIDENT ELECT, AMERICAN SOCIETY OF PHYSICIANS IN CHRONIC DISEASE FACILITIES

SEPTEMBER 16, 1971.

DEAR SENATOR CHURCH: It is common knowledge that you are a strong advocate for better health care of our citizens and especially for improved care of our disabled aging citizen. We are enclosing two documents which advocate certain improvements in Medical Care administration in our chronic disease facilities. Our Society feels that adoption of these proposals will strongly improve this medical care. We hope this information will be of help to you and of course we welcome your help on these proposals.

Sincerely,

J. R. GLADUE, M.D.

[Enclosure.].

RECOMMENDED MEDICAL STANDARDS FOR SKILLED NURSING HOMES

The Medical Standards recommended here were initially developed by the American Association of Nursing Home Physicians and the Maryland Association of Physicians of Chronic Disease Facilities. They have been selected from the Conditions for Participation in Extended Care Facilities; Regulations for Licensure of Skilled Nursing Homes in Maryland; and from the Standard for Accreditation of Skilled Nursing Homes and Extended Care Facilities by the Joint Commission on Accreditation of Hospitals. It is an attempt by the Medical profession to provide some guidance to other physicians in the field of skilled nursing homes through the development of minimal standards of care. Obviously as the trends in medical care change, there need to be some deletions, additions and possible rephrasing of the standards. It is with this in mind that the following standards have been developed.

1. *Medical director and medical staffs.*

(a) Each Extended Care Facility, Nursing Home, or related facility shall have a Medical Director who will be responsible for the development and implementation of the medical care policies of the facility. His duties and responsibilities are defined elsewhere.

(b) Whenever possible there should be a formal medical staff with by-laws and rules and regulations.

(c) Patients should have the right to be cared for by the physician of their choice.

(d) All physicians caring for the patients in the facility should be advised of the medical policies of the facility.

2. *Admission of patients.*

(a) Every patient admitted to the facility must have a primary attending physician responsible for the general medical care who has agreed to care for the patient from the time of admission.

(b) No patient should be admitted to the facility without adequate information, including current medical and nursing care, being submitted to the facility prior to or at the time of admission.

(c) If there is any doubt concerning the admission of a particular patient, then the pre-admission information should be reviewed by the Administrator, Medical Director, and the Director of Nurses. No patient should be refused admission for medical reasons without prior discussion with the referring physician.

(d) Every patient must be certified by his attending physician prior to admission as being free from active tuberculosis or mental disease warranting care in a mental institution.

(e) There should be a written list of the types of medical conditions that cannot be admitted to the facility.

3. *Patient records.*

(a) Each patient must have a history, including present illness, past history, review of systems and a physical examination recorded on the chart within 48 hours.

A hospital discharge summary containing the above information, or a history and physical done within one week prior to admission, if done by primary attending physician may be used.

(b) Upon the admission of the patient, his primary attending physician will become responsible for the evaluation of the patient's immediate and long-term needs. Based on this evaluation, the physician must prescribe the regimen of medical care which will cover medications, treatments, restorative services, diet, special procedures, and plans for the patient's continuing care.

(c) Each patient should have a chest X-ray within 90 days prior to or as soon as possible after admission. A complete blood count and urinalysis must be done on admission. A Fasting or Post Prandial Blood Sugar, Blood Urea Nitrogen and Electrocardiogram are strongly recommended.

(d) Patients should have a comprehensive re-evaluation including a physical examination and suitable laboratory studies at least once a year and more frequently if necessary.

4. *Frequency of visits.*

(a) Patients should be seen as frequently as deemed necessary by the primary attending physician, with suitable progress notes recorded on their charts at the time of each visit. All patients should be seen by the attending physician at least once a month.

5. *Medical orders.*

(a) All orders must be renewed in writing every 30 days.

(b) All telephone orders must be countersigned by the physician within 48 hours.

(c) Policies regarding stop orders should be developed by the medical staff.

(d) If a drug formulary is developed and adopted by the facility, the private physicians are urged to use it.

6. *Utilization review.*

(a) All medical records become the responsibility of the facility and may be reviewed by the Medical Director, Medical Staff or Utilization Review Committee.

(b) Patients' records will be reviewed by the Utilization Review Committee with the frequency prescribed by law unless otherwise specified by the Committee. All records and recommendations of the Review Committee should comply with the policies outlined in the Utilization Review policies of the facility.

(c) When a patient is scheduled for Utilization Review, the primary attending physician will be advised of the impending review.

7. *Ancillary medical services.* Private physicians are urged to utilize the ancillary services in the care of their patients, such as physical therapy, occupational and speech therapy and podiatry care.

8. *Medical emergencies.*

(a) If, in the opinion of the nursing staff, a patient is in need of immediate medical attention and the private physician cannot be contacted, or fails to comply with the request, the Medical Director or his designate is to be contacted.

(b) There should be a specific routine to follow in case of medical emergencies; including communicable disease outbreaks.

(c) There should be a specific policy for the transfer of patients to a hospital in emergencies. A copy of the transfer form must accompany the patient to the hospital.

(d) If, in the opinion of the Medical Director, in consultation with the Administrator and the Director of Nurses, a patient should be removed from the Home because of behavior, repeated failure to abide by the regulations, or because of a medical emergency, the primary attending physician should be requested to remove the patient from the facility.

9. *Suspension of privileges.*

(a) Physicians who fail to comply with the medical policies should be advised in writing of their delinquency.

(b) When Physicians fail to comply with the facility's Medical Policies, the Medical Director or his designate should assume the patient's care.

10. *Diets.* Therapeutic diets must be prescribed within the limitations of the diet manual recommended by the State Licensing Body, or as determined by the individual institution if it incorporates the recommendations of the State. A licensed dietitian should review special diets at least once a month.

11. *Inhalation therapy.* Intermittent positive pressure therapy will be administered to patients only upon the written order of the physician. It may only be administered by a nurse trained in the use of the apparatus, or by an oxygen therapist. Patients who have demonstrated their competency in the use of the apparatus may administer their own therapy.

12. *Review.* (a) There should be periodic check of patients' records to ascertain compliance with the medical policies.

(b) The Medical Director, or the medical staff should meet with the Administration and the Director of Nurses regularly to review problems in patient care or medical policies.

13. *Drug policies.* There should be definite written drug policies which are reviewed periodically by the pharmacy committee.

We wish to direct your attention to an HEW document (Part B Intermediary Letter No. 70–32 dated Nov. 1970) which encourages—nay, prescribes—a level of medical care for our aged Medicare beneficiaries which we feel is not only inadequate but also exceedingly callous. Whether this directive is the result of ignorance, indifference or insensitivity to the problems and needs of this already neglected segment of our population we do not know. We do not feel, however, that present or prospective patients in nursing homes—or the families who must reluctantly send their loved ones to such homes—would be encouraged or comforted by reading this document.

In an apparent move to lower costs of the financially burdened Medicare Program and under the guise of eliminating abuses, the Bureau of Health has arbitrarily limited physicians' visits to the aged Part B beneficiary in nursing homes to one per month. The reasons given for this regulation are:

1. "The non-acute nature of their illnesses seems to warrant observation of the patients by their physicians at infrequent intervals to observe their patients' conditions and their response to supportive measures, and to make necessary changes in their standing orders."

2. "We have been informed by our medical consultants that nursing home patients usually require physician visits only at relatively infrequent intervals. This was borne out by a recent survey we made of all carriers, which indicated that a majority of the carriers currently limit Medicare reimbursement to one or two physician visits a month to patients with non-acute illnesses."

May we state our reaction to the two "reasons" listed above? The letter refers to the non-acute nature of the illness as warranting infrequent physician's observation—to say the least, an unthinking, uninformed and very negative attitude. Instead, the Bureau of Health Insurance (Medicare) should know that chronically ill aged patients are less resistant to all forms of stress, physical, psychological and emotional, and that therapy must be brought to bear quickly to prevent irreparable damage and/or death. Studies show that morbidity and mortality are favorably affected by frequency of physicians' visits. Are you aware that, from a physical standpoint, the bedridden or physically inactive chronically ill patient (who needn't even be old, but advanced age certainly doesn't help!) is always subject to, and must therefore be constantly watched for, a number of conditions:

1. Heightened susceptibility to illness of any type, epidemic or otherwise, and the fact that even a minor cold or virus caught from an attendant or visitor could quickly and easily escalate into a major or fatal disease unless promptly noted and treated.

2. Kidney diseases or other urinary difficulties.

3. Bed sores, skin irritations, etc.

4. Cardiac failure and irregularities of rhythm must be recognized early and treated promptly.

5. Bowel difficulties which, unless watched and corrected, are far from minor problems to the patient.

6. Dietary deficiencies which may be brought about by the patient's condition or because he, even though offered a proper diet, may for various reasons not eat as he should. Diseases of teeth and gums are often implicated.

7. Changes which may occur in the effectiveness of medication, even though it may have been given over a long period of time without apparent difficulties. Such changes could be the result of changes in the patient's condition or of the

fact that sometimes (many examples come to mind) effects are cumulative and difficulties take months or years to become apparent. Many medications are still too new to assume that everything is known about them.

8. Changes in brain function, very common and resulting in confusion, disorientation and depression and/or agitation. These conditions can be treated effectively by the physician with the use of understanding, psychotherapy, and psycho-active drugs.

9. Deterioration of vision and hearing. The physician must be alert to changes which can affect the patient's ability to communicate. Most are correctable or can be helped.

In addition to the physical factor, emotional and psychological elements most patients in nursing homes are apt to be lonely, depressed, feeling neglected and unwanted. Emotional health has great bearing on physical health—one visit a month from their doctor is not likely to adequately take care of either need! As to the psychological aspect: Is not the most commonly expressed feeling of anyone entering a nursing home (and to those who hear someone has entered one) the idea that he has been "sent there to die"? Doesn't the directive we're discussing express the same attitude? Is this how we really intend to upgrade care in our nursing homes, and to make less despairing the lives of our elderly? Is there less suffering involved in a non-acute chronic illness than in one which is acute but curable? Cannot this suffering be somewhat alleviated—physically, emotionally, psychologically—by the attention, concern and care of a physician free to use his own discretion as to the number of visits needed based on his knowledge of the patient, his condition and its possibilities? And isn't such alleviation a worthwhile goal? How stand our national priorities on such matters?

You state that the policy of limiting visits is supported by your medical consultants and the experience of carriers. Since when has good medical care been determined by carriers' authority? And on what knowledge and qualifications is this authority based? We'd also like to ask the identity of the medical consultants you quote. It is well known that the quality of nursing home care is inadequate and has been cited as a national disgrace. There are, at the present time, very few physicians who are aware of nursing home needs. We know of none who could be convinced that the quality of care can be improved by an arbitrary limitation of visits on the assumption that the patients are old and incurable and therefore need little attention. Improved? Could the present inadequate care do anything but deteriorate under such conditions?

Medicare should support quality medical care for the aged, whether the illness be acute or chronic, and should reimburse a physician provider only for medically necessary services. A medically necessary visit to a patient would be a meaningful visit—one which would, of course, mean not only contact with the patient but also a progress note indicating the reason and results of the visit. We feel, however, that the judgment as to the medical necessity of the visit should be left to qualified persons.

The burden of proof that a visit is not necessary should rest with the intermediary. Verification is simple through examination of the records on a sample basis or more frequently when felt warranted. In view of the reasons listed earlier, we feel that the physician should not be arbitrarily required to substantiate all visits over one per patient per month. We feel that this directive is unreasonable, and could only result in further deterioration of institutional care for the aged.

Many other objections and arguments could be raised concerning the directive in question, but the crux of the matter is this: We object strongly to the tone of and the apparent line of reasoning behind the entire document. All arguments seem to be based on the fact that the people in nursing homes are old and incurable and therefore unimportant, that no effort should be made in their behalf, only minimal attention given them. We, however, cannot look upon them as "non-returnables" or "throw-aways" and therefore ready to be discarded. You consider visits to nursing homes always as less important and probably less necessary than office visits, house calls, hospital visits. Is this really a well-thought-out attitude? Can a house call to a home where the patient is surrounded and cared for by loved ones, a 15 or 20-minute visit to a doctor's office, a quick "hello, how are you feeling today?" in a hospital mean as much to a patient who will recover and rejoin his family and friends, or be considered more meaningful or helpful to the acute patient, than the feeling the nursing home patient gets from knowing that there will be someone in to listen to and care about his complaints, do some-

thing for his sore back or other problems? Nursing home patients, you know, aren't surrounded by loved ones, usually only by too few over-worked undertrained personnel who haven't the time for routine duties, much less for professional observation of the patients' conditions. And they haven't the hope of going home again, nor much hope of anything else. Visitors are usually scarce, and exceedingly welcome, but a visit from the physician is among the most welcome of all because he can bring relief and hope and comfort, scarce commodities in most nursing homes today.

Can a policy of one visit per nursing home patient per month be justified? We don't think so. How about checking with the patients, or the families of the patients, in the nursing home?

ITEM 2. LETTER FROM LILLIAN A. OLSON, M.D., AH-GWAH-CHING, MINN.

AUGUST 28, 1971.

DEAR SENATOR CHURCH: Since you are chairman of the Senate Committee on Aging, I thought you might have an open mind to a program which I am sure would give Nursing Home patients efficient but less expensive care.

1956–1961 I spent part of my work with the mentally ill aged at Ah-gwah-ching, and full time 1966–1971. It seems to me we could have much better coverage with good nursing care of each 24 hours if we would train women to become Geriatric Practical Nurses (GPN). Once trained adequately, they could replace some of the RNs and LPNs with lower salaries. The British train women as children's nurses with a shorter course. Why not GPNs?

The LPN does not need pediatrics or obstetrics here, only a little gynecology and some male genito-urinary, enough surgery to do a sterile dressing, enough orthopedics to handle a fresh fracture and later for rehabilitation of healed fractured and paralyzed limbs.

The middle aged woman who finds she must or wants to go into a field where she can earn her living usually shows herself open-minded and willing to learn. Our Aides here include many with intelligence and potential which would have been material for RN training if they were younger. RNs are needed as supervisors in these homes. But it must be true in other homes as well as here, that often an Aide is left on the floor to put up and distribute drugs without enough training to be allowed to do this work by the Nursing Board rules, without knowledge of indications and of side effects one might meet. Whoever is in charge of a floor at any time ought to be cognizant of significant symptoms, able to observe, check findings indicated, and report systematically to the supervisors and doctor.

I would think large Geriatric Care facilities with a greater variety of disabilities could be utilized for this training without going through a vocational school. Vocational schools in this area have several times as many applicants for the LPN openings as they can accept. So existing LPN schools (which seem to graduate effective nurses) would not be able to train the number who are needed for the many nursing homes. Most large homes must already have meeting rooms where classes could be held. Some money for visual aides such as are shown for LPN courses would be needed. LPN books also could be used plus special training for geriatrics.

After the first few weeks of lectures, I understand LPN students work a 4 hour morning shift daily. Although there would be some problems to give the student a variety of types of cases, her work still would be an asset to the institution, and like an apprenticeship in industry, she could be paid aide rates for the work she did, helping her with her expenses—no scholarships needed.

Many middle aged women who may want this type of course have children in higher education so they would not have easy money to pay their expenses. Floor activities should be planned with charge nurses to give a variety of experiences.

When hired for a Nursing Home, both the RN and LPN need to be oriented to geriatrics care. When not, patients are often misunderstood, with consequent lack of the kindness each ought to receive. Actually I am not able to get those in charge here to see a need for this kind of teaching, and must go over many symptoms with every new nurse to get her to comprehend what is needed. If and when she thinks she knows everything, it is often frustrating and time consuming to have to go back over and over again until we finally arrive at some kind of rapport.

Often nurses interpret new symptoms as "attention getting schemes" and thereafter the patient carries a stigma of purposely making the work harder, as

an excuse to ignore his complaints which at times can be serious. Once labelled a malingerer, it is for life if he remains in that nursing home, which only too often must be continued under a low-grade hostile attitude from the charge nurse down to the aides. I have found some aides, however, who fortunately cannot be corrupted by this unhappy aura.

The supervisors here are angered that I, a former high school teacher (none of them have training in education) and an M.D., should presume to enter "their field of work which is none of my business". Yet what the nurses and aides do is all my business if I am to write orders that can be carried out. The supervisors say I am belittling and degrading them, for only RNs should teach aides all they need to learn. I should teach the RNs first, many of whom do not want to learn anything new and would not put it across. We have some very fine RNs in charge on individual floors who are willing to learn. But they, too, have no right to teach anything but custodial care.

Answering my letter, the Nursing Service at the AMA said they were taking care of geriatrics nursing needs by trying to persuade new graduates to go into this field. I do not think a girl who has put so much of her time into a general hospital skills and techniques, should waste much of that training not used in geriatric facilities. It has seemed to me that nurses locally and nationally are not open minded to any suggestions they themselves have not conceived, which is actually the factor "belittling" them. With closed minds they are unable to obtain a full understanding of the goals of care of a more economic and effective way of reaching those goals. Teachers prepared to train LPNs now could teach GPNs, but they, too, would need orientation to Geriatrics, for many problems are different from general medicine.

Without being able to discuss this type of program with any nurse interested in education of our more intelligent middle aged women for a geriatric practical course, my estimate of time involved for teaching and floor experience may not be the best. If experienced aides who have shown dependability were chosen for the course, I would judge 6 months with lectures according to the LPN type of plan but limited to geriatrics. Perhaps 6 months more in taking actual floor responsibility with suitable pay would be practical, before the GPN is left alone with only the RN on call from her home as most often happens in smaller nursing facilities.

Cochise College, Douglass, Arizona, is offering a one semester course to train hospital aides and eliminate their LPN course. I am open to discussions with administrators and nurses about this type of program if it could be done without the rancor and sneers my efforts to present the possibilities have produced here. Many of our more experienced aides at this institution have shown interest which I think is genuine—not just being polite to me.

I would appreciate any consideration you would give to this idea.

Respectfully yours,

LILLIAN A. OLSON.

ITEM 3. LETTER FROM LORNA BONNET, IDAHO STATE UNIVERSITY, DEPARTMENT OF DENTAL HYGIENE

AUGUST 23, 1971.

DEAR SENATOR CHURCH: Mrs. Helen Thompson of the Mountain States Regional Medical Program recommended that I send you a copy of the final report of a project conducted by the Department of Dental Hygiene, Idaho State University in cooperation with three nursing homes in Pocatello.

Two major purposes of the project were to provide the opportunity for dental hygiene students to gain experience in working with elderly people in the nursing home environment and to determine the oral health treatment needs of nursing home residents. Results of the project indicate that all residents had oral health needs of some nature and that the experience was very rewarding and educational for the students.

If you have any questions regarding the project, please feel free to contact me.

Sincerely,

LORNA BONNET.

[Attachment.]

Improved Services for Patients in Nursing Homes in Rural Areas

(Sponsored by Wiche—Mountain States Regional Medical Program; Conducted by the Department of Dental Hygiene, Idaho State University, Pocatello, Idaho; Project director, Lorna Bonnet—July 1971)

INTRODUCTION

On October 23, 1970 the Idaho Council of the Mountain States Regional Medical Program reviewed a proposal from the Department of Dental Hygiene, Idaho State University, for the conduction of a project entitled, "Improved Services for Patients in Nursing Homes in Rural Areas." On that date the Idaho Council enthusiastically supported the project. All necessary forms, such as "Memorandums of Understanding" between the nursing homes participating in the project and the Department of Dental Hygiene were obtained. Information on insurance and liability, with Idaho State University being the responsible party, was secured.

Due to a misunderstanding between the project director and the Regional Office of the Mountain States Regional Medical Program, funding of the program was delayed. Specific concern to the Regional Office was that the Idaho State University proposal did not conform to the program design of a previous project conducted at Sheridan College in Sheridan, Wyoming. Idaho State University personnel were unknowledgeable about the stipulation that this project should conform to one previously conducted. The Regional Committee of MSRMP did, however, fund the program and a check for the amount of $8,400.00 was forwarded to Mr. Arlie R. White, accountant, Idaho State University, for deposit in a special account for expenses incurred while conducting the project on February 16, 1971.

CONDUCTION OF THE PROGRAM

Objectives

The project was conducted in accordance with the objectives specified in the initial proposal. General objectives were as follows: 1) to place dental hygiene students in nursing homes in rural areas for the purpose of providing direct service to patients; 2) to inform the nursing home operator of the kind of dental care necessary for maintaining the patient in an improved health level; 3) dental hygiene students working in cooperation with nursing home directors and employees were to assist nursing home patients in obtaining dental treatment for conditions designated as needing urgent care; and 4) educate the dental hygiene students so that upon graduation and work with practicing dentists, she will be oriented to caring for elderly patients and we will be prepared to exercise a leadership role in planning community programs for the neglected and poor.

Evaluation

An evaluation of each phase of the project was incorporated into the project proposal. The evaluation consisted of two questionnaires, the conduction of a baseline survey and the tabulation of data on the type and amount of treatment provided during the program by dentists and dental hygienists. One questionnaire was designed to evaluate the general knowledge of nursing home employees and to determine their opinions regarding the oral health conditions and oral health needs of their patients. The second questionnaire was designed to ascertain dental hygiene student perceptions about the aged; their cooperation, alertness, learning capacity, oral health problems, need for professional involvement with nursing home patients, and the students' personal feelings regarding their abilities to work in a nursing home situation. The baseline survey was to be conducted at the start of the program and readministered at the completion of the project to determine if there was any decrease in the severity of oral hygiene conditions and the presence and severity of periodontal disease.

Conduction of examinations by dental hygiene students

On February 26, 1971, inspections were initiated in the three nursing homes participating in the project. A total of 19 dental hygiene students participated in the examination. Six students were designated as the examiners for the project for all phases of the clinical procedures. The remaining students participated as recorders and tabulated data. Two students, Miss Kay Klassy and Miss Karen Slusser, were responsible for organizing the schedules and coordinating all activity with the nursing homes.

The following instruments were used for each examination: a number 23, single-end, Shepherd Hook explorer, a No. 5 single-end Marquis, periodontal probe, and a combination mirror and light instrument specifically designed for conducting oral examinations in locations other than the dental office.

A total of 170 of the 181 patients in the three nursing homes were examined. This represents a percentage examined of 93.92. A little less than 7 per cent of the patients were unable to be examined by dental hygiene students because of serious illnesses which prevented their being examined or, they had no desire to participate in the project. Upon completion of their examinations the dental hygiene students classified each patient according to the type of dental treatment needed. Three categories of treatment needed were established. One, those patients needing care, but not of a serious nature. The patients in this category had minor problems which did not cause discomfort. The second category was care needed, not urgent. This included those patients who had a moderate dental problem. Care was definitely needed, but the treatment could be prolonged for a short period of time. The third category was care needed, urgent. The patients in this category had severe dental problems and immediate attention was necessary for their continued health and comfort. Of the 170 patients examined, the students classified 76 or 44.71 per cent as needing urgent dental care. Forty-six patients, or 27.06 per cent were classified as needing care, not urgent, and 48 or 28.23 per cent of the patients were classified as needing care. A summary of this data is presented in Table I.

Conduction of examinations of urgent conditions by dentists

As a follow-through to the examinations conducted by the dental hygiene students, three dentists examined those patients which had been designated as having urgent dental conditions. Each dentist conducted the follow-through examinations with a group of students and utilized this as a teaching situation. It was anticipated that dental hygiene students would "over-call" oral conditions of the nursing home patients, expecially since this was the first introduction many of the students had in working with the geriatirc person. The results of the follow-through examinations are as follows: Of the 76 patients initially categorized as having urgent conditions, seven were not available for the follow-through examination. Two were deceased and five were dismissed or had moved. The follow-through examination, therefore, was conducted on 69 patients. Of those 69, the dentists categorized 17, or 25 per cent as needing urgent dental care. The oral conditions of 75 per cent of the patients the students initially examined did not have urgent dental conditions when diagnosed by the dentists. Table II presents the data on the follow-through examinations. It is interesting to note the improvement of the dental hygiene student in her ability to evaluate the oral condition of a nursing home patient as being urgent. Students examined all the patients in Bannock County Nursing Home first and the per cent of patients categorized as needing urgent care was ninety-five. The second nursing home in which examinations were conducted was Eastgate. Students performed at an 88.88 per cent over-call rate in this nursing home. The third nursing home examined, Hillcrest, showed the least per cent over-call—54.84. This indicates that the students were able to determine urgent conditions more accurately in Hillcrest after receiving experience in the first two nursing homes.

Compilation of baseline data

Tables III through X present specific data on the nursing home residents treatment needs. The data in Table III illustrates that the majority of nursing home residents examined were female. One hundred and nine, or 64 per cent of the patients were female compared to 61 or 36 per cent, male.

Table IV describes the specific needs of those patients categorized as "care needed." Under the category of prophylaxis for natural teeth, 11 males and 15 females were indicated as needing this service. Twenty three males and 52 females needed to have their denture cleaned, and a total of 12 males and 23 females were in need of a new prosthetic appliance of some nature.

The specific needs of those patients categorized as "care needed, not urgent" are defined in Table V. Twenty patients, 13 females and 7 males were in need of denture repairs. Seventeen persons, 15 males and 2 female, had dental caries, and thirty-nine persons, 28 females and 11 male, were in need of denture relines.

The specific treatment needs of those indicated as "care needed, urgent" are described in Table VI. Of the 76 nursing home residents in this category, 44 had a questionable intra-oral or extra-oral lesion, as indicated under "Pathology."

Thirteen persons were categorized as needing extractions and 17 were indicated as having attached gingival inflammation. A total of fifteen persons had denture sores which were causing discomfort.

The total number of persons with natural teeth and the categorization of natural teeth as decayed, filled or sound is presented in Table VII. A total of 35 of 179 nursing home residents examined had natural teeth. These 35 persons had an average of 15.71 natural teeth. Of the natural teeth present, an average of 6.54 were decayed, an average of 2.49 teeth were filled, and an average of 7 teeth were sound.

There were a total of 21 persons who were without natural teeth and who were without dentures. This is illustrated in Table VIII.

Table IX presents the total number of persons with dentures. One hundred and seven of the 170 nursing home patients had dentures. Ninety-four had both maxillary and mandibular dentures, 12 had only a maxillary denture and 1 had only a mandibular denture.

Table X summarizes denture repairs indicated. A total of 18 dentures were broken and in need of repair. A total of fifteen denture teeth were missing or broken.

Conduction of the questionnaire of nursing home employees

Results of the nursing home employee questionnaire are presented in Table XI. A total of 44 responses were obtained. The first seven items of the questionnaire were intended to determine the feeling, attitude or opinion of the nursing home employee in regard to their ability to conduct oral examinations, their desire to learn to conduct an oral examination and their general knowledge about dental health. In item number one when asked to evaluate their ability to do an oral examination and detect oral problems, six employees responded that they could conduct an oral examination well, and detect any oral problems, 18 indicated that they did not believe that they could conduct an oral examination and could not detect oral problems.

They were asked to indicate their desire to learn to conduct an oral examination in item number two. Sixteen employees indicated that they had a great interest to learn how to conduct this procedure. Four indicated that they had no interest to learn how to perform this procedure.

Item number three required that the nursing home employee estimates her degree of knowledge about dental health and the oral health needs of her nursing home patients. Twelve indicated that they felt pretty knowledgeable about dental health, where fifteen stated that they did not feel knowledgeable.

When asked if they would be willing to assist with the daily health care of the patients in item number four, thirty-seven responded "yes, they would be willing to assist with these procedures". Four indicated that "no, they would not; it would be very unpleasant for them."

Twenty-eight of the forty-four respondents had received a complete dental examination themselves within one year. Thirteen of the nursing home employees had not received an oral examination for over two years, as is indicated by the results in item number five.

In item number 6, twenty-five nursing home employees indicated that they would like to receive dental health information for their personal use. Two indicated that they didn't particularly care.

In response to item number seven, "Have you ever received any information on the oral health needs of nursing home patients?" Thirty-two indicated "No, they had not." Twelve indicated, "yes."

The following twenty-six items of the nursing home employee questionnaire were developed for the purpose of determining general oral health knowledge and perceptions of the nursing home employee. Two items, number three and number twenty-one had no correct response and were not considered in the evaluation. The number of correct responses to the questionnaire are summarized at the end of Table XI. The item and the correct response, the number of correct responses and the per cent are recorded. The per cent of correct responses ranged from 14 to 98 per cent. The average number who answered an item correctly was twenty-five and the average per cent of correct response was fifty-seven. It should be noted that those items where the poorest response was recorded were among the most technical items developed.

This questionnaire was intended to be readministered upon termination of the project; however, due to the limited time for the over-all conduction of the program, it was impossible to readminister the questionnaire to the nursing home employees.

Conduction of the Questionnaire of Dental Hygiene Students

A questionnaire was administered to fourteen of the students who participated in the project. The questionnaire was designed to determine the attitudes and opinions of students upon initiation of the project and upon termination. Responses to the questionnaire are presented in Table XII. Item number one was designed to determine if there was a difference in the student's attitude toward working with certain age groups. Before the project, no students selected the age group over sixty as being their first choices of age groups with whom to work. Upon completion of the project, two students indicated this age group as their second choice and two students indicated this age group as their third choice. Eight students indicated this as their fourth and fifth choice of age group.

Very little difference in attitude was noted by the second item where students were requested to indicate what they believed to be the severity or magnitude of the oral health needs of nursing home residents. Eight students indicated on both questionnaires that they believed nursing home residents had extreme oral health needs. No students indicated that they believe nursing home patients had no oral health problems.

When asked what the students believed the nursing home residents' attitude toward their instruction would be in item number three, only three students indicated the highest two responses in regard to the nursing home residents appreciating and being interested in their instruction. At termination of the project, seven students selected to the top two responses in this category.

Item number four asked the dental hygiene student to indicate what they believe the capacity of the nursing home patient to learn what they had to tell them would be. There was very little difference in the before and after questionnaires. No students indicated a very high learning capacity on either questionnaire.

There was a slight difference in student responses in item number five where the dental hygience student was to estimate the physical ability of the nursing home patient to follow through on their instructions. On the before questionnaire, one student indicated that she felt that nursing home residents to be extremely capable. On the post questionnaire, these students selected this category.

When asked to indicate how they believed nursing home employees would accept oral health information they provided in item number six, five students indicated they believed the employees would be favorable and appreciative of their information. On the post questionnaire, only one student indicated the highest rating of favorable or appreciative.

When asked to estimate how effective they would be in changing the attitudes and behaviour of nursing home patients and employees in item number seven, no student stated she thought she would be extremely effective on either questionnaire.

Item number eight asked the dental hygiene student what she believed was the level of her ability to conduct an educational and treatment program for nursing home patients and employees. On the pre-questionnaire, only five students indicated either of the two top categories as being very knowledgeable. On the post questionnaire, eleven students indicated that they thought that they were very knowledgeable or fairly knowledgeable about how to conduct an educational and treatment program in the nursing home.

When asked to respond to the question of whether the dental profession was sufficiently involved with patients in nursing homes, the students indicated in six responses that they thought more involvement was necessary on the initial questionnaire. On the post questionnaire, ten students indicated that they were certain that more involvement on the part of the dental profession was necessary.

Two non-comparison items were included in the questionnaire. One item asked the student to indicate her motive for volunteering to participate in the project. The three major reasons for participating in the project were: 1) to gain experience in examining patients with possible oral pathology; 2) to gain experience in providing a community service; and 3) for monetary reasons.

When asked to respond to how they felt about their participation in the nursing home project, and if they would participate in a project of this nature again, all students indicated that they would be willing to work in a nursing home on a part-time basis.

Treatment obtained

As specified in the initial proposal, dental hygiene students were to assist in obtaining dental treatment for the nursing home patients who had treatment

needs of an urgent nature. Of the seventeen persons diagnosed by dentists as needing urgent dental treatment, only one patient receives treatment under condition of the grant award. This person receive full mouth extractions at St. Anthony Community Hospital in Pocatello.

Dental hygiene students provided additional services in the form of education and the cleaning of prosthetic appliances up to the time of expiration of the grant on May 31, 1971.

CONCLUSIONS

In comparing the results of this project with the objective of the proposal there is evidence that all objectives were accomplished to a certain degree. The degree to which each objective was attained may be directly related to the amount of time involved for conduction of the project. The initial proposal was submitted with the understanding that if approved, the project would be funded for the period November 1, 1970 to May 31, 1971. Because of the delay in receiving funding until February 16, 1971 however, the project was decreased from seven months to three and one-half months. It is also important to note that during the period the project was funded the students were required to prepare for National Board Dental Hygiene Examinations, many students were not in Pocatello during the week of Easter vacation, there were final examinations for which to prepare and course requirements to complete.

Additionally, University regulations require that all purchase requisitions be placed on bid. As a result of this regulation, the majority of supplies and equipment ordered in February were not received by the University until the end of May.

In considering the degree to which each major objective was accomplished, the following information is submitted.

Objective No. 1.—To place dental hygiene students in nursing homes in rural areas for the purpose of providing direct service to patients.

The services specified under this objective include the following:

1. Conduct an oral inspection for the purpose of detecting the presence of oral lesions.
2. Conduct an oral inspection for the purpose of determining the dental treatment needs of nursing home patients.
3. Conduct an oral inspection for the purpose of determining the oral health care needs of nursing home patients, and for planning the preventive procedures to be provided by the dental hygiene student.
4. Provide specific dental hygiene procedures for the patients in the nursing home: scaling and polishing of removable dental appliances, providing personal instruction for the patients on the care of their teeth, appliances and oral tissues.

Dental hygiene students did accomplish this objective. Students spent a total of 678 hours in the nursing homes conducting examinations, determining treatment and oral health care needs, providing home care instruction to individual patients and cleaning removable dental appliances.

Objective No. 2.—Inform the nursing home administrator of the kind of dental care necessary for maintaining the patient at an improved health level. Upon completion of the oral inspection the dental hygiene student would tabulate and categorize the findings and provide the nursing home operator with the following information.

1. Those patients who need immediate referral to a dentist because of a suspicious oral lesion.
2. Those patients who need dental treatment for prosthetic sores, improperly fitting prosthetic appliances, periodontal disease, and dental caries according to the following classification system.
   a. care needed
   b. care needed, not urgent
   c. care needed, urgent
3. Techniques the nursing home attendants might employ to assist patients with their personal oral health care.
4. Techniques nursing home attendants could use to detect emergency or urgent dental conditions and the procedures to follow for taking care of the problem.

The degree to which this objective was attained is minimal. Although students did inform nursing home personnel of those patients who needed immediate referral to a dentist and did categorize all patients according to care needed, care needed, not urgent, and care needed, urgent, students were unable to accomplish the last two specific objectives. In the students opinion the time they had avail-

able to spend with nursing home attendants to instruct them as to how to assist their patients was minimal. The time spent in teaching nursing home attendants to detect emergency or urgent dental conditions and the procedures to follow for taking care of the problem was also considered inadequate for the full attainment of this objective.

Objective No. 3.—Dental hygiene students working in cooperation with nursing home directors and employees would assist nursing home patients in obtaining dental treatment for conditions designated as urgent. Dental hygiene students would perform the following specific functions:

1. Schedule appointments for the nursing home patients requiring urgent dental treatment with one of the dentists participating in the program.
2. Arrange for transportation for the nursing home patient to and from the dental office.
3. Complete reimbursement forms for the dentist.
4. Inform the nursing home director of the treatment provided and any recommendations for special oral health care if necessary.
5. Evaluate the post-operative progress of the patient at appropriate time intervals.

Degree of attainment of this objective is considered minimal. Of the seventeen patients considered by dentists as requiring urgent dental treatment, only one received appropriate care. However, there is every reason to believe that with appropriate time, this objective could have been fully accomplished.

Objective No. 4.—Educate the dental hygiene student so that upon graduation and at work with practicing dentists she will be oriented to caring for elderly patients and will be prepared to exercise a leadership role in planning community programs for the neglected and poor.

Although difficult to evaluate immediately after the graduation of students, there is evidence that this project objective was attained. From the results of the dental hygiene student attitude and opinion questionnaire, it was noted that positive responses were evident in important categories. Dental hygiene students seemed to develop an appreciation for working with this age group of people as described in item number 1. There was a marked increase in dental hygiene student opinions on what they considered their ability to conduct an educational and treatment program for nursing home patients and employees. Dental hygiene students are convinced that more involvement on the part of the dental profession in caring for the needs of these patients is necessary and all students indicated that they would be willing to participate in a project of this nature again.

TABLE I.—NUMBER OF PERSONS EXAMINED ACCORDING TO TREATMENT INDICATED

	Bannock	Hillcrest	Eastgate	Total	
				Number	Percent
Number examined	51	82	37	170	
Care needed	13	28	7	48	28.23
Not urgent	15	21	10	46	27.06
Urgent	23	33	20	76	44.71

TABLE II.—FOLLOW-THROUGH EXAMINATIONS ON THOSE PATIENTS DESIGNATED AS NEEDING URGENT DENTAL CARE

	Bannock	Hillcrest	Eastgate	Total
Number examined	20	31	18	69
Diagnosed by dentist as urgent	1	14	2	17
Number over-called	19	17	16	52
Percent over-call	95	54.84	88.88	75.36

TABLE III.—TOTAL NUMBER OF PERSONS EXAMINED

	Bannock	Eastgate	Hillcrest	Total
Male	16	15	30	61
Female	35	22	52	109
Total	51	37	82	170

TABLE IV.—NUMBER OF PATIENTS: CARE NEEDED

	Prophylaxis				Denture cleaning				New prothesis			
	Bannock	Eastgate	Hillcrest	Total	Bannock	Eastgate	Hillcrest	Total	Bannock	Eastgate	Hillcrest	Total
Male	3	3	5	11	5	6	12	23	3	2	7	12
Female	3	5	7	15	11	19	22	52	3	2	18	23
Total	6	8	12	26	16	25	34	75	6	4	25	53

TABLE V.—NUMBER OF PATIENTS: CARE NEEDED, NOT URGENT

	Denture repair				Dental caries				Denture reline			
	Bannock	Eastgate	Hillcrest	Total	Bannock	Eastgate	Hillcrest	Total	Bannock	Eastgate	Hillcrest	Total
Male	4	1	2	7	1	1	13	15	4	4	3	11
Female	6	3	4	13	0	1	1	2	10	7	11	28
Total	10	4	6	20	1	2	14	17	14	11	14	39

TABLE VI.—NUMBER OF PATIENTS: CARE NEEDED, URGENT

	Bannock	Eastgate	Hillcrest	Total
Pathology				
Male	4	5	6	15
Female	9	8	12	29
Total	13	13	18	44
Extraction indicated				
Male	2	2	4	8
Female	2	0	3	5
Total	4	2	7	13
Inflammation of att. ging.				
Male	4	1	4	9
Female	3	1	4	8
Total	7	2	8	17
Denture sore				
Male	2	1	1	4
Female	4	2	5	11
Total	6	3	6	15

TABLE VII.—TOTAL NUMBER OF PERSONS WITH NATURAL TEETH: DECAYED, FILLED, AND SOUND

	Bannock	Eastgate	Hillcrest	Total
Total number of persons	10	9	16	35
Total number of teeth	146	147	257	550
Average number of teeth	14.60	16.33	16.06	15.71
Total number of decayed teeth	75	76	78	229
Average number of decayed teeth	7.50	8.44	4.88	6.54
Total number of filled teeth	27	18	42	87
Average number of filled teeth	2.70	2.00	2.63	2.49
Total number of sound teeth	45	60	140	245
Average number of sound teeth	4.50	6.66	8.75	7.00

TABLE VIII.—TOTAL NUMBER OF PERSONS WITHOUT NATURAL TEETH AND WITHOUT DENTURES

	Bannock	Eastgate	Hillcrest	Total
Total number of persons	1	6	14	21

TABLE IX.—TOTAL NUMBER OF PERSONS WITH DENTURES

	Bannock	Eastgate	Hillcrest	Total
Maxillary and mandibular	30	28	36	94
Maxillary	4	3	5	12
Mandibular	0	1	0	1
Total	34	32	41	107

TABLE X.—DENTURE REPAIRS INDICATED

	Bannock	Eastgate	Hillcrest	Total
Maxillary denture broken	5	2	5	12
Mandibular denture broken	3	2	1	6
Teeth missing or broken	7	3	5	15
Total	15	7	11	37

TABLE XI: *Baseline Questionnaire: Nursing Home Employees*

To: Employees of Bannock, Hillcrest Haven and Eastgate Nursing Homes.
From: Lorna J. Bonnet, Project Director.
Mountain States Regional Medical Program: Improved Services for Patients in Nursing-Homes in Rural Areas.

Attached is a questionnaire which must be completed by nursing home employees in Pocatello, Idaho. The purpose of the questionnaire is to provide baseline data which will be used to evaluate the effectiveness of a program designed to improve the oral health status of nursing home patients.

This is *not a test* per se and will not affect your position with this nursing home. It is important that you answer *all* questions.

Do not sign your name. Please complete the questionnaire and return it to your administrator's office within twenty-four hours.

Thank you.

Responses

Bannock Nursing Home	10
Hillcrest Haven	21
Eastgate Nursing Home	13
Total	44

Idaho State University
Department of Dental Hygiene

MOUNTAIN STATES REGIONAL MEDICAL PROGRAM: IMPROVED SERVICES FOR PATIENTS IN NURSING HOMES IN RURAL AREAS

Baseline Questionnaire: Nursing Home Employees

Directions: Circle the *one* number which *best* indicates your feeling, atittude or opinion at this time.

1. Estimate your ability to do an oral examination and detect oral problems your patients might have:

5 Could conduct an oral examination well and detect any oral problem.
4
3
2
1 Could not conduct an oral examination, could not detect oral problems.

2. Indicate your interest or "desire" to learn to conduct an oral examination and learn to detect oral problems:

5 Have great interest to learn how to do this.
3
2
1 Have no interest to learn how to do this.

No answer.

3. Indicate what you consider is your "degree of knowledge" about dental health and the oral health needs which your nursing home patients might have:
5 Feel pretty knowledgeable about dental health.
4
3
2
1 Don't feel knowledgeable about dental health.
4. Would you be willing to assist with the daily oral health care of your patients?
5 Yes, especially if I had the time and was versed in the proper methods.
4
3
2
1 No, this would be very unpleasant for me.
No answer.
5. How long has it been since you received a complete dental examination?
— 1–12 months.
— 1–2 years.
— over 2 years.
6. Would you like to receive dental health information for your personal use?
— Yes.
— No.
— Don't particularly care.
7. Have you ever received any information on the oral health needs of nursing home patients?
— Yes.
— No.
If yes, please indicate how you received the information, i.e., short course, one or two lectures, etc.:
Directions: Circle the *best* answer. Mark *only one* answer for each item.
1. How often should a denture be cleaned?
a. Once a day.
b. After every meal.
c. Once a week.
d. It is not necessary that dentures be cleaned regularly.
2. Dentures are more advantageous than natural teeth:
a. Because they don't decay and cause pain.
b. Because they're cheaper to repair than natural teeth.
c. Because they can be removed if they cause discomfort.
d. In most cases, they are NOT more advantageous.
e. a, b and c.
3. Dentures should be made for geriatric patients who:
a. Need them.
b. Need them and want them.
c. Need them, but do not want them.
d. Do not need them, but want them.
4. You will know when a denture or oral appliance needs adjusting because—
a. The patient will complain about the denture.
b. The dentures will clack or "chatter" when the person eats.
c. It is NOT always possible to tell when a denture needs adjusting.
d. All of the above.
e. a and b.
5. Sometimes it is difficult for a patient to use his dentures when speaking or eating because of:
a. Muscular tremors.
b. Lack of muscular strength.
c. Poorly-fitting dentures.
d. All of the above.
e. b. and c.
6. Any adjustment or repair of dentures should be made by:
a. A dentist.
b. A nurse.
c. A nurse's aide.
d. A patient himself.
e. All of the above.

7. What could you do to help relieve dryness of the mouth of a nursing home patient who wears dentures?:
a. Regularly clean the patient's dentures.
b. Encourage the patient to wear his dentures whenever possible.
c. Discourage the patient from wearing his dentures except while eating.
d. Nothing as far as dentures are concerned.
e. a. and b.
f. N.A.
8. What percent of the patients in this nursing home wear dentures?
a. 5–10%.
b. 20–40%.
c. 40–60%.
d. 60–80%.
e. 80–100%.
f. N.A.
9. What should be done for a patient with a denture problem?
a. Advise patient not to wear the denture.
b. Advise patient to wear denture only when eating.
c. Try to secure someone to make a denture adjustment or repair.
d. N.A.
10. The most common site of oral atrophy (decrease in size and function of tissue) found in nursing home patients is:
a. Salivary glands.
b. Cheek muscles.
c. Gum tissue.
d. Lips.
e. c. and d.
f. N.A.
11. Nursing home personnel:
a. Should not directly concern themselves with a patient's oral condition.
b. Should only be concerned with cleaning their patient's teeth.
c. Should note any oral problems a patient has and seek professional advice when necessary.
d. N.A.
12. The main problem of lime or "tartar" deposits on teeth of the geriatric patient is it:
a. Increases tooth decay.
b. Irritates soft tissues.
c. Causes eventual tooth loss.
d. a. and b.
e. b. and c.
f. N.A.
13. Dental decay is:
a. A major problem with geriatric patients.
b. A minor problem with geriatric patients.
c. NOT a problem with geriatric patients.
d. N.A.
14. Common oral complaints of geriatric patients are:
a. A sore bone beneath the gums.
b. Burning tongue.
c. Dryness of mouth.
d. Discomfort when chewing.
e. All of the above.
f. N.A.
g. a. and d.
15. Which of the following would be considered as the major dental problem in nursing home residents who have their natural teeth?
a. Gum disease.
b. Decayed teeth.
c. Burning tongue.
d. N.A.
16. The oral health of nursing home patients:
a. Has little effect on their total health.
b. Is a poor indication of their total health.
c. Has no direct relationship to other diseases of their body.
d. Is a vital factor in their total health.
e. N.A.

17. A nursing home patient who complains of burning tongue would most likely be lacking in:
a. Vitamin A.
b. Fluids in the diet.
c. Vitamin B complex.
d. Vitamin C.
e. All.
f. N.A.
18. Decreased saliva flow in nursing home residents would result in:
a. Difficulty in speaking clearly.
b. A dryness of the skin, tongue and gums.
c. Difficulty in chewing and swallowing food.
d. All of the above.
e. N.A.
19. Nursing home patients:
a. Don't need dental care since in many cases life expectancy is only a few years.
b. Don't want dental care because they, themselves, don't believe it's necessary
c. Should receive care only on an emergency basis to alleviate pain and discomfort.
d. Should be offered regular dental care to avoid oral discomfort and enable proper chewing of foods.
20. The importance of having nursing home personnel examine their patients' oral condition is:
a. To recognize the existence of a problem.
b. To recognize the type of problem.
c. To recognize the treatment indicated for the problem.
d. To recognize the need for professional dental care.
e. Both a and b.
f. Both a and d.
g. N.A.
21. The geriatric patient tends to ignore, neglect, or fails to notice his dental problems because:
a. He doesn't really care about his teeth.
b. He doesn't want to complain to nursing home personnel.
c. He has resigned himself to accepting his dental problem.
d. He probably does not have a dental problem.
e. a and b.
f. a, b and c.
22. How often should nursing home residents have oral examinations?
a. Only when they have oral discomfort.
b. Only upon request of the family or patient.
c. Every two years.
d. Every year.
e. N.A.
23. Nursing home patients need to have their teeth cleaned:
a. Only when they have their natural teeth.
b. Not necessary when they don't wear dentures.
c. If they wear dentures, it's necessary to clean the dentures only.
d. Whether they wear dentures or not, the skin in the mouth should be cleaned.
e. N.A.
24. Which condition in a patient's mouth would require the most immediate attention?
a. Decayed teeth.
b. Gum infection.
c. A sore caused by a denture.
d. A sore other than that caused by a denture.
e. All.
f. N.A.
25 Oral cancer:
a. Is an increasing cause of death in the United States.
b. Is prevalent in older age groups.
c. Must be diagnosed by a biopsy.
d. All of the above.
e. N.A.

26. What per cent of the residents in this nursing home do you believe might have oral cancer:
a. None.
b. Five per cent or less.
c. Ten per cent.
d. Fifteen per cent.
e. Twenty per cent or more.
f. N.A.

SUMMARY OF CORRECT RESPONSES TO NURSING HOME EMPLOYEE QUESTIONNAIRE

Item and correct response	Correct response	
	Number	Percent
1 a	19	43
2 d	27	61
3 Eliminated.		
4 d	30	68
5 d	26	59
6 a	43	98
7 b	6	14
8 d	18	41
9 c	41	93
10 c	32	73
11 c	38	86
12 d	15	34
13 b	11	25
14 e	29	66
15 a	16	36
16 d	16	36
17 c	9	20
18 d	31	70
19 d	43	98
20 f	21	15
21 Eliminated.		
22 d	37	84
23 d	38	86
24 d	9	20
25 d	26	59
Average	25	57

TABLE XII. DENTAL HYGIENE STUDENT RESPONSE: PRE AND POST ATTITUDE AND OPINION QUESTIONNAIRE

	Number of responses per rating—									
	Before					After				
	5	4	3	2	1	5	4	3	2	1
1. Rank the following age groups according to the age of people you prefer to work with most. Use a 1 to 5 rating scale with 1 being the more Preferred:										
a. 12 years of age and under	1	2	4	1	4	2	1	4	1	4
b. 13 to 20 years of age			1	7	4			1	7	4
c. 20 to 40 years of age		1	4	3	4	1	5	1	1	4
d. 40 to 60 years of age	3	5	3	1		3	4	4	1	
e. Older than 60	8	4				6	2	2	2	
	No problems									Extreme needs
			1		2	3		4		5
2. Indicate what you believe to be the severity or magnitude of the oral health needs of nursing home residents:										
Before						1		5		8
After						2		4		8
	Most not interested									Most interested and appreciative
			1		2	3		4		5
3. In regard to providing oral home care instructions for nursing home patients, indicate what you believe was the patient's attitude toward your instruction:										
Before			2		2	7				3
After			3		1	3		4		3
	Low learning capacity									Very high learning capacity
			1		2	3		4		5
4. In regard to the ability of nursing home patients to learn what you have to tell them, indicate what you believe their capacity to be:										
Before			4		3	5		2		
After			3		3	6		2		
	Incapable									Capable
			1		2	3		4		5

TABLE XII. DENTAL HYGIENE STUDENT RESPONSE: PRE AND POST ATTITUDE AND OPINION QUESTIONNAIRE—Continued

	Number of responses per rating—									
	Before					After				
	5	4	3	2	1	5	4	3	2	1
5. Rate the nursing home patients on their physical ability to follow through on your instructions:										
Before			1		4		4	4		1
After					1		6	4		3
	Not favorable, not appreciative									Favorable, appreciative
			1		2		3	4		5
6. Indicate how you believe nursing home employees will accept oral health information you provide:										
Before			1		2		4	2		5
After					3		7	3		1
	Ineffective									Effective
			1		2		3	4		5
7. Indicate how effective you believe you will be in changing the attitudes and behavior of nursing home patients and employees:										
Before					4		5	5		
After			2		1		7	4		
	Not knowledgeable									Very knowledgeable
			1		2		3	4		5
8. Indicate what you believe to be the level of your ability to conduct an educational and treatment program for nursing home patients and employees:										
Before			1		2		6	2		3
After							3	7		4
	More involvement not necessary									More involvement necessary
			1		2		3	4		5
9. Consider the present involvement of the dental profession with patients in nursing homes, indicate your feeling in regard to this involvement:										
Before							4	5		6
After							2	1		10

NON-COMPARISON ITEMS

Before Questionnaire

What were your motives for volunteering to participate in this project: Check those that are most applicable to you. Check *only three.*

1. Monetary reasons: 7.
2. Gain experience in providing a community service: 10.
3. Personal interest in working with the geriatric patient: 3.
4. Gain experience in examining patients with possible oral pathology: 12.
5. To assist in meeting the oral health needs of these patients: 4.
6. Gain additional experience in patient education: 5.
7. Gain experience in learning to motivate nursing home personnel: 1.
8. Other (please specify): No response.

Post Questionnaire

How do you feel about your participation in the Nursing Home Project? Would you participate in a project of this nature again? If so, under what conditions:

1. Have no desire to work with nursing home patients again: 1.
2. This has not been a rewarding experience; don't believe it is possible to be effective in this type of situation: No response.
3. Believe nursing homes should employ a dental hygienist to conduct education and treatment programs on a full-time basis: 5.

4. I would be willing to work with nursing home on a full-time ☐, part-time ☐, basis: Yes 12; full-time 0; part-time 12.

5. Please comment on the aspects of this project you enjoyed, what you did not enjoy. (See Comments Appendix A.)

Appendix A—Dental Hygiene Student Comments

Responses to post questionnaire non-comparison item two

1. No response.

2. To me there was a lack of organization of the project, i.e. I showed up at a nursing home assigned to me, but due to lack of communication the doctor I was to be working with never showed. Also, what we were informed would be our duties never became our duties.

I enjoyed the experience of working with the patients. It helped me to gain confidence in my knowledge and actions.

3. No response.

4. No response.

5. No response.

6. I liked providing patients with concern and attention. Very few cared about oral health, but seemed to have a great need for attention. In doing so, I felt I provided in addition a service in detecting any abnormalities present.

7. The aspect of this project that I did not enjoy was the "time conflict with getting requirements in."

8. Enjoyed making patients more comfortable. (did not) Employees on the whole unconcerned.

9. The hours were hard to fit in with classes and study time for me.

10. Enjoyed working with some of the patients (those who were coherent, interested.) Did not enjoy apparent apathy of a few of the nursing home (unprofessional) staff at one of the homes.

11. Making the old people happy and comfortable. All the experiences were eye-openers—and all very worth my time.

12. Enjoyed talking to some of the people—those that were interested and liked to talk. They appreciated us. Did not enjoy seeing those very old people that were very sick and kept moaning and groaning, or couldn't even sit up in a chair. It was rather depressing.

13. Enjoyed the feeling of being able to be of service to these people. Felt they really needed the attention. Wish more of them could get it on a regular basis.

14. I enjoyed working with the older people, the employes, and the administrators. I also liked working with the other hygienists. The patient education was the most enjoyable part of the job.

I like the challenge of trying to be an organizer, but I disliked the lack of organization and the constant time conflicts.

Appendix B—Summary of Expenditures

Expenditures, Dental Hygiene Nursing Home Project, Idaho State University

Special project grant 08-063-239, Western Interstate Commission for Higher Education, Mountain States Regional Medical Program

I. Personnel: Employment of dental hygiene students

678 hours, 45 minutes at $3.00/hour:

Allocation	$4,800.00
Expenditure	2,036.25
Unencumbered	2,763.75

II. Consulting services and provisions of treatment

Allocation	$1,750.00
Expenditure	540.00
Unencumbered	1,209.55

I. Equipment

A. Purchase:	
Allocation	$1,000.00
Expenditure	816.42
Unencumbered	183.58
B. Rental:	
Allocation	$200.00
Expenditure	none

IV. Supplies

Allocation	$300.00
Expenditure	68.29
Unencumbered	231.71

V. Travel: Dental Hygiene Students

167 miles at 10 cents a mile:	
Allocation	$350.00
Expenditure	16.70
Unencumbered	333.30
Total allocation	8,400.00
Total expenditure	3,478.11
Total unencumbered	4,921.89

ITEM 4. LETTER AND ATTACHMENT FROM D. WAYNE JACOBSON, PRESIDENT, LEISURE HILLS NURSING AND CONVALESCING HOME

MAY 26, 1971.

MY DEAR SENATOR MOSS: For the past several months, severe public criticism has been directed at nursing home operations in this country, and more particularly at the profit motivation of proprietary nursing homes. We, as members of the nursing home industry and operators of proprietary nursing homes feel that we should make available to you and the Subcommittee on Long Term Care examples of innovations in the care of the elderly in our homes, which we feel are significant of the type of care being rendered to residents and guests in many proprietary homes.

We feel it has long been the opinion of many in this country that the nursing home was the final stop for the majority of senior citizens admitted to this type of facility. In many instances this is true—the terminal cancers, acute cardiacs, advanced Parkinsonian—cases we can only serve through good care, comfortable surroundings, understanding, patience and love. However, a great number of those admitted for care to nursing home facilities can overcome at least some of their functional loss, and many can be returned to their homes and communities as useful citizens. A conscientious administrator of a nursing home can and will, with the help of the attending physician, nurse supervisor, social worker, physical and occupational therapists and mental health personnel, evaluate each admission and initiate a care program for each individual patient, striving to reach two major objectives: (1) optimum function for the individual within the limits of his capacity, and (2) the enlargement of the limits of that capacity. Remotivation, we believe, should be one of the key words in any nursing home, whether that facility be proprietary or non-proprietary.

In connection with our policy of high standards of skilled care and remotivation, we began an intensive program of physical and occupational therapy in our nursing homes. We were the first, to the best of our knowledge, to incorporate into our physical therapy program a hydro-therapy pool section. This was of unique design, conceived by the present owner-operator, serving a threefold purpose. This two-level pool area incorporated training steps, swimming exercises and whirlpool treatment in one location. Our completely modern physical and occupational therapy departments were equipped with the latest equipment and staffed with licensed personnel and aides in sufficient numbers in order

that the greatest number of patients might be given every opportunity to utilize their full capabilities. As a result of this type of program, we are able to state that many of our guests have progressed remarkably in the area of remotivation, and have been able to return to their homes and families or have been discharged to a lesser care type facility, where they have once again become independent, active members of the community in which they reside.

We are enclosing for your review documented cases of patients who were admitted to our facility and who, as a result of special care, diet observation and a concerted effort by our physical and occupational therapy departments, together with the remainder of our staff, were returned to their families, community or lesser care facilities. These are only a few of our most recent cases, but our records will reveal that many of our admits were later discharged—to the amazement of members of the medical profession, the families and the patient themselves. We have on record many cases of the type cited, some more severe than those decumented and some of a less severe nature. However, we believe that this sample of cases in our facility is typical of cases in other facilities, proprietary and non-proprietary alike. We have taken patients from state operated mental institutions who have resided in these institutions for thirty or more years. These people adjust readily to the nursing home environment, and are cared for at considerably less cost than at the state or federal institutions.

It appears that the present trend in this country on the part of the general public and also those in positions of political influence is damnation to the private enterprise system. The competitive spirit of the free enterprise system has made this country the most productive nation that has ever existed, and this system has risen to meet every challenge and obstacle. We are willing to move forward and to meet the ever increasing demands on our industry, but this must be done with foresight, sincere concern and a knowledge of the problems which face those of us involved in the care of the aging in this country.

We appreciate your concern for the Long-Term Care Patient, and commend you for the time and effort you have put forth on their behalf. We, too, as nursing home operators are concerned, and hope to convey to you and your committee, by the outline of cases enclosed, that our desire to furnish the best possible care at the least possible cost to the patient and the taxpayer is and shall continue to be the policy of this and other nursing homes under our management.

Very truly yours,

D. WAYNE JACOBSON, *President.*

[Attachment.]

DOCUMENTATION

Case No. 719, Female, Age 81—

Diagnosis: Congenital Heart Failure, Fracture Tibial Plateau and Femeral Epicondyle (left).

Admitted: January 1, 1970.

Treatment: Physical and Occupational Therapy began on day of admission. Partial to full weight bearing. Eager to work in Occupational Therapy. Low Salt diet. Hydrocollator packs used per Physical Therapist and attending Physician's Orders. Patient discharged on March 15, 1970 to home with daughter. Ambulatory at time of discharge. Has visited nursing home occasionally since discharge.

Case No. 692, Female, Age 59—

Diagnosis: Diabetic, Amputee, Right Leg below knee, Generalized Arteriolosclerosis, Cardiac Decomposition, Arthritic.

Admitted: September 23, 1969.

Treatment: Occupational Therapy started immediately, working with hands for improvement in arthritic condition. Physical Therapy started on 10–10–69 with emphasis on whirlpool treatment in hydro-therapy section. Arthritic condition improving and muscle activity in left leg very good. Fitted with artificial limb on 6–2–70 and walked in parallel bars. Fitted with special shoes per Physical Therapist and Physician. Doing very well with prosthetic device. Clinitest negative. Continues with Physical and Occupational Therapy. October 31, 1970, patient discharged to her apartment. Continues therapy weekly on out-patient basis. Getting along very well on her own and feels very independent.

Case No. 759, Female, Age 74—

Diagnosis: Severe Arthritic, Obese.

Admitted: May 13, 1970.

Treatment: Special low calorie diet for obesity. Occupational Therapy suggested to patient and began immediately. Physical Therapy began on 5–25–70. Patient complains constantly of being too ill and arthritic to help herself. Pool treatment suggested by Physical Therapist and Physician. Begins to cooperate and says she feels much better, not so much pain in legs. Demands much attention from administrator. 7–24–70 Physical Therapy discontinued at patient's request. Two weeks later, Therapy resumed at suggestion of administrator and Physician. March 3, 1971, patient discharged to her apartment, weight loss significant and arthritic pains alleviated. Does own cooking, cleaning, etc. Visits nursing home occasionally.

Case No. 772, Male, Age 88—

Diagnosis: Arthritic Legs, Pernicious Anemia, Heart Disease.

Admitted: July 7, 1970.

Treatment: Moves only with assistance upon admission. Special diet. Enjoys Occupational Therapy, building, sanding and some painting. Physical Therapy started on 7–27–70, passive, active and resistive exercises with gait training. Cooperative and pleasant. Therapy continued until 9–11–70, discharged to family on 9–12–70, ambulatory.

Case No. 753, Female, Age 67—

Diagnosis: Extreme Obesity, Acute Bronchitis, Cardiac Decomposition, Diabetes Mellitus, Hypertension Cardiovascular Disease.

Admitted: April 25, 1970.

Treatment: Weight 310 lbs. at admission. 500 Calorie diet. Does not wish to ambulate. Much effort to walk to lobby. Enjoys Occupational Therapist and department aides. Intake of fluids watched closely. Physical Therapy commenced on 4–27–70. Walking on parallel bars, pool treatments. July 25, 1970, discharged to home, blood pressure normal, blood sugar normal, weight 211 lbs. Patient visits nursing home regularly, has continued on diet and exercises suggested by Physical Therapist. Weight now 165 lbs.

Case No. 709, Male, Age 91—

Diagnosis: Arteriosclerotic Heart Disease, Cardiac Failure.

Admitted: November 24, 1969.

Treatment: Edema of legs. Cooperative in Therapy departments and with staff members. Complains of soreness in legs during therapy treatments. Persistent, wishes to continue Physical Therapy so he can go home. Hydro-therapy pool section enjoyed by patient and complains of less leg pain. May 14, 1970 patient discharged to own home. No edema of legs or heart murmur at time of discharge.

ITEM 5. LETTER AND MATERIAL FROM FRANK E. MATHER, M.D., BOISE, IDAHO

MAY 26, 1971.

Senator FRANK E. MOSS,
Chairman, Senate Subcommittee on Long Term Care,
U.S. Senate, Washington, D.C.

The enclosed materials are submitted with the intent they be included in the hearings considerations of the Senate Subcommittee on Long Term Care.

They are based upon a sincere constructive intent and represent no sponsoring group, association, or agency. They are simply the convictions of a physician who has served on two sides of the health care system; as a private practicing physician, and in an administrative capacity as director of a state licensing and certification section for health facilities. Motivations for these expressed convictions are based solely upon the responsibility an individual assumes to patient care as a physician regardless of what status or office he may hold.

To find violators and summarily fix the blame on them for an ailing health care system is not a difficult task. We have many potential candidates. A service is rendered if we identify and treat the cause of the illness rather than randomly attacking its symptoms.

The basic symptoms are few in number. From the basic symptoms, identification of cause should be possible.

Symptoms:

1. Inadequate provider performance:
   a. Less than desirable quality of care.
   b. Failure of the delivery of services to reach all of those in need.
   c. By some a moral failure to fairly charge for services furnished.

2. Inadequate administrative performance:
   a. Incomplete and inept information to the public about the program (1) mechanics; (2) limitations; (3) nature and goals.
   b. Unresponsive action to program needs (1) lack of responsible, informed, professional leadership at the delivery level at least; (2) failure at state, regional, and central levels to provide appropriate supervision, knowledgeable guidance, and minimum controls for providers, intermediaries, carriers, and state agency functions.

Symptomatology is abbreviated, however it is adequate to identify the basic illness cause as being within the program structure and management itself. Providers will function better when they are able to identify overall constructive leadership, encouragement, and supervision in providing health care. The public and lower levels of program administration will respond on the same basis.

Beyond this point we face a philosophic illness where the doctor is the legislative arm of government. Serious complications to the illness exist. Health care has been placed in the field of political influence where its fortunes wax and wane with that cyclic circus known as elections. Also it is subject to the leadership and direction of that ponderous, immovable, at times hopeless identity known as bureaucracy.

It is an improper service to the patient and public to vigorously attack the isolated symptoms and ignore the causitive agents of the illness in the health care system. I have included two examples of how we might begin treatment at the fringes of the illness, knowing that this case must be in the hands of the specialist, legislative leadership.

Until proper treatment is initiated a valid warning should apply to these national health care programs: "Caution, government may be hazardous to your health".

How many new names, terms, and identifications can be imposed on a long established business or system, without adequate explanation, before that business sinks from pure communications and understanding breakdown?

"That breakdown crisis is not far removed in our health care system" is widely predicted by many. A fair number think it's already here.

The question and the warning are related. Lack of communication and understanding are one major factor in the impending crisis.

In no other segment of the health care delivery system is this any more evident than in the Nursing Home Industry. This intermediate grade of care with its chronic, routine character make it subject to avoidance and neglect. A segment vulnerable to early failure.

There is need for an informational tool to sort out the created bits and pieces of health care so that providers, especially nursing homes, can identify their role. If there is such a tool it has either not worked or has not been distributed yet.

Here is one that works. In fact it may be coupled to licensure standards and practice to aid in that field.

What it's all about is attempting to provide medical care to patients. So we look at the patient, his illness or infirmity, his response pattern to it, and fashion a profile from this information. Now if the segments of the system of care will key into this profile we have a reasonable chance of an understandable system. and an educational tool.

To set up the patient profile one measure would be the degree of dependency on others for care as a result of the illness. The second measure would be the time span of the dependency. We have the elements necessary to produce an idealized graph of the patients need for care that will serve our purpose.

For practicality, numerical levels of care (categorys) are assigned. The goal here is the fewest possible levels to avoid producing as many gray area decisions of patient assignment to levels that we can. All of the present categorys of care must fit into our profile since we are using the basis for which they were created, the patient and his illness. Six Levels of Care were determined to be adequate. The limits of these levels fully anticipate some overlapping of patient assignment since this is often a difficult judgmental decision.

The six Levels of Care are listed here with comparison references only. Strict definitions would be dependent upon state or regional standards and practices.

Level I: Comparable to acute hospital inpatient care.

Level II: Comparable to acute convalescent care or extended care.

Level III: Comparable to nursing home care or stabilized status of illness requiring continuous nursing care for his dependency.

Level IV: Comparable to board and room with supporting personal care but not continuous nursing care.

Level V: Home professional nursing care for the convalescing patient or the patient capable of living at home if some professional nursing care is provided.

Level VI: Clinical and preventive services to essentially ambulatory patients.

Superimposing these levels on the patient dependency profile provides a graphic visual aid of the system of care.

This system is simple. Coupled with the graphic aids it provides an effective aural communication tool to clarify a confused health care system in the minds of providers. This has been especially true in the nursing home field. (With a few simple modifications it is effective in the same way in the Mental Health Care Field.)

Since I mentioned coupling this concept to Licensure a brief word on this. To meet the trend of multiple Levels of Care being offered by one facility one can utilize the concept to simplify licensing procedure. It is necessary to issue only one class license, a Health Facilities License. This license states that the facility is authorized to provide any combination of the Levels of Care for which it is approved by state standards and inspection. One license and one survey.

I submit this material for consideration since many of the problems in long term care are based upon misunderstanding. A tested simple educational tool will help to eliminate many of these.

In defense of the nursing home administrator and the professionals supplying services to nursing home patients I call your attention to an excellent example of a quality care program initiated by an administrator and one of his consulting professionals. Look at what has been done to develop a program by an administrator and his facility pharmacist. First in recognizing need for improved pharmacy services to nursing home patients; second in supplying a sound method of drug control in a critical area.

In addition to the contributions to care inherent in the system consider two important points:

(1) An excellent example of the responsibility assumed by individuals, involved in providing primary care, to the patients they serve. The individual intimately involved in providing care stands in a prime position to create appropriate programs. They are a part of the machine they make. These individuals are not likely to fashion a cumbersome, inefficient system for themselves.

(2) Programs or systems created by providers must be examined and evaluated by professionals with experience and knowledge of the care provided as the system is introduced to; assure protection of the patients interests, to determine the applicability of the system to other facilities.

(It is obvious we need good quality programs, and having acquired such, they must be promoted for others to adopt. We must not expect the provider who developed the system to be the sole evaluator, nor can we expect or ask him to abandon his primary interest and skill in providing care to promote the expansion of the system at the expense of this responsibility.)

In the case of this pharmacy system it was evaluated during development by experienced professionals, physician, pharmacist, and nurse. It was supervised in its introduction. Its expansion to other nursing homes that followed was encouraged and promoted by professionals of the Licensing and Certification Agency working with the system developers. These are the ingredients of quality care development "on the firing line".

The defect that prevents this effective and orderly development in too many cases is the lack of essential knowledge, interest, and catalytic effort at the administrative and supervisory level in governmental agencys. For lack of a fork need the dinner be lost?

Sincerely,

FRANK E. MATHER, M.D.

ITEM 6. LETTER AND ENCLOSURE FROM DONALD H. WILSON, ADMINISTRATOR, THE ASBURY METHODIST HOME

AUGUST 12, 1971.

DEAR SENATOR MOSS: Because of *your vital interest* and concern *for the elderly* men and women who are being cared for in nursing homes and related facilities we wanted to call your attention to the fact that a *model of outstanding*

residential and nursing care for the elderly exists just a few short miles from our office in the Nation's Capital, and to invite you to come to Gaithersburg to see first hand an example of *what can be done* to provide outstanding care for the elderly, and to be our guest for dinner in our dining room at 12:30.

The enclosed material will give you an insight into the excellent program we provide. Please accept our invitation at your earliest convenience.

Cordially,

RONALD H. WILSON.

[Enclosure.]

UNIVERSITY OF MARYLAND SCHOOL OF SOCIAL WORK,
OFFICE OF THE DEAN,
Baltimore, Md., March 25, 1970.

Mr. RONALD WILSON,
The Asbury Methodist Home,
Rolling Acres, Gaithersburg, Md.

DEAR MR. WILSON: It is the purpose of this letter to provide you with some impressions of my visit to the Asbury Home on 2/16/70 regarding the possible involvement of staff at the home in a course being offered by the University of Maryland for those who work with the elderly.

I was immediately impressed by the fact that I was welcomed to the home by residents rather than an individual specifically hire as a receptionist. Although I hold no grudges against secretaries and receptionists, I feel it is part of the unusual and striking feature of this home that the residents welcome you to *their home.* The treatment that I received during my stay by Mr. Wilson and the residents was extremely warm and inspiring. I was taken on a tour of the home by one of the residents (again, this in itself, differentiates this home so much from any I have ever been in before) who proudly provided a picture of a warm, comfortable, and free atmosphere. At one point, while noting that a kitchen on the lower floor was used by a resident to bake, she noted that "family" members did their baking in that kitchen. I asked what she had meant by "family" and the reply was simply "people who live here". This woman was in no way false in making this statement and it appears that residents here do, in fact, feel part of a family setting.

I was very favorably impressed by the cleanliness (yet without the kind of over-sterility one so often can see and smell in many other homes) and the general decor. I feel it is a wonderful idea to have persons who enter the home bring with them furniture if they wish. This not only provides lounges in other areas in the building with some beautiful, and in some cases antique pieces of furniture but I imagine this eliminates the complete break with all one has from the past that usually accompanies nursing home admission. I whole heartedly agree with the policy that also permits residents to furnish their own rooms should they wish. Too many nursing home residents suffer from the mentally stifling and depressing presence of every room looking exactly alike the other with modern mass produced and bulk bought furnishings.

As I am sure is the case with some people who visit the Asbury Home, I was particularly impressed by the many stores on the lower level. The striking beauty of the doll shop and the antique room are almost impossible to put in words. The past lives of residents at the Asbury Home as quite obviously respected and cherished by the home's administration. It must undoubtedly be a good feeling for residents to know that many aspects of their own paths will not totally dissolve with them upon their own death. The ice cream parlor, post office, hair dresser and hat shop must provide a great deal of pleasure for residents. These stores, for me, represented a kind of freedom so often lost by persons entering nursing homes. The residents of the Asbury Home had places to go even within the home. In addition, summer weather brings with it the opportunity to sit outside on spacious grounds and fish in the lake and enjoy beautiful scenery. In general, residents were offered a kind of privacy and degree of independence which is sorely lacking in other nursing homes. I do realize that many nursing homes have residents requiring significantly more custodial assistance than those in the Asbury Home, but the importance of privacy and independence to as great a degree as possible is something that should be considered much more by many nursing homes.

I left the Asbury Home feeling warm and hopeful for the future. Seeing this facility somehow gives one the feeling that a nursing home can, in fact, be a place one might really want to go when age reduced one's ability to function comfortably outside a protective setting. As I said to Mr. Wilson, I wish those

government officials with the power to assist this nation's senior citizens would visit the Asbury Home and then return to their states to duplicate this home as often as possible throughout the country.

I truly look forward to future visits to the Asbury Home.

Thank you.

Sincerely,

STEPHEN A. LESCHT,
Program Director.

"WHAT ASBURY MEANS TO ME"

Asbury—proper name—Home for the Aged: haven, refuge, sanctuary.

Just as the migratory birds find Marsh Island a sanctuary on their flight from one clime to another, just so do I find Asbury a refuge—not a retreat—on my journey from my earthly home to an unknown land.

The older birds know the route, the air currents, the streams and the fields along the way, yet they are grateful for this protected haven in which to rest and get their bearings. I, too, know the signposts that point to the destination I hope to reach. I, too, am grateful for a quiet place in which to get my bearings, and for the reassuring Thursday nights messages from devout men who have spent years studying the road map.

Just as the birds with no exertion on their part find their physical wants satisfied, so I, without the petty annoyances that plague the homemaker, find my life made comfortable with clean linen and appetizing food served in a charming environment.

Asbury means liberty to be myself without disrupting anyone's schedule. As I grow older, mind and body sometimes are weary without reason and I need solitude. No one questions my right to seek sanctuary in my own room, to close my door, to nap, to read, to sew, or to pray. And no one enters without knocking!

Asbury means freedom from that boring monotony which is often responsible for the deterioration of both mind and body in older people. The planned activities, the visits from talented groups, the books and magazines available in the libraries, add that variety which is the spice of life.

Asbury means association with a sympathetic staff—whose courtesy is unfailing—whose time is never so limited that a little cannot be spared to listen with interest to a tale of woe or one of happiness.

Asbury means the joy of being treated as a reasonable adult; one who can be relied on to observe the laws of courteous living without restraining rules. What bliss to go "to bed with the chickens" or to stay up to quietly finish that last exciting chapter.

Asbury means a home I can brag about with no infringement of good taste. I can show my visitors its attractive features with pride in our excellent housekeeper who is responsible for its immaculate beauty; pride in Dr. Wilson whose dream it is, and pride in the many Methodists who helped him realize that dream.

Asbury means a chance to serve without the frustrations that beset older people—the difficulty of getting about, and the dependence on other people are only two of many. Without leaving home, I can put my one talent to use.

Asbury's beautiful surroundings mean daily assurances of God's love. The stately trees, the rolling lawns, the gorgeous shrubs, the fragrant flowers are a balm to eyes and heart. I stand at my window, and see the sun touching the hills with the rosy light of early morning and know this is my Father's World.

EDITH ROBERTSON.

ITEM 7. LETTER FROM JAMES J. BRENNAN, ADMINISTRATOR, MARY LYON NURSING HOME, HAMPDEN, MASS.

JUNE 11, 1971.

DEAR SENATOR MOSS: Your planned public hearing with regard to hearing positive and constructive testimony on the contributions of Nursing Homes to modern society is greatly appreciated by myself and all my colleagues. We have been waiting for this opportunity of having equal time for a long time. Thank you very much.

I am writing to you in two capacities; namely, as an individual Nursing Home operator desiring to tell the world how health care programs for the elderly have been greatly strengthened by significant resident involvement in activities designed to prolong their *"living"*. Meaningful activities are every bit as important to those residing in Nursing Homes as their daily diet of medications.

Also, I am writing to you as Chairman of the Massachusetts Federation of Nursing Homes Public Relations Committee.

First, as the Administrator of the Mary Lyon Nursing Home, I want to tell you of the many activities conducted to extend "living" for the residents of our Home by adding enjoyment and enrichment to their lives. Some of our activities are conducted by volunteer members of our community. For instance, a local businessman donates his valuable time to conduct art classes once a week during his busy daytime. He has given greater meaning to the lives of our residents to whom we have already pledged "THE BETTER LIFE".

The art work being done by our residents is so good that the Sunday magazine section of the Springfield, Mass. newspaper has requested the right to do a story on them. In fact one of the works of art will be the cover picture. This is scheduled for early August 1971. It is interesting to note that none of the residents did any oil painting prior to this time.

The motto of our Home, is *"We Serve the Dignity of the Individual"*. These words are imbedded in the wall at our main entrance in 3 dimensional letters. Each member of our staff is guided by this motto.

I want to tell you how, not only does the community come to us, as with the art classes and other activities, but we also go out into the community. Recently, we accompanied some of our residents to the Shrine Circus. Their happy faces told the story as they ate hot dogs, drank soda-pop and had a grand time.

I want to tell you how our residents are overheard saying to one another, quote "I've never enjoyed myself as much as I am now", unquote.

I want to tell you of seeing residents walking down the hallway singing a happy tune just as they would if they were in their own home.

I want to tell you of residents who delight in showing visitors, who are strangers to them, around our Home because they are proud of what it is, what it stands for and the significant part they themselves play individually to make it the Home that it is.

I want to tell you how my own small children say, "I wish I lived in the Nursing Home, because they seem to have so much fun all the time".

In my other capacity, as Public Relations Chairman of one of the largest Nursing Home States in the United States, I want to tell you of the tremendous job being done throughout the Commonwealth of Massachusetts by all my colleagues.

I want to tell you how Nursing Homes in Massachusetts are sponsoring a legislative bill to permit Nursing Homes to serve as Day Care Centers for the elderly of the community. These Day Care Centers will serve a much needed purpose by allowing elderly men and women to come to our Nursing Homes and spend the day with us. Meals will be provided as well as the opportunity to participate in all of the already active programs designed exclusively for the elderly. Just being with people who have much in common will prove valuable.

I want to tell you of another legislative bill being sponsored by the Nursing Homes in Massachusetts requesting the opportunity of sharing many of our professional staff members with the community. We are requesting the opportunity of setting up out-patient clinics in communities where the services of Therapists (Physical, Speech, Occupational, and Recreational) are not readily available to the handicapped. Nursing Homes in that community may already have this professional on their staff and could very easily help a few more people when he or she routinely visits those residing in the Nursing Home. The pressing shortage of Therapists makes this a necessity.

I want to tell you of the many in-service training programs being conducted in most of our Nursing Homes to better help our staffs to extend the "living" of those entrusted to our care.

I want to tell you how it is the goal of the Nursing staffs of most Nursing Homes to get residents well so they can go to their own homes as soon as possible.

I want to tell you of the Dietary requirements in Massachusetts requiring better diets for the residents of our Homes. A Registered Dietitian is required on the staff of each Home as a consultant.

I want to tell you how our Nursing Homes are not only providing for the needs of the elderly, but also the needs of all convalescent patients, regardless of age.

I want to tell you how Religious services are held regularly in our Nursing Homes to provide for the Spiritual needs of our residents.

I want to tell you how Nursing Home residents in some facilities in Central Massachusetts volunteer their time and bring happiness to others by going out and visiting members of the community who are shut-ins in their private dwellings.

I want to tell you how residents in several Nursing Homes in Western Massachusetts decorate floats and personally ride on them in the 4th of July parade.

I want to tell you that many residents of many Nursing Homes in our Commonwealth go on bus trips to places of interest.

Senator Moss, I would sincerely appreciate the opportunity of personally telling you in detail about all of these things and the many other things that are being done in this new era of health care.

It was not known how much in depth you desired me to develop any of the aforementioned items. However, I am ready to develop any of my information as much as you wish. If you desire further background material, please notify me immediately so I can provide it to you by return mail.

Thank you again for being so thoughtful by arranging a public hearing to hear the Nursing Home side of the story.

Sincerely,

JAMES J. BRENNAN.

ITEM 8. LETTER FROM THOMAS P. LEWIS, ADMINISTRATOR, KINGSPORT MANOR, KINGSPORT, TENN.

MAY 26, 1971.

DEAR SENATOR MOSS: We have been advised that your Subcommittee on Long-Term Care will hold a public hearing on the contributions of nursing homes to modern society.

Having been active in the Nursing Home field since early 1967 as an Administrator and part-owner of an Extended Care Facility and presently serving the State of Tennessee as a member of the Board of Examiners for Nursing Home Administrators, I feel strongly that all relevant information to the subject should be placed in the Subcommittee's possession before the close of the hearing.

The modern nursing home has contributed the following toward resolving the special health care needs of our aging population:

1—By making available beds needed for long-term nursing care.

2—By making these beds available at a patient cost from ¼ to ½ the cost of equivalent nursing care in a regular hospital.

3—By providing a professionally supervised environment for rehabilitation of the elderly who may have that potential, despite stroke or other debilitating diseases commonly associated with the aging process.

4—By providing Tender Loving Care of trained therapists, activity programmers, professionally planned dietary management.

5—By providing the elderly with homely atmosphere among their contemporaries, at the same time relieving families of the burden of dealing with the special needs of a generation whose interests are often times quite alien to the younger family members.

Until this message reaches the public, the Nursing Home Industry has little attraction for private enterprise and its future development prospects are dim indeed.

Respectfully submitted.

THOMAS P. LEWIS.

ITEM 9. LETTER AND ENCLOSURE FROM MILTON JACOBS, VICE PRESIDENT, PANCH

MAY 27, 1971.

Hon. FRANK E. MOSS,
U.S. Senate,
Washington, D.C.

Enclosed you will find a copy of a report by the Ad Hoc Committee on Flexible Payment Systems for public assistance clients in public and private facilities.

This is essentially a program of health care delivery that deals with the problems of availability of service levels of care, proper payment for services on a competitive basis that has fixed ceiling cost based on historical averaging. It is unique in the fact that controls within the program can create operational realistic budgets. Proper payment for service can insure the investment by both tax paying and non-tax paying organizations in new facilities to take care of our country's needs. It will not be the responsibility of our states or the Federal Government to spend millions of dollars in gross capital expenditures to provide the needed facilities to advance health care programs for our dependent elderly.

We have had the cooperation and support of our administrative agencies here in Pennsylvania concerning this program. We have hopes that this program will be phased in to replace the antiquated system we are now suffering with.

I appeared as a witness at the hearing that Mr. Dennenberg, Ph. D., the Pennsylvania Insurance Commissioner, held several months ago concerning Blue Cross rate increases and innovative programs to help cut down operating costs in the delivery of health care.

This comprises the input and energies of many, many people with long years of expertise in health care delivery and although we do not consider this Utopia for all our problems, we do feel that the concept will certainly be a giant step forward to helping the crisis of health care delivery to the elderly.

If this program as presented seems to offer some merit in this area, I would be most pleased to meet with you to discuss it in greater detail, or appear as a witness in public hearings that will be held by the subcommittee on long-term care.

Yours very truly,

MILTON JACOBS.

[Enclosure.]

AD HOC COMMITTEE ON FLEXIBLE PAYMENT SYSTEMS FOR PUBLIC ASSISTANCE CLIENTS IN PUBLIC AND PRIVATE FACILITIES

NOVEMBER 30, 1970.

ALFRED C. KRAFT, M.D.,
Commissioner, Office of Medical Services and Facilities, Department of Public Welfare, Harrisburg, Pa.

DEAR DOCTOR KRAFT: It is with some degree of pride and perhaps even a greater feeling of anticipation that I submit to you the suggestions of our Ad Hoc Flexible Payment Committee. Since the time of our first meeting, until the present, our Committee has worked diligently in all areas of reimbursement in an effort to establish the means of providing realistic payment for services that will provide improved services and standards to our medically indigent. The effort has at times been frustrating and at times philosophic differences brought us to an impasse, but due to the tenacious conscientious attitudes of our Committee, we feel that we have formed a basis of "payment for services" that is realistic in its extent of funding as related to the improved services it will provide.

In the area of reimbursement, it is suggested that either one of the following methods would be used. In either case, it would be the plan that would provide the lesser of the two systems in regard to payment to the provider.

Plan A—would pay 110% of the average certified and/or audited costs by the region (6) so designated by the Office of Medical Services. Averages would be determined by like facilities of equal size for the same type of service offered.

1. These costs to be determined with a form similar to the Medicare (Title XVIII) chart of accounts.

2. These facilities can be subdivided into classification of services as follows. This would entail six levels of care—this under the following nomenclature:

a. Sub-Acute hospital.
b. Short term medical oriented post hospital facility.
c. Long term medical oriented restorative facility.
d. Intermediate care "A."
e. Intermediate care "B."
f. Personal care home.

Each facility would make an annual election as to the type of care or subdivisions of care it would provide. Notice must be given to the department at least 90 days prior to the beginning of the new year of the election.

Plan B—would pay published charges, these to be listed at the beginning of the contract year. All charges must be the same as those made to self pay patients.

Of the two plans mentioned payment to the contractual institution will be the rate that is lower between Plan A and Plan B.

It is suggested that an interim rate be used at the start of this program using random samplings from medical cost reports or audited financial reports by independent certified public accountants. All reports relative to this program to be submitted within 90 days of the close of the fiscal year. In cases where such reports are not received in the indicated 90 days, a fixed scale of percentage deductions should be made to the previous contractual rate until the required reports have been submitted. This would not be a fine in its concept, and all monies due the provider would be paid upon the submission of the required reports.

In reviewing the administrative problems of all the plans and methods we have reviewed, it seems to me that this plan in its basic simplicity is reflective to many many advantages in regard to patient care and over all cost. Some of the advantages that come to mind are as follows:

1. More providers of service will seek to join this program, therefore, making more hospital beds available for the critically ill and by proper utilization review bring the proper level of care to the patients needs.

2. This method will serve to increase the standards of care by having more providers join the program. This will create the availability of more beds and thus will give the Office of Medical Services and Facilities the "where to all" to close down and transfer patients from non-licensed (bootleg) homes.

3. It will restore for the first time the human dignity of the patient by allowing him the freedom of choice. The patient will no longer be an object of disdain, but a human being whose needs to be served will be competitively sought after.

4. The program will assure higher levels of standards through competitive free enterprise, knowing the level of care will be economically justified.

5. Utilization review of patients in the hospital will be able to place patients in five different levels of care relative to the patients' needs.

6. This plan does not require significant additional state administrative overlay as other intricate systems and point structures as evidenced by Illinois, Michigan and Massachusetts.

7. The possibility of utilizing the same fiscal intermediaries of Title XVIII is a consideration. This could reflect in substantial savings.

8. It is not unreasonable to consider the fact that there could be savings of from one to five days of high cost hospital care in the proper use of this program. In a recent article in the Philadelphia Bulletin dated November 17, 1970 related to this program and spoke of an average per diem cost of $80.00 per day. Based on this information, hospital costs for the medically indigent could be greatly reduced and the proper use of all facilities could provide better care at the same or lower overall cost.

In the course of this report, I touched on the subject of levels of care. It is the feeling of our Committee that this would be in the realm of six distinct levels of patient care. Please note that even though we speak of six levels of care, we have classified them under three categories of "Skilled Nursing Care"—Intermediate "A"—Intermediate 'B"—and "Personal Care". They are listed as follows:

CRITERIA—LEVELS OF CARE

I. Skilled Nursing Care

A. Types of facilities:

1. Sub-acute hospital.

2. Short term medically oriented, post hospital convalescing facility. This would take in patients of all ages including drug addicts and alcoholics for care.

3. Long term medically oriented restorative facility. This would use the professional skills of a medical director to insure its philosophy of restorative services.

II Intermediate "A"

4. Long term nursing care oriented facility that would possess the ability of some restorative services, but with emphasis on sustaining chronically ill patients.

Intermediate "B"

5. Long term facility with lower staffing requirements as related to the needs of a semi-medical facility. Patients in a facility of this type would require more of the social services, rehabilitative, occupational therapy and other services of this type.

III. Personal Care Institution

6. This facility would be a custodial care (personal) care institution.

CRITERIA AND DEFINITIONS

I. Sub-acute Hospital

This facility to be used either on the basis of a post hospital admission or in cases so designated by the patient's physician admission directly from the patient's home. This facility is able by its organization to diagnose and treat situations of medical need without the use of general hospital beds and facilities. Some of the written requirements are as follows:

1. A medical director whose responsibility it shall be to review all cases on admission and periodically thereafter. He will head and supervise a staff organization.
2. The medical team shall have available the service of all medical specialties including a podiatrist and an opthamologist.
3. There should be in depth diagnostic evaluation.
4. Portable x-ray equipment and a basic lab should be available.
5. Provisions for a pharmacy or drug room should be made if possible.
6. Medical records must be maintained. It is suggested that a medical librarian be used on a consultant basis.
7. Diagnostic history and laboratory work to be done in the facility.
8. A functioning U.R. Committee to determine levels of care needed and proper utilization of facility and transfer agreements.

II. Short Term Medically Oriented, Post Hospital Facility

This related to convalescence. This can be one of many types and take in patients of all ages including drug addicts and alcoholics.

This facility would provide a service which *must* be furnished by or under the supervision of trained medical or para-medical personnel. The fact that the service is performed by trained medical or para-medical personnel does not in fact mean that it is a skilled service. A service which can be safely and adequately self-administered or performed by the average and medical person, without the direct supervision of trained medical or para-medical personnel, is a nonskilled service without regard to who actually provides the service. Some of the written requirements are as follows:

1. A part time or full time medical director to insure medically directed services.
2. Staffing as per state minimum requirements.
3. A functioning U.R. Committee.
4. The availability of all medical specialties.
5. Transfer agreements.
6. All other criteria as published in rules and regulations pertaining to skilled nursing homes.

III. Long Term Medically Oriented Restorative Facility

1. Part time or full time medical director to insure medically directed services.
2. This facility would emphasize rehabilitation.
3. Functioning P.T. department.
4. Availability of services of:
   a. Speech therapy.
   b. Rehabilitation.
   c. Occupational therapy.
   d. Physical therapy.
5. Functioning U.R. Committee.
6. Transfer agreements.
7. All other criteria as published in rules and regulations pertaining to skilled nursing homes.

Intermediate "A"

This would be a long term nursing care oriented facility that would possess the ability to provide restorative services, but with emphasis on sustaining chronically ill patients.

1. Would provide a sufficient number of trained and/or experienced personnel shall be employed to provide a minimum of two hours of bedside care per resident day.
2. There shall be a written care plan.
3. Restorative care—there shall be an active program of restorative care aimed at assisting each resident to achieve his highest level of self care.
4. All orders under the written direction of a physician.
5. Would provide "skilled nursing care"—all services to be performed by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse.
6. Residents shall not be admitted if:
   a. Acutely ill and require medical, surgical or nursing care beyond the capabilities of the institution. Under no circumstances shall persons who require skilled nursing care be admitted to intermediate care facilities.

   As the prime objective, a transfer agreement should be made between a hospital and a skilled nursing home in order to provide reasonable assurance

that transfers of residents can be effected whenever such transfer is medically appropriate as determined by the attending physician.

b. Suspected or having any communicable diseases including tuberculosis, in its communicable stage.

c. Carriers or persons suspected of being carriers of communicable diseases.

d. Mentally ill who are dangerous to themselves or others.

e. No children under fourteen years of age except in homes licensed exclusively for convalescent and handicapped children, unless approved by the department.

f. Care services—the home shall provide care appropriate to the resident's need with authority, functions and duties clearly defined, with personnel chosen for their training experience and ability in conformance with adopted rules, regulations, policies and procedures.

g. Supervisory personnel—

(1) Bed capacity 2–34: Supervisor, 1 R.N. or L.P.N. on duty during day shift eight hours per day, five days per week, plus a responsible person who by experience is capable of assuming responsibility for two days.

(2) Bed capacity 35–74: 1 R.N. or L.P.N. as supervisor during the day shift for eight hours a day, five days a week, plus 1 R.N. or L.P.N. minimum of 40 hours per week. Schedules shall give maximum coverage, including weekends, holidays and evening shift. Coverage for a total of 80 hours of licensed nursing service per week.

(3) Bed capacity 75–125: 1 R.N. or L.P.N. as supervisor, 8 hours per day, five days per week, plus 2 R.N.s or L.P.N.s each shall work a minimum of 40 hours per week. A total of 120 hours of licensed nursing service per week.

(4) Bed capacity over 125: 1 R.N. or L.P.N. to serve as supervisor eight hours per day, 5 days per week, plus a sufficient number of R.N.s and L.P.N.s to serve around the clock, seven days a week.

(5) Additional factors staffing for providing care: Several factors will influence the total requirement for personnel to provide sufficient care. Such factors are the degree of helplessness of the resident, the physical layout of the institution for travel to activities, the type of facilities provided; the amount and type of equipment to be used for resident care and the skills needed to use such equipment in providing care (or promoting self-help through the use of prosthetic or therapeutic devices); and the extent of the staff's training and experience to provide care services.

(6) Minimum personnel on duty: As a precaution against a need in case of an emergency, a ratio of personnel on duty to residents shall not be less than 1 to 25 or fraction thereof at any time. Dietary and housekeeping personnel are to be excluded from this count.

(7) On call assistance: Homes which are not required to have an R.N. or L.P.N. on duty at all times must make provision for an R.N. or L.P.N. to be available by telephone for advice, or if necessary, emergency services.

(8) Utilization Review: Utilization Review is required for all residents supported by the Federal intermediate private paying residents.

(9) Transfer plan, annotation—Continuity of Care: In order to achieve continuity of care to residents as the prime objective, a transfer agreement should be made between a hospital and a skilled nursing home in order to provide reasonable assurance that transfers of residents can be affected whenever such transfer is medically appropriate as determined by the attending physician.

Intermediate "A"

Long Term Care—services rendered to residents whose illness is not acute and whose care needs have stabilized at a level which requires no more than eight hours a day of care under the supervision of an R.N. or L.P.N. prognosis is that such service will be required for an extended period.

Intermediate "B"

Long Term Facility with lower staffing requirements as related to the needs of a semi-medical facility. Patients in a facility of this type will require more of the social services, such as rehabilitation, occupational therapy, speech therapy and other services of this type.

Personal Care

This means those services which an individual would normally perform for himself but for which he is personally dependent on others because of advanced age, infirmity, physical or mental limitations. Personal care includes (but is not

limited to) assistance in walking, getting in and out of bed, bathing, dressing, feeding and general supervision and assistance in daily living.

Personal care patients must be: (1) Ambulatory, (2) Able to service own medications as per 802.1, (3) It is recommended that the criteria under rules and regulations 502 be rewritten as to the physical and mental requirements of patients.

These are the thoughts of our Committee relative to our charge. We hope that these thoughts can be constructive in helping to provide the means of improving patient care for the medically indigent as well as increasing the standards of all the facilities in this Commonwealth. We, the members of this Ad Hoc Committee express our appreciation for being chosen to serve in this vital area.

Yours very truly,

MILTON JACOBS, *Chairman.*

AD HOC COMMITTEE MEMBERS

PENNSYLVANIA ASSOCIATION OF NURSING AND CONVALESCENT HOMES

Mr. Milton Jacobs, Cedars of Tel-Aviv Nursing Home.
Mr. Morris Yoffe, American Medical Affiliates.
Mr. C. T. Baumgard, Lutheran Home for Orphans and Aged.

PENNSYLVANIA ASSOCIATION OF NON-PROFIT HOMES FOR THE AGED

Mother Mary Stephan, Garvey Manor.
Rev. Dean Shetler, Church of the Brethren Home.
Mr. Bernard Liebowitz, Philadelphia Geriatric Center.

PENNSYLVANIA ASSOCIATION OF COUNTY HOME SUPERINTENDENTS

Mr. Emory J. DiDonato, Westmoreland County Home.
Mr. John S. Nichols, Delaware County Home.
Mr. Edward R. Desautels, Mercer County Home and Hospital.

Appendix 3

LETTERS DESCRIBING PROGRAMS AND ACTIVITIES OF NONPROFIT HOMES

In the Committee's search for positive and innovative nursing home programs, a generous response was received from nonprofit homes. While the letters and material submitted are too numerous to print, they have been of great value. Senator Moss, Chairman of the Subcommittee on Long-Term Care, extended his appreciation to all who took the trouble to write and directed that 37 of the most representative letters be reprinted in this volume.

The letters follow:

SACRED HEART HOME,
Clarence, N.Y., December 16, 1971.

Re Innovative Programs.

DEAR SENATOR MOSS: Our letter is prompted by your recent letter to Mr. Frank G. Zelenka of the American Association of Homes for the Aging. It is my understanding that you are interested in innovative programs of care and services provided to the aged by long-term care facilities.

Sacred Heart Home is operated by the Brothers of Mercy. This Order devotes most of their effort to the care of the elderly. I am the first lay administrator of their facilities in Western New York. The material which accompanies this letter was organized by Brother Andre Moher, the Director of Nursing.

On receiving Mr. Zelenka's memorandum and a copy of your letter, we were very enthused about a governmental agency inquiring of nursing homes about the programs which they are presenting for the senior citizen of today. Only too often has this age group been told what to do, or has even been neglected, but we see now that this is being remedied and you are now interested in what the nursing home has to offer. We hope that, in the near future, you will even take this a step further and ask the Senior Citizen Councils what they would want and expect of a nursing home.

As to the programs which are offered here at Sacred Heart Home, we are happy to say that all are functioning daily and to their fullest capacity. The staff and patient work together toward the individual goal, and seeing the patient progress is all the answer we ask.

Programs now functioning at Sacred Heart Home include the following:

1. The social service department

Medical social work is a professional service to patients, physicians and the community and has been developed in this nursing home for the purpose of helping people with environmental and personal difficulties related to their illness, recovery and preservation of health. Like any other department in a nursing home, it has the same goal—that of providing the most comprehensive care possible for all its patients.

Every health problem creates a social crisis in the life of the patient and his family. Through intervention at time of crisis, social work attempts to prevent or reduce the incidence of conditions that aggravate health problems, as well as to resolve them. The two professions, medicine and social work, are joined in a common endeavor with the same objective.

Social work attempts to assist the person to deal more adequately with the situation in which he finds himself, whether through bringing about some change in his environment, or in his attitude, or both. More and more emphasis is being placed on the treatment of the "whole person"; no longer is it sufficient to diagnose and treat the disease or illness alone. Now, and in the future, it is of great importance to know about the MAN who has the illness, to have an

increased understanding of the inter-relationship of the medical, social, emotional and economic factors involved in the illness.

Increased attention has been placed on trained manpower and skilled professional services in order to take care of the medical, social, emotional and spiritual needs of each patient. Social Service is meant to be an integral part of this new focus.

2. The Evaluation Committee

The purpose of the Evaluation Committee is to determine the progress that the patient is making, make recommendations concerning his future care, and ascertain the appropriateness of the patient's placement within the institution.

If a case is determined to require Health Related Care, or if the patient can be cared for at home with the assistance of the Public Health Department, this is pointed out. This is done mainly because to misplace a resident into a setting which is not conducive to his well-being, is doing him psychological harm which could be more damaging than any physical ailment.

The committee meets each week. It is comprised of a physician, nurses and other paramedical professional personnel that oversee the care of the patient. This committee functions in addition to, and separately from, the Utilization and Review Committee.

3. Diagnostic Services

All diagnostic services provided are available either in the institution or in the local community. Appointments are set up at the convenience of the residents, even if this is at the expense of those providing the service.

Examples of services: X-rays, E.C.G., Optometry, Audiology, Clinical Laboratory, Dentistry, Physician's office visits, Podiatry.

Where possible, the family is involved. Taking the patient out helps them to feel that they are still a member of the family and the community.

4. Dietary Programs

The resident is asked to assist the staff in selecting foods which they would enjoy. Their likes and dislikes are listened to and remotivation discussions on food has been a great asset to the dietary department in planning menus.

A registered dietician visits the institution for consultation on menu planning weekly. It is the responsibility of the full-time dietary technician to see that the Food Service Department carries out the recommendations of the consultant.

5. Remotivation Therapy

Remotivation is a structured activity which enables the nursing assistant to reach patients in a meaningful and constructive way, over and above daily custodial care.

Remotivation is not psychotherapy in the strict sense of the word. It is, instead, a method of aide-patient interaction which increases and strengthens the contact between the aide and her own patients. Although designed originally as a technique for use in remotivating patients suffering from mental illness, Remotivation has been found to be equally useful in nursing homes, with all types of patients including those suffering from physical disorders, confusion, and those convalescing from mental disorders.

In most mental disorders in the aged, there are parts of the patient's original personality which remains relatively untouched. In certain areas, his personality and his interests remain healthy. Frequently, the untouched parts have to do with everyday ordinary things which we take for granted, such as the way a tree grows, the history of our state and all the multitude of things with which we live. These topics stimulate the patients to begin thinking about things outside of himself and provide him with an opportunity to talk about these things freely. The patient begins to realize that there is something different from his present life. It is a time in which someone is paying attention to him and recognizing him as a person, and that he is a part of a group. This technique provides an opportunity to set up a fresh relationship, even though the patient and aide have been seeing one another all day.

Along with all that the aide can give to the program is Remotivation, the program can also give something to the aide. It increases contact with her patients in such a way that it is not just part of the ordinary everyday routine. It provides a useful method of helping patients toward reality, thus making her an active and contributing member of the therapeutic team. Even more, it can stimulate the aide to take more interest in her patients and, therefore, more interest and pride in her job and herself.

6. Reality Orientation Program

The major objective of Reality Orientation is the reorientation of those patients to reality regardless of age or infirmity.

The fundamental purpose of Reality Orientation is to insure that in the next ten or twenty years we, as a society, will not repeat the tragic mistakes of the past and allow the senile syndrome to become inherent. We must begin an introspection of what we are and are not doing as professionals and laymen to reverse the "irreversible" stigma of senility which plagues thousands of elderly individuals whose problems are caused by emotional breakdowns similar to so many other age groups and treated, but, in the elderly, are lumped together and titled arteriosclerosis or hardening of the arteries. Senility can be a learned behavior. What other causes of senility are there than merely the term so often used (arteriosclerosis) that disguises so many other reasons: the loss of one's place in life—retirement—loss of income, loss of family and friends, spouse, loss of physical prowess, disabilities and infirmities, and even the loss of identity. What part does institutionalization play in helping or hindering the individual to recover? What environmental factors—Society's attitude towards aging that are present that cause the progression of an illness, be it physical, psychological, emotional or social in nature? These are the questions which we must begin to ask ourselves if we are to re-examine what has been done and what we have yet to do to bring the elderly back to society as members. Members of the human race liable to disease, both mental and physical as any other age group, and entitled to the same opportunity for treatment and recovery. Because it is this attitude towards aging which has resulted in thousands of individuals being institutionalized for life and becoming "senile"—the tragic truth that to expect and anticipate such behavior is to reap such. A society of 65 year olds and over who have an enormous social and emotional adjustment to make—not only the unfulfilled aspirations of middle age, disabilities and infirmities, but the added image of "Old Age". This image of age as being regressive, infantile, unneeded, unwanted, must stop. The dehumanizing situation of a living person with all the needs and desires of any person being denied the right or opportunity simply because one has grown "too old" for such things.

Reorientation of the patient is carried out through the Reality Orientation Program. This involves the entire institution in the patient's plan of care. An attempt is made to reorient the patient to a stage of present reality. This includes keeping the patient aware of time, place, date, self-identity and autonomy. All employees that have any contact with the patient are formally trained in the techniques of the program on an on-going basis. The Team Approach to Care is used utilizing Attitude Therapy. Everyone is responsible for reinforcing the basic facts of reality such as the patient's name, place of residence, etc.

The institution strives to create and sustain an environment which carries out Melieu Therapy. The patient is involved in the activities of the institution. An attempt is made to constantly stimulate and motivate him. In order for Melieu to be effective, it demands that environment be structured by the use of consistent attitudes. The staff reinforces desirable behavior and discourages inappropriate behavior.

7. Activities Program

The vast majority of geriatric patients have a great deal of time which, when not being used constructively, can be an instrument for the destruction of self or others. The hardest task that faces the activities program is to have this time spent in fruitful endeavors, not sterile ones. Life is an ongoing and changing process and, even in the "sunset years", this must hold true if man is to live and not vegetate.

In reality, one does not re-create the past, but, more important, constructs a present that is approachable, acceptable and livable without the feeling of dependence. It must be believable in the sense that the patient does, and is not always done for.

"A planned and diversified schedule of recreational and social activities should be designed to help patients use their physical and mental capacities to the fullest possible extent. Successful, diversional therapy should engender self-confidence, and should preclude the withdrawn attitude often typical of the aged ill by encouraging participation in group activities commensurate with the individual patient's ability to perform."

The staff only stimulates; it is the patient who must create, because it is their life and not ours. We are the stimulators and motivators, but, in truth, they

are the participators. The image of self is one of the most important factors in life. It motivates or supresses activity; it can destroy or build. Every man needs a self image. We look to others for some of this and then to ourselves. The individual must feel independent and worth contribution not distribution. Therefore, if rehabilitation is to be a reality in the fullest sense of the word, then we must begin to look at all the possibilities that stifle independence and create dependence.

In reality, no one wants to grow old. But it is a natural phenomenon and this should be productive and not sterile. Productive in what sense is another question. For some, it may be adjustment to handicaps and infirmities; for others, a way to live, not merely exist, with age. A problem facing many Americans is what to do in their leisure time, especially older Americans who are no longer needed or wanted for their labor capacities. Play to them is for children or those who have nothing else to do. To them, our attempts at having recreation for them is to amuse and babysit befuddled old men who sit from morning till night, just sitting. Our own attitudes of recreation foster this belief—that work is not play nor play work. It is a traditional attitude that might have functioned excellently forty years ago, but now has changed because man's environment has. In an age of mechanical and scientific technology, no one can afford to ignore the probability that recreation is essential to the fulfillment of life. In the word itself, recreation is two other words, re-creation. In a sense, that is what we must do—to re-create a life than a man never had time to live and now has so much time and so little purpose to try. Because the patients are old does not mean living has ended. Senile is not only a state of mind, it is a state of being. We, the staff, help to foster the stereotype image of an old man sitting in a chair reminiscing about the "gold old days," but, upon asking what year it is or who the President of the United States is, only replies that he has forgotten. We work with these men day in and day out and perhaps we see too much of one thing and too little of others. We see all the physical ailments, the incontinents, the treatments to be done, the trays to be passed; all the human physical care is well done, but we fail to see the patient as a person first who has the same five basic needs as any other person. We must begin to realize that activities and recreation are not to keep one busy or amused, but play an integral and important part of every man's life (socialization) regardless of age or infirmity, and that re-creation is always possible as long as man lives and believes that integrity and dignity have no age or time or place, but are the fundamental precepts of all mankind.

8. Volunteer Program

The word Volunteer means "One who enters into, or offers himself for, any service of his own free will; to enter into, or offer oneself for, any service voluntarily."

The role of the volunteers is an essential one because they represent the outside world. More than anyone else, it is the volunteer who can stimulate the patient to care once again about what is going on outside his own, often very sterile, existence. The volunteer represents the lifeline from the Home to the Community and back.

"A lifeline is more than a link to mere survival . . . Our presence, our attitudes, our encouragement provide some of the strength which is needed for our patients to continue to live in the full sense."

In truth, not everyone can or should be a volunteer. Therefore, it is important to remember that the well-being and happiness of the resident is the first and foremost concern in the Home.

"Technical skills can be taught in pre-service and inservice training, but such traits as patience, emotional stability, well adjusted personality, and sympathetic understanding must be present in an individual before he can be accepted as a leader, either professional or volunteer."

The ability for the volunteer to be flexible is crucial in a Home such as this where informality is stressed—a home-like atmosphere over an institutional one. Due to circumstances which may arise such as: residents being sick, or the nursing preference of residents for other therapies, or changes within the activities program, a pre-set schedule cannot always be adhered to.

"Orderliness is desirable—to a point. Patients cannot live nor employees function to the patients' advantage if orderliness is carried to extremes. 'Organized confusion' just might indicate that the management puts the total welfare of patients first."

The attitude of the volunteer plays an important part in her effectiveness with the geriatric resident. It can help to foster independence or dependence, a self identity or a "senile" one.

"Negative attitudes in our culture towards aging play no small part in aggravating the problems and decreasing the satisfactions of later life."

The volunteer in many instances fills the "family, friend" need of a resident who otherwise would have few or no visitors. The psychological need by all to be wanted, and needed, is no different among the old than it is in the young. By the mere fact of leisure time, all the time, only enhances this need.

The benefits reaped as a result of dedicated volunteers are two fold; not only does the Home and the resident benefit, but also the volunteer and eventually the outer community.

"It has been found that the relationship between a resident and volunteer is effective, not only to accomplish the creative art, but also to help meet the psychological needs of a resident. Volunteers who became well acquainted with the residents soon overcame their innate fear of people who are dependent and helpless. Understanding the personality of the residents helps to expel fears and misgivings which may have been their first impression."

The need for more knowledge concerning the aged is vital in a society which increases its over sixty age population by leaps and bounds. If we are to be a productive and creative society, we must learn to make use and not misuse all of our resources. Our own attitudes form our behavior and, therefore, it is crucial that we become involved in learning more about a realm of life which we shall come into, unless death terminates this. Therefore, the acquisition of knowledge is essential; not only to the volunteers participation in recreation with these men, but also to ourselves and the increasing knowledge that life after sixty can be lived and enjoyed rather than merely endured.

9. Nursing Service

The Department of Nursing Service has based its philosophy of life holding that every individual is created by God, is composed of body and soul, united in an essential unit, possessing an intellect and free will for the purpose of serving God through the Christian apostolate of commitment to the chronically ill with primary emphasis on the geriatric patient.

We believe that professional nursing is concerned with meeting the health needs of individuals and families, and that these health needs include physical, psychological, emotional, social, economic and spiritual needs.

We believe that no person requiring care in an institution should be isolated from the community setting and that the patient should be given every opportunity to contribute to and utilize the resources of community living.

When the patient is unable to contribute and to utilize community resources in the community setting, we believe that every effort should be made to bring the community to the patient.

We believe that the Nursing Service Department is a learning atmosphere for those interested in nursing care as well as an area of research in the promotion of health and the prevention of disease.

We believe in promoting activities related to the improvement of patient care in the nursing unit and in the effective utilization of both professional and non-professional personnel.

10. Rehabilitation

Rehabilitation holds the key to a useful, accomplished life for the individual. Here we believe rehabilitation not only holds this for the patient, but the staff as well. Our philosophy of inservice education in rehabilitation is to open up doors of knowledge and practical application of this knowledge to enable the staff to understand the best potential, not only of the patient but of himself.

Nursing care in rehabilitation strives to help each individual live as independently as possible and to function as efficiently as possible within his abilities. This program of inservice education in rehabilitation endeavors to give the ancillary and professional personnel a working understanding of basic rehabilitation concepts, transfer principles, and activities of daily living. Since the approach of total patient care is essential in the rehabilitation regime, the utilization of the multidisciplined therapies becomes an integral aspect of the program. Once a working understanding of these concepts and techniques in rehabilitation is established, the next step of inservice education is to give the ancillary and professional personnel an understanding of how the different therapies (physical, occupational, recreational) correlate to effect the tools of rehabilitation in the practical realm of everyday living. Once the staff is able to see the role each person contributes in relation to the other disciplines in giving total patient care, their functioning becomes more meaningful, avenues of

communication open, a real team approach evolves and the term, "total patient care," becomes a reality.

11. Inservice Education

The primary responsibility of Inservice Education is to effect the best possible total patient care through the growth and development of all levels of personnel in all departments which have patient contact. The philosophy of Inservice Education is founded on the commitment to the nursing care and rehabilitation of the geriatric patient. We, in Inservice, are committed to: helping each patient to live his life fully and to make that life meaningful through education, adjustment and acceptance of disease entity, chronic illness and the rehabilitation process; education and health teaching for the family members so that they may be an integral part in the patient's nursing care and rehabilitation; helping each professional person attain and practice his professional ideals by working as a member of the health team; enable each staff member to understand the ideas and attitudes of geriatric patient care so that each person (no matter what discipline or service he renders) may become a contributing member of the health team and feel a sense of personal growth; utilizing community resources to retain the identity of each patient as being a member of the community through the fostering of concepts of geriatric care and rehabilitation at the community level.

We believe that Inservice Education is only relevant if it develops its programs from the needs of the patients and staff. Inservice Education is a continual, flowing process whose true value is measured by how the concepts are applied in the daily practical situation. Inservice programs are as basic, meaningful and consistent as is the daily nursing report given on the clinical unit. We believe that Inservice Education should foster and encourage an environment where the interchange of ideas between disciplines and departments is as natural as the flow of a river to the sea. We believe that Inservice Education should provide opportunities for each individual to grow and develop. We believe that Inservice Education should stimulate the individual to seek these opportunities and to accept the responsibilities inherent in growing and developing.

12. Physical Therapy

The physical therapy program in Sacred Heart Home extended care facility is both preventive and treatment-oriented. Wherever possible, patient function is maintained, developed and restored with major emphasis on the avoidance or correction of deformity and the alleviation of pain at joints, muscles, or nerve centers. Implicit in the administration of a successful physical therapy program is an understanding of the psychosocial needs of the physically handicapped patient. A positive motivation on the part of the patient is a necessary concomitant to an optimistic attitude on the part of the treatment staff to effect a successful program of the physical rehabilitation of the chronically ill and aged.

13. Occupational Therapy

Occupational Therapy is any purposeful work of an educational, industrial, creative, self-help or recreational nature ordered by a physician and carried out under the supervision of a qualified Registered Occupational Therapist to prevent disability, maintain function or restore lost skills.

The occupational therapists is professionally skilled by selection and education to administer the program to meet prescribed objectives. The media used by the patient, the manner in which he performs, the atmosphere of his environment, and his relationships with the professional staff and other patients are the dynamic factors in occupational therapy. Since the occupational therapist receives from the physician specific treatment orders, he is, in turn, responsible to him for reporting techniques used and results achieved.

Presently, at Sacred Heart Home, Occupational Therapy has three broad objectives or functions which are: 1) Physical Restoration, 2) Psychological adjustment and 3) Homemaking Evaluation and Training. It should be kept in mind that for any one diagnostic entity or classification indicated in the examples, two or more functions might well apply and, under certain conditions, or at different stages of treatment, all three could pertain. A synthesis of each of these three major objectives follows.

Physical Restoration.—To fulfill this function, occupational therapy's objective is to achieve maximum physical capacity and independence through one or more of the following:

(*a*) Restoration or improvement of joint range, muscle power, endurance, and/or coordination—e.g., fractures, peripheral nerve injuries, lesions of the central nervous system.

(*b*) Development of adequate substitutions where normal function cannot be restored—e.g., brain and spinal cord injuries, cardiac and pulmonary conditions.

(*c*) Training in the use of a prosthesis in the event of loss of a part—e.g., amputations, or in the special development of substitute skills in case of sensory loss—e.g., blindness, deafness, aphasia.

(*d*) Maintenance of function in progressive disease—e.g., Parkinson's, Multiple Sclerosis.

(*e*) Training in Activities of Daily Living such as dressing, eating and writing.

(*f*) Fabrication of and training in the use of splints and adaptive orthotic devices.

(*g*) Improving general stamina and work tolerance—e.g., cardiac disease, pulmonary surgery, etc.

Psychological Adjustment.—Typical of the objectives of occupational therapy to achieve this function would be the following:

(*a*) To aid adjustment to illness, hospitalization and disability through precision of controlled and graded development of skills for:

1. Promoting acceptance of a return to normal functions.
2. Providing investigation into possible recreational areas.
3. Aiding in re-socialization.
4. Providing an outlet for emotional stress and tensions.

(*b*) To guide patients toward a reorganized self concept following permanent disability on onset of chronic disease. Diagnostic examples: psychosomatic disorders, general medical and surgical cases, pediatric disorders, orthopedic and neurological conditions.

(*a*) Assisting personal skills such as relationships with co-workers and supervisors, ability to follow directions, take criticism, tolerate pressures, etc.

Homemaker Evaluation and Training.—The simulated work atmosphere of the typical occupational therapy setting facilitates objectives and functions such as:

(*a*) Exploring interests, aptitudes, skills and work habits.

(*b*) Testing and evaluating physical and mental abilities with reference to work requirements.

(*c*) Developing motor and intellectual capacities.

(*d*) Maintaining the special skills required to return home.

(*e*) Assisting the disabled homemaker in readjustment to home routine through work simplification techniques—e.g., joint sparing techniques, one-handed homemaking, homemaking from a wheelchair level, effective reach and work range.

The scope of function of the occupational therapist includes, among others, the following skills:

(*a*) Observation or the act of taking notice, gathering and perceiving data with a purpose. It is a perception gained from the full use of all five senses plus intuitive reasoning.

(*b*) Evaluation or process of determining value, amount or effectiveness. It implies judgment added to observation, records and reports.

(*c*) Interpretation or the act of producing meaning from facts. Interpretation of occupational therapy principles, objectives, media and results are necessary for better understanding and coordination of patient, personnel and other departments.

(*d*) Treatment Planning or the methodical arrangement of the successive steps conducive to the attainment of the prescribed end. It is the formulation of a scheme for achieving the desired result.

Such are the programs instituted here at Sacred Heart Home. I hope that this information will be of benefit to you. If we can be of further assistance, please feel free to contact us.

Sincerely,

WILLIAM J. MCGRAIL,
Administrator.

BISCAYNE MANOR,
Miami, Fla., December 27, 1971.

To: United States Senate, Special Committee on Aging, Frank E. Moss, Chairman, Subcommittee on Long-Term Care.

From: The Rev. Thornton Lewis, Administrator, Biscayne Manor Home.

Subject: Description of Home and programs, etc., as requested by Frank G. Zelenka, Associate Director, Director of Public Affairs, AAHA.

Biscayne Manor Retirement Home is sponsored by the Miami District, United Methodist Church. It stands between the nursing home and the resident home in

that it offers special services to those within its care. Our aim in this Home is to treat each one as a full person of infinite worth, and not as a part-time person and thing! This place is their home and we do everything possible to create the kindness, love and concern found in family living. Under *no* circumstances do we consider this an institution.

Though we may use the word "retirement" in our name, we do not suggest, in any form, that the folks who come here to live should retire from the world. We endeavor to help them remain a part of the world by arranging for programs of such nature and concern to come into the Home to enlighten and stimulate all who live here as well as urging our residents to get involved in outside the Home affairs. We firmly believe that there is a need for each one to have something to do within the scope of their physical capacity regardless of their age or disabilities. Besides attending their church groups and services, there are those who work for the Red Cross and Cancer organizations as well as attending civic, fraternal and community affairs.

Mental, emotional and spiritual growth does not stop with the so called "declining" years. People need to be helped and guided in their inter-personal relationships, especially in these years living in the midst of a new and numerically larger family. Very often new friendships have to be made and many folks find this difficult after years of living in one sphere of experience where old friends and long family ties made the desire and acquisition of new friends and interests either unnecessary or undesirable.

A brand new outlook on sharing, loving, self-discipline and the outreach of concern is so often needed in order to help people to "get along" with their neighbors and fellow-home dwellers. At the same time, each one needs to feel that this is their "home." Hence, many times a new set of values has to be encouraged and formulated within the hearts and minds of all. To meet this need, the Administrator serves as Chaplain, assisted by the Director of Residency, both ordained Methodist ministers. Their doors are always open for pastoral counseling as a service to the residents, as well as the staff. It is important that people feel free to bring their problems and concerns to someone who is trained to help them find their answers. We are never too busy to listen. We are person oriented rather than problem oriented.

Concern for health is so important to these people. We are not a Nursing Home though it is our hope that before too long our planned program will be completed to extend ourselves to include an infirmary and convalescent-nursing home facility. Elderly people need to feel secure in the future years and should be able to realize the remainder of their time as a part of a family and in their home even though the home may be one such as this. To help overcome this barrier now and to meet their need for security, we have a Director of Health Services with a 24 hour nursing service that is set up to keep people well. Our R.N.s and nurses' aides are so important to the success and well being of such a Home, because they evidence concern and love and they maintain a constant vigil 24 hours a day, 365 days a year. If an emergency should arise in the wee hours of the night and the nurse should be busy, the switchboard is maintained 24 hours and is right on the job to give the necessary assistance.

Services offered by Health Service:

1. Supervision of medications.
2. Supervision of tub baths.
3. Intra-muscular medicines by RN weekly as per Doctor's instructions.
4. Flu injections yearly.
5. Yearly chest X-rays.
6. Appointments made with dentist, doctor, etc., and arrangements made for transportation and someone to accompany them.
7. Checked if not in attendance at any meal.
8. Encouraged to be active and participate in activities.
9. Assisted with any treatments ordered by a doctor.
10. Assisted with hygiene problems—clothing washed, etc.
11. Complete nursing care in an emergency until arrangements can be made for hospitalization or other suitable facility.

When residents can no longer care for themselves in this Home and must be placed in a Nursing Home or hospital, they are not shut off from us even though they physically leave us. We still maintain a family relationship by visits, gifts, letters, cards, birthday and holiday rememberances etc. People need to feel the sense of security of belonging to someone and some place.

One great concern for a number of our people is that of finances. What happens if their money runs out? This is most definitely a real problem. While this Home is sponsored by the Methodist Church and is a non-profit organization, we can manage only to subsidize persons to a relatively small degree. Otherwise we could not stay afloat. Just this month we were notified by the Florida State Dept. of Health and Rehabilitative Services that the allowance of $200.00 per person per month for the seven (7) people who live here receiving this aid is to be cut back to $175.00 per person per month. We return $13.50 to each person monthly thus giving us $161.50 per person per month to cover their cost here. We already are subsidizing them approximately $75.00 per month each and now this new ruling means an additional $25.00 cost per person per month to be absorbed. The question we ask is where could the State put these people for what the State is willing to pay where they would be cared for as we care for them and where they will be treated as persons of infinite worth with love and concern for the whole man? This problem of sufficient financial aid is a vast one and needs implementing immediately. People should not need to feel demeaned because they need financial assistance from our affluent society.

Food is another of the important services to our people. In this Home we have an outside dietary concern in charge of our meals though the food is prepared in our own well equipped kitchen and served family style at the tables in our attractive dining room. This family style service means free choice for persons. Not the cheapest way to serve food but the most loving. A manager is in charge of the menus and she welcomes suggestions from the residents. Special attention is given to holidays with festive meals and decorations and unusual special buffets at Christmas and New Year's Day etc.

Several of our residents are involved in the affairs of our Home. One is our Librarian and she maintains our small library. One leads a weekly session of singing. A member handles the logging of the gifts that come to us in the way of articles, furniture, food etc. One woman is the hostess for groups that come in to put on programs. Still another maintains a supply of clothing for those who may be in need and every now and then she holds a sale with a very low price so that those who need them may not have to be recipients of charity but can "pay" for their needs. Another resident arranges the seating in the dining room and handles the floral and seasonal decorations. Still another works at the flowers, plants and shrubs around the outside of the Home. A number have been involved in discussion groups and from this has come a willingness to share experiences and hobbies and to show travel slides etc. Several folks, men and women, take turns playing the piano or organ for our daily devotional services. Others man the Gift Shop when outside visitors come.

The Home Auxiliary, made up of representatives from the Miami District Churches, works to supply the many extras needed to enhance and upbuild the Home and a few of our own residents are active in this. A station wagon has been given by this auxiliary to serve as a courtesy car to transport people downtown once a week or to keep appointments during the week. Birthday and holiday parties are under the direction of this Auxiliary and no one is forgotten.

The Home offers a Day Care program to the community that has further potential than we can offer right now because of limited facilities. However, we do have a few people here who come to spend the day and have a good noon dinner meal and sometimes breakfast and enter into whatever projects or programs are going on during the hours they are here.

We believe such a program as this can meet the needs of many people in the area who could still live at home but who are not able to shop and cook and plan for themselves. Or who live with their families and need to have supervision during the day or just need to get away from the hustle and bustle of growing family life.

To encourage further spiritual growth, there are daily morning devotions except for Thursdays when the group singing fills this spot. Each Thursday evening a devotional period is held right after supper when a member of the clergy from the various religious walks of life outside the Home is invited to bring the message. On Sundays our people are encouraged to attend and participate in their choice of church services. For those who cannot travel about so, there are twice a month services and Holy Communion offered here at the Home.

May we suggest to your committee that in your study and research on senility that you borrow from the studies on retarded children especially in the field of the use of drugs to relieve this senile condition. Also, though your committee

seems to be geared to Nursing Homes, may we suggest further implementation of homes such as ours which are more than just resident homes to aid the vast numbers who do not need nursing home care, but do need a place of security, love and concern and where they are able to maintain their dignity and self-respect.

Activities within the home

Hand-craft classes, Music, Art, Game periods, Library, Television Lounges, Shuffle Board, Weekly Movies, Devotional programs, Inter-personal Discussion Groups, Gift Shop, Beautician twice a week, Doctor's Clinic weekly, Hearing Aid Clinic weekly, Chiropodist weekly, Church Services twice a month.

Programs brought into the home

Girl Scout Visitation every other month.
Sunday afternoon visits from local College young people.
Area Music Club monthly programs.
Church Circle meetings about every week.
Monthly Auxiliary meetings.
Area Choirs and Choral groups.
Special programs during the Holidays.

Staff training

1. Various courses given by the federal and state governments through the local Jr. College have been taken by Director of Nursing and the Administrator.
2. Three (3) Seminars a year are conducted on a national basis by the General Board of the United Methodist Church for the training of Administrators and members of the Boards of Directors.
3. Every two (2) years our nurses aids are given a first aid course.
4. Fire Drill training by the local Fire Department given to all the staff periodically.

Reverend THORNTON LEWIS, *Administrator.*

UNITED PRESBYTERIAN FOUNDATION OF KANSAS,
Newton, Kans., December 3, 1971.

DEAR MR. MOSS: I understand from the American Association of Homes for the Aging that you would like to have information on homes which have an "innovative program". I am happy to enclose the accompanying literature which gives information concerning the six Presbyterian Manors which we now have in the State of Kansas, all of which are under the operation of the United Presbyterian Foundation of Kansas.[1] These homes are both Retirement Homes and Skilled Nursing Homes. The average entrance age into our homes is about eighty. These people come to us of their own free will. Retirement people are free to come and go as they please and as they are able. In the last year, we have had one man from Newton Presbyterian Manor who visited six weeks in Alaska. He is past ninety years of age and in good physical condition. We have had a couple from Topeka Presbyterian Manor who were delegates to the International Rotary Convention in Sydney, Australia, and spent six weeks touring the South Pacific.

We have all kinds of crafts, recreations and hobbies at all these Presbyterian Manors. In each place we have a person that we call a "Fellowship Director". Our meals are served family style with people having all the "seconds" they want. We have Registered Dieticians who plan the meals for all of these Manors. Our retirement people all have private rooms and so do many of our nursing people. In fact, the only time that we put two in a room are when both are bedfast and want the company of another person.

No one has to ever leave any one of the Manors. We offer skilled nursing care to those who need it and out of the 463 people that we have, about half of them require skilled nursing care. Also, half of our people are folks without any children. Most of these are people that were never married. The only family that they have is what they have in the particular Presbyterian Manor in which they live. Incidentally, we have one woman who is 106 and three or four others that are past 100. We receive people without regard to their race, their color, or their creed. Most of the folks that we have are Presbyterians but we have several people in each Manor that are not. We have about fifty people in the different

[1] Retained in committee files.

Manors who are on Welfare in one form or another. When these people go away, as many of them do now and then, they are always eager to get back "home".

At Topeka Presbyterian Manor, we are an approved Extended Care Facility. At Newton Presbyterian Manor and Kansas City Presbyterian Manor, we have the staffing which would let us be approved, but we have no interest in seeking Medicare approval. People come to us invariably for the rest of their lives and sixty days of Medicare would only be a "drop in the bucket".

We refuse employment to anyone who is not sympathetic with older people and who is not interested in our program. However, we do give employment to folks of all races, colors and creeds. We have eighteen Mexicans, four or five Indians and twenty or more Negroes in our employ. All of the Presbyterian Manors are spotless. One thing that is said to us many times in all the Manors is, "There is no odor here". Also, there are no bed sores, and that in spite of the fact that we have some people who have been bed fast with us for even ten years.

I am glad of the opportunity of writing this letter to you. The term "awful nursing home" which is frequently in the papers these days, just does not apply to any home which we operate. The people of Kansas know this fact and are not shaken in any way by the things that are said publicly so far as any of the Presbyterian Manors are concerned. We invite you or any member of your committee to make a personal investigation of any of these Manors, with or without notice, and even to have a meal with us, with or without notice.

With best wishes, I am

Sincerely yours,

GEORGE W. NELSON,
Executive Secretary.

GLENHAVEN,
Glencoe, Minn., December 15, 1971.

DEAR SENATOR MOSS: This letter is in answer to your request through Mr. Frank Zelenka for innovative programs of care or services in the long term health care field.

We had an opportunity to meet recently during your sub-committee's hearings in Minnesota. I presented testimony in my position as Chairman of the Geriatric Conference of the Minnesota Hospital Association. I am writing now as an individual administrator. By way of background I set the scene with the following information.

We operate both a 67 bed general hospital and a free standing 75 bed nursing home. Both are city owned. The nursing home, built in 1958, was purchased by the city in 1967. In the nursing home we have three "levels of care"—ECF under Medicare, Skilled Nursing and Intermediate Care Facility, Level I (This latter a term used only in this state and roughly corresponding to the older general classification of "nursing home.")

When you ask about innovative programs I must admit that what I'm about to describe is probably not too unusual, but it is relatively new to us. Two years ago we set a course to develop a series of activities within our institution. We began by securing the services of a consultant occupational therapist. With her help we planned three programs 1) Creative Activity—things our patients could do with their hands, 2) Group Occupational Therapy—such things as supervised exercises with their hands, limbs and bodies, bean bag throwing, dexterity exercises in fitting things together and, 3) physician ordered occupational therapy treatments. Our tentative time table was: phase 1—January 1970, phase 2—April and phase 3 in June. The program was an instant success! Our timetable had to be moved up. We began phase 2 on February 15 and phase 3 on April 1. I cannot describe the effects. Overnight many of our residents suddenly had a "reason for living." For quite a number it was a day and night mental attitude change. There have been other benefits, too. Aside from religious services and monthly birthday parties we had not utilized volunteers to any great extent. The first two of these programs require volunteers. These programs are conducted Monday, Wednesday and Friday afternoons for two hours each day. During the first year 66 volunteers, ranging from teenagers to those about ready to join us, devoted 2700 hours to this program. Their involvement and some very devoted employees is what has made the program successful. A by-product has been not only greater community involvement but more importantly greater community understanding. Another plus has been the donation by several area manufacturers of stuffing material for patient made toys. These have been industry waste products very suitable for our purpose. Our Creative Activity program features many things

made with the hands but by far the paramount activity is the making of stuffed toys. I walked into our activity area during off hours the other day and observed an 87 year old man busily snipping pieces of stuffing material. With a twinkle in his eye his comment was, "This is fun. I've got to keep ahead of the production crew. You know we have so many orders for Christmas." Each participant makes the first one of a new project for himself or herself. After that they are offered for sale. Proceeds go for purchased supplies. The program has not only been self-sustaining but the fund is now at a point where some specific needs of the home may be met through this source.

The second area to which I will address comment is not an innovative program necessarily but an area in which I feel quite strongly. There are only about a half dozen places in this state that have hospitals and free standing nursing homes under the same ownership and management. We are one. I feel this is tremendously advantageous for the total follow through of patient care, particularly as it relates to involvement of the medical staff. It has been said that given this situation you have the medical staff under your thumb in a position to exert pressure. Undeniably this is true, but need not be (and in our case certainly is not) a factor. It does mean, however, that more for the good of the patient can be accomplished. Take for instance the Utilization Review process. In our case we had a Utilization Committee before Medicare came into being—one which has been held up as a state example many times. It was no problem, then with the acquisition of the nursing home, to superimpose this process on an already existing activity. Today our UR committee meets for both institutions weekly. What I'm saying is that, in my opinion, a medical staff responsible for the largest segment in the total gamut of health care, provides a unique opportunity to have a more viable patient health care picture. If there were some way to reach this point in the overall picture of the delivery of health care, I believe health care as a total boxed in entity would be more meaningful and produce better results.

As long as I have been this voluminous I'm going to cover, briefly, one more problem area as I see it in this state. (I cannot speak for other areas.) An ECF Medicare requirement in the area of social service requires that all patient-contact employees have training in social work as it relates to the aged. It further stipulates that only those with a Masters in Social Work are eligible to do this training. Fine, I couldn't agree more with the specific need for an understanding on the part of all associated with the older patient of the specific social and mental problems encountered and how to deal with them. However finding a qualified MSW to conduct such a program in many areas of Minnesota is almost like searching for the proverbial needle in the haystack—and if you are successful in finding one, the cost of such services is prohibitive. In Minnesota at least, and I've been given to understand nationally, we need more MSW's.

I hope, Senator Moss, this information is useful. I know that you realize the conditions you heard about here in Minnesota are isolated and uncommon. We are proud of the delivery of health care in this state. We feel we do as good a job as any and better than most. A good indication of this is the fact that our nursing home administrator licensure program we have used, among other things, the PES exam. Of the states using this so far (36 or 38 I believe) the average score in this state was the highest in the nation! This supports our contention that we're providing the best possible and ever improving health care.

Yours is a difficult job—and one that needs to be done. I salute you for the manner and thoroughness with which you are accomplishing it.

Very sincerely yours,

FRED SHRIMPTON, *Administrator.*

RIVER GARDEN HEBREW HOME FOR THE AGED,
Jacksonville, Fla., December 15, 1971.

DEAR SENATOR MOSS: At the suggestion of Frank G. Zelenka of A.A.H.A., I am projecting our program in serving the aging and infirm in a 175-bed institution.

River Garden has been evolving and developing a continuous idealogical and philosophical base for its existence since its founding in 1946. The rationale for its founding lies in the 5th Commandment of honoring our Fathers and Mothers which is projected into the concept that all the elderly are our collective parents. And collectively, we provide the gamut of services needed to maximize their potentials despite the erosions of physical and emotional and mental strengths with the passage of time.

Another concept we stress is the indivisibility of the total personality which includes the social, interpersonal, physical, emotional, and mental components. To focus on any one disability is to fragmentize the individual who in most instances are not able or capable of reconciling his other needs with the specific services.

Our basic approach is the recognition of the need for planning for a total life style for the long term patient. Because the reason for his admission may be the stroke and resultant handicaps, does not mean that he does not require the other gamut of services essential to living a full life, despite handicaps.

Another major consideration in evolving a philosophy of "care" is the recognition of the reality that the patient entering our facility "backs" in because his family and or society has been unable to provide for him in his own home, or that of his children.

Without being moralistic or judgemental, his admission represents "rejection" by him. He exhibits all the characteristics and behavior pattern of the rejected and rationalizes all his problems due to the specificity of a physical disability.

The composite patient is a combination of poor physical health, some mental deterioration, feels rejected by his family, is frustrated because of a limited prognosis and is in general a very unhappy and frightened individual. All too often, it is not the characteristics of the physical disability of chronic diseases that are so disabling but how this patient views his handicaps and whether he is not using them as weapons to punish his family and/or society for the trials and tribulations heaped upon him.

It is the recognition that the nursing home becomes the substitute for the family which is our basic approach. The whole concept of family life is involved in the process of evolving this substitute and dynamic interpersonal relationship for the ailing and lonely patient. Despite his deterioration, senility, or disability, he still requires the same warm emotional relationship as a member of any age group in the family. No individual can live in a vacuum, isolated in a lonely bed or relegated to emptiness of a large room filled with other patients but must be part of a group setting in which he feels he belongs.

Therefore, the nursing home must begin to develop more emphasis on the latter half of its name in order to create the atmosphere as close to family life as possible. Meeting the physical needs, no matter what standards of care, is insufficient. The patient isolated in his bed cannot flourish nor can he live in the atmosphere of impersonal care. It is essential to his well being that he have the warmth and love of human relationship to continue to live to the maximum of his capacity.

In too many nursing homes, there pervades a spirit of defeatism, apathy, and indifference. Often such homes become known as "that warehouse for warm bodies." In such a setting, the patients seem to be just sitting and waiting for death to relieve the monotony.

Such atmosphere is obviously unwholesome and entirely unprofessional. It is the reflection of the attitude of the operator who looks at his patients as so many bed occupants, and each occupied bed represents income. It is also a reflection of the lack of understanding of the role of the nursing home as a bona fide medical adjunct to provide proper facilities for the long-term patient.

The creation of a warm climate in the nursing home is the responsibility of the administrator himself and sponsor. His attitude toward the patients will be reflected throughout the Home. His respect for the dignity, rights, feelings, and needs of his patients will be transmitted to his staff. As a basic service to his patients, he must offer those intangible ingredients of "tender, loving care." With this attitude and respect for the individual, a homelike atmosphere can be created.

The techniques and program required to develop this atmosphere do not involve unusual expenses or a highly trained staff. They only require a deep and abiding interest in the welfare of the patient to show him that someone really cares whether he lives or dies.

In addition to the creation of a congenial and homelike atmosphere, it is essential to develop among the patients a feeling of belonging and sharing with one another. This is a difficult concept to transmit because the reaction and attitude of the patient to the nursing home are so individual. If the administrator is able to develop this feeling, it will be reflected in the way the patient expresses his attitude toward the home and it will determine whether he feels he belongs or is only living out his days.

The development of this feeling of belonging is not a complex task. It is merely an extension of the first theme—interest in the welfare of the patient. Providing

pleasureful and meaningful group experiences will go a long way in developing good morale. Sharing with other persons an interesting experience can develop a relationship on other levels than the day-to-day gripes about food or bathing schedules. The shared TV program, the sermon of a visiting minister, group singing, or games can elevate the morale of the entire group.

The administrator, with a little ingenuity and imagination can develop a wide range of group activities geared to the needs of his patients. An appeal can be made to the clergy to accept the responsibility of pastoral visits for group services or giving individual counseling. Likewise a church sisterhood, or woman's civic club could be interested in providing friendly visitor services for the lonely, friendless, or forgotten patient. The smiling face of the friendly visitor very often is more valuable to morale than any other aspect of treatment. Another illustration of simple group activities which might be adopted is the "monthly" birthday party, honoring those who share the same birthday month. The value of still being singled out as an individual is inestimable. Birthday parties could be made a project of a Boy or Girl Scout troop or a church youth group. Participation of youth in activities shared with the aged creates as nearly homelike an atmosphere as possible because of the patients' identification with their own grandchildren. It is immaterial whether it is group singing, bingo, charades, or other game which is organized. The importance of these activities is the sharing of a pleasurable activity with another human being.

The nursing home need no longer be isolated from the community or its resources. Help is available from many sources such as the Department of Welfare, City Recreation Department, County Health Department, Visiting Nurses, American Red Cross, Civic Clubs, and so on. These are people of good will who sincerely are interested in serving humanity. The administrator must shake off his lethargy and open his doors for outside help. By encouraging people to come into the home and encouraging the residents to go out, he will create normal living patterns.

As the role of the nursing home in the community is beginning to be defined, the more progressive homes recognize their responsibility for enrichment programs as well as skilled nursing services and balanced diets. It is not only humane but good sound business practice. The reputation of a nursing home is dependent upon the satisfied patient and his family. The patient who feels he belongs and is proud to be part of the home is the best advertising media.

The administrator must always be conscious of the fact that his facility, no matter how good, is merely a substitute for the home life of the patient. It can be a good substitute or shoddy, dependent upon the interest and enthusiasm with which the administrator views his patient.

Operating a nursing home is no easy task and presents many administrative problems in the areas of staff recruitment and relationship with the medical profession and families as well as the public.

Most of these problems tend to resolve themselves when the morale and spirit of the nursing home reflect the atmosphere of a satisfied clientele who are still interested in life and living. The nursing home is successful when patients come to live there and not to die.

To sum up a rather lengthy dissertation on a philosophy of nursing home care, its basics are in respect for the dignity of the human being; a concern about all aspects of his needs and evidence from society that someone really cares about him.

I trust that this outline will be helpful to you in evolving some guidelines for a national policy on serving the infirm aged.

Sincerely,

SIDNEY ENTMAN, *Executive Director.*

DAUGHTERS OF MIRIAM CENTER FOR THE AGED,
Clifton, N.J., December 8, 1971.

MY DEAR SENATOR MOSS: We recently received a communication from Frank G. Zelenka, Associate Director, Director of Public Affairs, American Association of Homes for the Aging. He indicated your interest in compiling an inventory of innovative programs of care and services provided to the aged by long-term facilities. I am very pleased to learn of your interest and will try to give you some concept of program activities which we feel are most important in our programming for the long-term aged patients.

As a preamble, I believe you should know that Daughters of Miriam is celebrating its 50th anniversary this year. Dedicated originally to the care of the aged and orphans, in the 1940's, in line with professional opinions regarding child care, all of the children in the facility were placed in foster homes so that Daughters of Miriam then was a facility primarily for the long-term aged. It was also during the '40s that infirmary care of the aged began, and is now a basic program of our facility. I am sending you under separate cover a copy of our Journal which, I feel, will be of interest to you.

Now, to certain basic programs which are meant to enhance the day-to-day life of our elderly patients and residents:

FRED ABELES MEMORIAL SHELTERED WORKSHOP

Established in 1961, the workshop has been licensed by the State of New Jersey as a sheltered facility. Beginning in 1961 with twenty-five participants, over a ten year period this has expanded to an average of fifty-five residents in daily attendance. Residents are paid on the basis of their productivity and our remuneration to workshop participants, which was $2,686 in 1961, reached a total of $20,587 by 1971. Income went from $2,377 to $43,564. Although income has increased, naturally the cost of operation has kept stride and the operation still requires deficit financing by our facility.

Many of our patients are concerned that their work time may be interfered with by other program activities and their desire to be gainfully employed has a tremendous impact on each and every member of that shop. To watch elderly men and women well in their 80s and 90s in productive activity, is a sight to gladden any eye.

SPECIAL RECREATION PROGRAMS

Daughters of Miriam Center employs two and a half full time recreational therapists. Because of the size of this facility, which is broken into six separate units, the program activities, unfortunately, are not on a regular day to day basis, since our staff must rotate among the various infirmaries. Some of the programs in which the residents and patients participate are: Arts and crafts, cooking, music and sing-alongs, Bingo, bowling, movies, trips to theaters and other recreational areas and points of interest and shopping trips. Such trips are arranged for and are, of course, limited to those who are physically able to participate. Patients are transported on shopping trips either by car on an individual one to one basis, or on a bus attended by volunteers as well as a member of our nursing staff.

Every month, through the auspices of one of our auxiliaries, we celebrate the birthday of all residents and patients whose birthdays fall within that month. Family members of the birthday celebrants are invited to accompany their parents to the party, where there is entertainment and refreshments and a birthday candle lighting ceremony.

Movies are shown twice a month on the premises and these programs are supervised by one of our recreation department members and by members of our nursing staff.

All legal and religious holidays are celebrated with appropriate activities.

It is interesting to note that the productivity of many of our patients also benefit the facility, since many of the articles which are made are sold to the visiting public. The individual who made the article has the right of determination as to price and distribution of purchase price. (A sample of a New Year's card is enclosed*).

SPECIALIZED RECREATION PROGRAM FOR SENILES

This program was innovated one and a half years ago and financed by one of our auxiliaries. It enabled us to hire a part-time worker to work exclusively with the mentally impaired patients. Simple methods of communication; awareness of time, date and place; recognition of each other's names are important facets of this program. Regrettably, we are not on the same level as many of the New York facilities which have much larger programs and staffs. For us, however, this has been a beginning to try to maintain some reality orientation for these severely impaired individuals. It is hoped that some of this reality orientation, which is followed up by nursing staff in regard to toilet re-training, may have a sharp impact in reducing the number and extent of our incontinent pa-

*Retained in committee files.

tients. We recognize that this is a hard core group, but we feel that professionally we must continue our efforts to fight against the problem of senility among our aged.

ADOPTION PROGRAM

Recognizing the need for our long-term patients to have contacts with the outside world, for several years now we have had a program utilizing teenage volunteers to visit our resident population. Usually a one to one relationship of substitute grandparent and substitute grandchild develops. Although this has been a limited program because of the number of teenagers who are interested in the aged and who are available, we feel this program has tremendous value for our patients.

OTHER VOLUNTEER PROGRAMS

Our volunteer department has enrolled approximately seventy-five women from the community to participate in our daily activities. They assist in ceramics, arts and crafts, and music. They are extremely important in relieving staff members of the responsibility of feeding some of the patients. They assist in bringing patients to our physical therapy department, which operates five days a week, Monday through Friday, from 8:00 a.m. to 12:00 noon. A classic story of the importance of bringing the outside world into this facility is characterized by a recent incident when a volunteer asked one of the residents whether she could bring her anything when she visited again on Wednesday. The resident's response was, "Only bring yourself, darling."

BARBER AND BEAUTY SHOPS

These are maintained on a regular basis with regularly scheduled hours. This facility is used by a large portion of our resident population. It is particularly significant to our women residents who still have the desire to remain presentable and attractive in spite of their years and infirmities.

CLINICS

Every Wednesday morning we operate a dental clinic and a podiatry clinic for our residents and patients. These are run on the basis of regularly scheduled appointments and enhance the comfort of the long-term infirm.

PHYSICAL THERAPY

Mentioned previously, this program is meant not only for rehabilitation but also provides care and attention to those patients who are categorized by government under its Medicare program as non-restorative. It is our firm belief that when the aged person comes to our physical therapy department, it not only provides diversion but its primary import is the psychological and physical impact of not feeling discarded, unwanted and neglected. We feel very strongly that even though government may not be willing to pay for these services, they have value not only psychologically, but physically by slowing down the deterioration process of the patient with active physical exercise and manipulation of extremities.

SPECIAL EVENTS

Although there are a number of special days set aside for which unique programming is involved, we are particularly gratified with our twice a year barbecues, held outside of the building in our beautifully landscaped garden area. The usual barbecue food of hot dogs, hamburgers, cole slaw and potato salad is served. Special diets and concerns are forgotten for a few hours, as the elderly participate not only in the eating phase of the barbecue, but in the outside amusement and entertainment which is provided for them.

Another special activity occurs around election time when local candidates come to the facility to talk to our residents. On Election Day, arrangements are made for all of our "Ambulatory" residents to be taken to the polls to vote. Those unable to go to the polls have absentee ballots provided. We have found that this active participation in one of our democratic procedures has tremendous psychological overtones for our aged people.

The long-term facility under religious auspices not only provides a more comfortable emotional setting, but because of its community support, is able to provide more in programming than the "for-profit" facility. Physical surroundings

and quality of nursing and medical care are important, but perhaps of equal, if not greater importance is the opportunity to provide programs and activities which encourage our aged residents and patients to look forward to another tomorrow.

It is regrettable that so many times publicity in our newspapers stresses the sub-standard nursing homes. It is the proverbial "rotten apple in the barrel" which is publicized for its shock impact on the community. There is the other side of the coin and we of the Daughters of Miriam staff sincerely feel government should recognize and make part of its subsidy program the kind of programs which most non-profit facilities offer to their aged.

I hope the foregoing may be of interest to you. Should you ever be in our area, we would be most happy to hear from you so that we could personally show you the life and times of the Daughters of Miriam.

Sincerely yours,

MERVIN SILVERMAN,
Assistant Executive Director.

METHODIST MANOR, INC.,
HOME FOR THE AGING,
West Allis, Wis., December 10, 1971.

DEAR SENATOR MOSS: In behalf of Methodist Manor, Inc., I am pleased to respond to Mr. Frank Zelenka's communication of November 24, 1971, to members of the American Association of Homes For the Aging.

Our home, while serving the aging for a relative short period of time, having opened in 1961, has been outstandingly progressive in its approach to the care of the elderly. It has lived up to its motto on the cornerstone, "With years a richer life begins," by having created an atmosphere, attitude and image in the Metropolitan Milwaukee community of outstanding excellence of service. Without the dedicated leadership of our Church, Board of Directors, personnel, and community our present reputation could not have been possible.

To attribute the great measure of success to innovative programs would be to misread the impact of our mission. We feel that the success which has made our Home distinctive has been a philosophy, an attitude and a recognition of the need as well as an obligation to care for the total person in all of his social necessities of life. While not entirely attributable to program such success comes only from being a part of the life of the people and Home in which we carry out our responsibilities and mission.

Our Health Center, a skilled nursing home, while in operation for merely twenty seven (27) months has made an additional impact upon our community. It is recognized as a leader in skilled nursing care in Wisconsin because of our philosophy of concern, compassion and love for our patients; "Ye have not done it unto one of the least of these, my brethern, ye have done it unto me."

WHAT HAS BEEN THE KEY TO SUCH REPUTATION?

I. Humanization! Every patient regardless of circumstances, physical or mental infirmity, is a human being, (not a number or dollar) and a child of God in need of care by understanding people with hands, minds and hearts providing loving skill and care. Many cliches have been propounded by those in the "business" to demonstrate and even to justify existence. However, I cannot emphasize strongly enough my pride in the work our staff is doing, how they are helping us to fulfill the mission which we have set out to accomplish, and the dedicated skills of love and compassion which they prove day by day in caring for our aged.

II. Nursing! Our 168 bed unit is providing care, in many instances, unequaled in even the finest of general medical hospital units. Our personnel not only undergo intensive training upon employment but are required to regularly participate in an on-going in-service education program.

III. Comprehensiveness! Without caring for the total man, all of his physical, mental and social needs, one misses the mark. Within budgetary restrictions placed upon us, our facilities are dedicated to the premise of providing a comprehensive scope of services to fulfill the total needs of the aged: food, clothing, shelter, medical and nursing care, recreation and activity, social. Beyond these normal necessities most recent additions to the total scope of our services include:

a. A Urologic Clinic service; consultative, instructional and maintainitive to the total welfare of the institution.

b. A Dental Care Clinic; consultative to anyone providing not only prophalactic care but also hygenic instruction and advice, and

c. A teaching program for persons with low or lessening vision together with a health and social maintenance program for such persons (Braille reading and writing).

Unique to homes in our area are two (2) programs in Physical Therapy, in addition to the normal services provided by Physical Therapy:

a. Physical Therapy Inservice for Nursing Assistants wherein aides actually do the things patients learn to do, i.e., pushing a wheelchair with one arm and leg as a cardiovascular patient would; walking with a walker doing a non-weight bearing gait on one leg as a hip fracture patient learns to do, and

b. Ambulation, Range-of-Motion Maintenance Program which is a cooperative venture of Physical Therapy, Occupational Therapy and Nursing Service, a team approach wherein by individual evaluation the staff workers to illict the maximum ambulation and range-of-motion capability of each patient and resident.

What implications does this have for a sound national policy? Our great society and nation has provided the most outstanding resources, services and facilities for the unborn, the newborn, children, adolescents, adults, etc. up to the elderly. To say that the elderly have been totally forgotten would be a miscarriage of fact. However, to those of us providing elder care, services and facilities at a quality level comparable to that being provided for other segments of our society, yet constantly being downgraded with unreasonable allegations and unfounded generalities as facts, I feel that we should be accorded the same considerations in all "halls of justice" as other segments of health care.

To leave an impression of "holier than thou" or "lilly white hands" is not my intent. I have specific thoughts regarding implementation and financing of such a program.

1. Philosophies of what long term care "IS" and is "All About" must be rooted and grounded in a service concept of non profit financial objectives, health maintenance oriented and motivated, and undergirded with the highest Judean-Christian tenets of love and compassion.

2. While ultimately everything that has philosophical, conceptual or humanitarian ideals resolves itself in dollars, I implore you and your committee to recognize that the quality of health, and more particularly aged care, which the American consumer is demanding (and deserves as a right) cannot be bought cheap. Herein it seems to me is the greatest diametrically opposed inconsistency presently being forced upon our great institutions caring for the aged. In a climate of economic inflation, greater demands for comprehensiveness of health care services, greater emphasis placed upon quality care and up-grading of standards for care of the aging, we find ourselves faced with increasing costs being re-imbursed with fewer dollars. It doesn't make sense!!

The day is long gone when society "shelves" or "crypts" its aged. Why should the technological advances of science and medicine accrue only to the birth defects, heart, cancer and stroke, mental health and comprehensive regional planning? Adequate financing mechanism based upon quality, depth and cost of service must be encouraged and implemented. Abuses must be dealt with punitively; yet success should be rewarded with incentives for increased unparalleled excellence.

Methodist Manor enjoys excellent relationships with government agencies, and with government financing and insurance in its physical plant. I would invite you and/or members of your committee to visit our facilities to personally sense the feeling, atmosphere and dedication to which we address ourselves each day as we minister to the aging of our area!

Trusting that your efforts and those of your committee will make a significant impact upon future national policy for long-term care of the aging, and with best wishes in this Holiday Season, I am

Sincerely yours,

R. ARTHUR WAGNER N.H.A., *Administrator.*

THE OHIO PRESBYTERIAN HOMES,
Columbus, Ohio, December 9, 1971.

DEAR SIR: I was pleased to receive a communication from Mr. Frank Zelenka, Executive Director of American Association of Homes for the Aging in which

Mr. Zelenka related that after your two years of inquiry in Nursing Home problems, you are preparing a report of your findings to the Congress of the United States. It is my fervent prayer that our Congress will see fit to take positive action on your report. In the day to day operations of a Nursing and Retirement Home as we have at the Mt. Pleasant Presbyterian Home in Monroe, Ohio, there are a number of problems that the average person is unaware of. I believe that the Nursing Home Industry should pursue a program of education for the general public. One of our first hurdles during the initial interview is to combat the guilt feeling of putting Mother or Dad away that the family usually has. They haven't had any contact with a modern Nursing Home and they are still thinking of the warehouse for people of ten to fifteen years ago, they were literally waiting rooms of death.

Secondly overcoming the feeling of resentment of the prospective resident: they feel that when they enter one of our Homes that they are giving up all of their independence, privacy and diginity by becoming "one of the poor people that have to live in an old folks home". I would like to relate our procedure in helping these people make the somewhat traumatic adjustment from trying to take care of themselves, to a situation where we furnish a life for them that they are unable to furnish for themselves.

When a prospective resident enters Mt. Pleasant Home, in Monroe, Ohio, the Social Director meets this resident. Making the friendliest approach possible. The resident is taken to his room and along the way they will have the opportunity to meet other permanent residents of our facility. After a short conversation with the new resident and the family during which time the Social Director will be able to get an insight on this person, the Social Director assigns a buddy to them. This buddy is very important to the new resident, as he will make new acquaintances for them and acclimate the new resident to our facilities, telling them of the mealtimes, the various procedures we use, telling them of activities we have, which include diversional, recreational and religious type programs. A form is used to help the Social Director keep abreast of this resident as to their interests and is reviewed from time to time.

For all of our residents we provide as much entertainment and diversion as can be found.

Every Wednesday evening a Prayer Service is offered with ministers of all faiths bringing the message. Sometimes special music is furnished by their choirs or a soloist. In this way every resident is made to "feel at home" with the type of service he had been used to prior to coming to us. The Sacrament of Holy Communion is observed at least 3 times during the year with special observances during the Lenten season and at Christmas. Bible recordings are presented bimonthly and sometimes an old-fashioned Hymn Sing is conducted.

Three times a week our own Bus, driven by an LPN, who understands and loves these people, travels to the local shopping center, to the Dr's offices and other places, where transportation is needed. Also, the use of this bus provides trips to museums, the baseball game to see the Cincinnati Reds play, the Cincinnati Symphony in concert, and just plain sight-seeing trips to Hueston State Park and Ft. Ancient State Park to see the fall foliage. Several times a year shopping trips to various shopping centers in Cincinnati and Dayton.

For diversional programs we find outlets in many ways. Our local Civic Clubs and Industry will provide interesting lectures on any subject. Poetry readings and Book Reviews are made. Movies of interest and slides of vacation trips both at home and abroad are used. Musical programs are given by Vocal and Barbershop Harmony groups, instrumental groups; an annual outdoor Band Concert around our fountain in the garden is a must for everyone. Christmas Cantatas are looked forward to. Visits from youth groups such as Boy and Girl Scouts are welcomed along with favors, gifts and scrapbooks.

In our Nursing Center we welcome the teenage Volunteens and the Grey Ladies under the auspices of the American Red Cross. They help provide many hours of guidance with a Record Player, a Book Cart, and the use of bedside games to while away the evenings. Since we have Husbands and Wives in different sections of our facility such as Dormitory and Nursing, the Holiday season can be a brighter one for them both as special attention is made to bring them together at mealtime to provide the special touch of home.

Our resident activities are varied and extensive with each Program geared to the various sections of our Home.

THERAPEUTIC ACTIVITY PROGRAM

1. Daily Workshop Sessions for Nursing Center Patients—purposeful work and craft activity tailored to patients' individual needs for general exercise and social experience.
2. Complete Work Shop Facility—open daily for Dormitory Residents including ceramics, loom weaving yarn work, woodwork, varied creative projects, holiday decorations and service projects for the community.
3. Game Night Activity—planned game recreation for residents complete with prizes held twice monthly.
4. Special Events:
   A. Annual Bazaar—Residents create all items for sale to residents and visitors. Proceeds invested back into Therapeutic Activity Program.
   B. Annual Hobby and Art Show—to give recognition to residents.
5. Therapist visits bedfast patients and provides simple work activity when indicated for social contact.

PROJECTED PLANS

1. Music Therapy Program:
   A. Rhythm Band, record music, and sing alongs for Nursing Center.
   B. Game Recreation—for bedfast and wheelchair patients.
   C. Gardening Program for Dormitory Residents—own flower gardens and Garden Club.

We encourage visits by school groups of all ages, church groups of all kinds and Civic Clubs so that they may observe our operations first hand. When people have had some exposure to what we try to do to maintain a purposeful and meaningful life for our residents, then when they need our facilities for friends or relation, they come with a different attitude than what they have at the present time.

The Mt. Pleasant Home Campus consists of 42 acres. We have 84 individual cottage units, 58 residential rooms, 15 bed partial care section and a 80 bed skilled nursing section. At the present time we have a population of 230 people.

I hope this information will assist you in preparing your report and that your recommendations will be carried out.

With best wishes, I remain,

Sincerely,

MT. PLEASANT HOME,
BERT LERCH,
Administrator.

CROWELL MEMORIAL HOME,
Blair, Nebr., December 10, 1971.

DEAR SENATOR MOSS: First, I wish to express to you our thanks as president of the Nebraska Association of Homes for the Aging, Non-profit, and our appreciation for the many fine things you have done in the field of the aging since you have been involved in the Special Committee on the Aging.

I now have a letter from Frank G. Zelenka, Associate Director of Public Affairs for the American Association of Homes for the Aging, asking that we send to you any innovative program of care and services provided by our agencies. I am really a little hesitant to state to you that these are innovative because some of them I know other homes have used for some time. However, in answer to his request we will try to explain some of the services we are doing or initiating at this time to promote better care for our residents.

First of all we have now for the last two years had a full time Director of Activities and also a full time Director of Volunteer Services. This of course has made immeasurable changes in the welfare of our residents. We have all kinds of crafts, including a ceramic group with many classes and also a very fine kiln. The work that our people turn out is tremendous. This is all done strictly for the benefit of the patients. While these items are sold, all this money is put back into the program to provide more services and materials for the residents to work with. They all participate regardless of any money they may or not have for the items that are made. Also, we have through this volunteer services program added to the crafts, pulled in many talents and done many things to energize our own people. Also, we are now starting a program to bring the people in from outside of the community which I will next explain, to better relate ourselves to the community.

Many Homes in the State of Nebraska have now through federal funds started meals on wheels. We ourselves at Crowell Memorial Home are starting a meals on wheels program without any federal assistance. We are doing this on our own, letting people pay when they are able, on purely a cost basis and having it delivered by volunteers. We are also working through the local Welfare Agency for Washington County and we will provide services to these people through welfare at cost or less, whatever the needs may be. The idea of this program is to meet the needs of not only the poor people of the community, but others who may need the services but have no way of securing it. If we do provide to these people, it will also be on no more than a cost basis. This is not particularly innovative, only the fact that we are doing it on our own.

Second, we are starting a telephone service whereby we will call residents of the community who are in need of this service. We will call them at least in the evening and in the mornings to make certain that they are in good condition for the day and the night, offer them any particular help we may be able to offer them within our limits. In cases of emergencies we will either answer or see to it that a Doctor or some other representative of the community answers the needs that they may have.

The other program that we are initiating is involved in what I mentioned earlier, in the crafts. We are organizing a Senior Citizens group or club which will meet at least once a week. When these people come together we will have them in for a noon meal and then provide an afternoon of recreation, crafts, fellowship, whatever helps to meet their needs in the best way. We have great hopes for this program and they will have their own organization, we will simply supervise it and provide the personnel and space.

As Spring and Summer will come upon us, we are creating a new recreational and play area for them, including things such as lawn bowling and miniature golf, this type of recreation which they are interested in and will open it to the elderly and near elderly in the entire community.

As we move ahead with these programs we expect some fine results and interest within the community. There are other new ventures which we are studying, but these are the ones we are initiating no later than January 15, 1972. Some of these we have already announced and are starting now.

We have a Physical Therapy Department and we have offered to the Doctors and the people of the Community the use of these facilities and our Physical Therapist for the time that he is here and then continued exercise program by our Nurses and Aides as it may be specified by the Doctor and the Physical Therapist. We feel this is one way we can reach into the entire outside community. This service would not be limited to just the elderly.

Again, we appreciate your interest in the field and whatever we may be able to offer in the way of constructive help to you we certainly offer our services.

Sincerely,

Rev. Guy B. McClure,
President, Nebraska Association of Homes for the Aging.

Teton County Nursing Home,
Choteau, Mont., December 3, 1971.

Dear Senator Moss: In answer to Mr. Frank G. Zelenkas request I am submitting this description of our nursing home. I hope this will be of some help.

The Teton Nursing Home at Choteau, Mont., is a small forty bed home. It is the only nursing home in the county. We are fifty miles from Great Falls, Mont., our nearest city of any size. Choteau has a population of 1500 and a population of 6116 in the county. The home is county operated. We are fortunate to have three doctors and a hospital.

First, I shall try to tell you what we have to offer as a nursing home. Our home is three years old. Our residents rooms are colorfully decorated, furnished with good brand named furniture, colorful drapery at nice sunny windows, comfortable chairs, good reading lamps, and sufficient storage for their clothing and personal belongings. We have a carpeted reading room and a carpeted living-dining area that we also use for entertainment, church services, and craft. We have a very well equipped kitchen. We use geriatric chairs, wheel chairs, and walkers depending on their needs. In the center of the building is a patio that is carpeted and furnished with patio furniture and planters.

Our home is located on Main Street which caused some concern as to the feasibility of the location. Time has proven this not to be a fault as many other

factors have determined this to be a better location. First; we are only two blocks from the fire station and three blocks from the hospital. We are only one block from the Doctors office and another Doctor just across the street. Secondly, the residents can walk to the stores, some of which are less than a block away to shop for their little items they need. Churches are within walking distances. Should one of our patients get out of the building on us or lose their way on the street, there is always someone on the street to give us a call or will help them back to us. (I shudder to think of what could happen to them in this case, had we been forced to build out of town.

We use the "5 Meal Plan." This is one of the nicest things that we do for our old people. It has many advantages besides being a way to more normal living. Mainly, they can sleep later in the morning. At seven we serve coffee, toast, or a roll to those who are awake and wish for a cup of coffee. Brunch is served in the dining-room at 10 a.m. This meal consists of juice, fruit, cereal, eggs, breakfast meats and milk. Following this is a snack at noon (fruit, soup, pudding, etc.). The dinner is served at four o'clock. This meal consists of meat, vegetables, breads, salads, and deserts. At bedtime another snack is served, usually a milk product or a sandwich. We find that they rest better at night, not nearly as many "night calls." I understand that the nursing homes who have tried this plan have a problem of getting the cooperation of the personnel because the work routines have to be changed. They then become discouraged and give up to the old way even knowing that this is ideal for better living of our older people.

We are getting a nice start on an in-service training program. One of our registered nurses is attending work shops that are training nurses to teach. We hope to have a nice program going by spring.

It being a small community, many of the church groups, youth organizations, and other clubs offer their services to the nursing home. By comparison to our larger homes, I understand our volunteer help is doing much more for our people than what is being done in the larger home. This is, I'm sure, because there is more personal interest. I am not convinced that the large complex nursing home can compare to the smaller home in providing the "home like" atmosphere, nor the "personal" care that we can give in a small home. We know, personally, most of our residents or the families on admittance.

Our staffing pattern exceeds the minimum set down by the State Board of Health, but I have no more employees than I feel I need to adequately care for our patients. Our patients are dressed completely each day and are taken up from their beds two and three times daily. There are homes who are not so well staffed that cannot get their patients up this many times during the day, and this is very important to their well being to keep them out of their beds as much as possible.

Our laundry is sent out. Their laundry comes back nicely ironed. We make all our gowns similar to the old hospital gown but out of flannel. They are so warm and soft.

There is still much to be desired in our home to become a model home. We have no physical therapy. I feel very strongly about the lack of this. This may be worked out in time too.

We have not been able to hire licensed practical nurses who are graduates of a school. We have four who are waivered. I have a full time director of nurses. We cannot get any of the other registered nurses to work full time. They do relieve the L.P.N.s on their days off. So we are not in full compliance because of not being able to secure the services of graduate of a school Practical nurse. The State Board of Health and the Department of Welfare is aware of this. Their inspectors and review teams tell us that they feel we are doing a good job, and if you care to write to these departments about us I'm certain they will verify this statement.

I have a dietitian consultant who gives us a few hours of her time each week, but I plan all the menus and they have been approved by the dietitian consultant from the State Board.

All in all, I am very proud of our small home, and to those of you who are concerned about those of us in isolated areas I invite you to inspect our Home and to visit us at any time.

Sincerely yours,

Mrs. Valera Dittus,
Administrator.

RETIREMENT RANCH, INC. OF CLOVIS,
Clovis, N. Mex., December 7, 1971.

DEAR SENATOR MOSS: I have especially enjoyed following your activities in the field of aging and those of your Special Committee. It was a pleasure to have met you at a reception held in your honor by the American College of Nursing Home Administrators back in the fall of 1969, at the Sheraton Hotel in Chicago. I have agreed with most of your philosophy in the field of aging. It gives me real pleasure to make a contribution to the brighter side of caring for those elderly persons who have been placed in our trust.

I feel that patient care is the whole of two parts. The first being that physical area of pill giving, bed changing, and food serving—the basics. The other is the area of the patient's sense of well-being. It is most important how he sees himself in view of the surroundings we have built. In line with this we have made it a practice of referring to our patients as "residents" no matter how grave their condition. The following are policies and plans we have incorporated into patient/resident care to make the resident's surroundings more enriching to his personal well-being:

We encourage a resident in the Retirement setting to bring his own furniture. This gives an added sense of home—having personal possessions and worth. It also lowers the monthly cost for room and board.

We have made beauty and barber services available on a "no cost" basis. This allows all who are physically able to do so to use this service irregardless of economic background. A further benefit is that they feel well-groomed, better able to interact with others, and to have greater self-esteem.

We provide a Diversional Activities Center with full time paid staffing plus volunteers. The resident's have named this Center the "Happy Room". Here they make:

(1) Items for personal pleasure—adding to their room their own personal touch.

(2) Items for their family—in a "prefab" society such as ours, these items take on greater meaning.

(3) Items for sale to the public—this gives an added sense of productiveness and feeling of being needed. It also adds to their personal income.

The Diversional Activities Department plans daily activities in the Happy Room, in the Section for the Forgetful, Church activities, picnics, outings to points of interest, and many other events to meet individual needs.

We provide a larger parlor area for both the Retirement Section, ICF, and ECF Sections. These areas are used by the residents as a meeting area for socialization, for TV viewing, as a game area, and for reading.

We encourage the use of our dining room as a means of strengthening social ties among residents.

We provide in-building Physical and Speech Therapy for residents.

We have set aside an area we call the "Section for the Forgetful". This area is segregated by electronically operated doors. For the most part, this allows the residents to move freely about without being restrained. This type of area helps remove the feeling of being confined. These residents are provided an enclosed outdoor recreation and patio area, their own dining area, their own daily planned activities by the Diversional Activities Department, their own nurse station, parlor and TV area.

We provide spacious grounds that are landscaped and cared for to bring pleasure of a relaxed, orderly, and beautiful environment for all residents.

We have provided carpeting throughout. This lessens the institutional feeling of the building. It is safer, makes the resident feel more sure footed, and helps prevent slipping and falls. Each room's carpet is different in color, from its neighbors, as-well-as the color scheme being different. This lessens the feeling of institutionalization also.

It is our sincere hope that some of the ideas we have implemented will be food for thought for your committee and others of our profession to whom patient/resident care is more than a physical exercise of mere maintenance.

Sincerely yours,

RICHARD SNOW, F.A.C.N.H.A.

VALLE VERDE,
THE SANTA BARBARA BAPTIST HOMES INC.,
Santa Barbara, Calif., December 1, 1971.

DEAR SENATOR MOSS: This letter is being written in response to a request to Frank G. Zelenka, Director of American Association of Homes for the Aging, relating to "imaginative approaches" to nursing home problems. I, for one, am extremely pleased to have been asked to participate in this collection of information and I compliment you and your committee for the approach that you have taken toward this very difficult subject. I hope that you will excuse the fact that most of this letter is being written in the form of a list; however, from the standpoint of its preparation and perhaps from the standpoint of its reading, this may prove to have been of some advantage.

A word of explanation is probably due prior to listing some of the services and methods that we use here at Valle Verde. The Valle Verde convalescent hospital is an adjunct to a retirement community and many of the items to which I will make reference are provided primarily to residents of our retirement community. However, in many instances, they are open to residents of the community at large, especially to retired people. I see no reason why most of the items and innovative efforts that we have made here could not be employed in most convalescent hospitals. There are probably some regulations which would need some modification in order to protect convalescent hospitals in a liability sense but the most necessary ingredient to accomplish some of these programs is motivation on the part of proprietors and operators of convalescent hospitals.

1. Extensive Outpatient Services to Retirement Community

(*a*) Through a staff of physicians we provide regular medical office hours at the convalescent hospital location. The principal advantage here being that convalescent hospitals are located in the communities where people live and it makes medical facilities and doctors' offices more convenient for patients to reach. This is especially a problem with senior citizens where transportation is frequently difficult.

(*b*) Our staff of nurses are available on a regular basis for consultation with outpatients or with residents who have questions. Frequently an RN or LVN can detect a problem which should be called to the attention of a physician or can put the mind of the senior citizen at ease about a condition which appears to their trained eyes to be minor.

(*c*) We provide a shot clinic where we dispense Vitamin B–12, diabetic shots, flu shots, and others. Of course this is under the direct supervision of a physician and only upon his orders, but once again, convenience is an important factor and in this particular case, we do it at cost rather than charging patients the high level of charge that would be found in the doctor's office.

(*d*) TB check: In the past we have arranged for the mobile unit to be set up at our convalescent hospital and invited the surrounding area to come and use it here. This, in Santa Barbara is no longer possible and we are now going into a Tine test, once again under the supervision of one of our staff physicians.

(*e*) Our nurses answer calls for help from all of the residents of our surrounding retirement village and also for a couple of community people. For residents of our retirement home this is handled through an intercom system or over the telephone and is a service that could be made available to communities by convalescent hospitals.

(*f*) Occasionally our convalescent hospital arranges for medical and dental transportation for outpatients.

(*g*) Another service of our convalescent hospital is providing assistance through our consultant dietitians and through nurses, helping outpatients to understand various aspects of special diets.

(*h*) Occasionally on an outpatient basis we provide baths, medication dispensing and occasional short term day care in our lounge or dayroom area.

2. Educational and Training Activities

(*a*) At Valle Verde we work with a nearby school of nursing in regard to the above mentioned shot clinic. Students under the supervision of our nurses and the school's own instructional staff are given an opportunity to practice giving shots to people. We have found that our patients and outpatients respond very well to this participation in the educational process of young nurses.

(*b*) Each year twelve in-service educational programs are planned and are open to staff of other nearby convalescent hospitals. The participants in instruc-

tion in these classes include our dietitian, therapists, laboratory technicians, fire safety experts, masters in social work, etc.

(*c*) Occasionally families or spouses are trained in the care of patients released for short or long-term from our convalescent hospital. This enables the bed sometimes to be vacated more quickly and of course helps in the saving of money for the families.

(*d*) At times forums for residents or community persons are held at our convalescent hospital on relevant topics. Naturally these would usually be related to health.

(*e*) Various materials and publications are distributed or circulated through the nursing home, either to staff or residents of the community.

(*f*) A lending library is maintained in the convalescent hospital for staff on various relevant subjects.

(*g*) On the job in-service education is planned and it is supplemented with motion pictures, slides, tapes, film strips and other visual aids.

3. *Recreational Therapy and Volunteer Opportunities Within the Convalescent Hospital*

These are especially important to the older or long-term care patient.

a. We have recently embarked upon an effort to employ various props and equipment in developing a reality therapy approach to care for long-term patients. For example, one item we are now employing is a giant calendar (3 ft. by 4 ft.) and a felt ring, a large faced clock at eye level, and the names of the day along with other reality tools to help in keeping patients, especially those who are failing mentally, to keep in touch.

(*b*) We are now involving our volunteers, better off patients, and staff in cooking (treats, not meals) and other direct patient services including performing these services right in the patients' rooms. For example, we place a grill on a movable cart and take the grill to the patient's room beside their bed and perhaps cook some bacon or something else that has a very good odor to it right in the patient's room.

I realize that the above list is rather lengthy and I don't mean to imply that our convalescent hospital is employing all of these various techniques and providing all of these services every day, but we have found that these and other community type services can be provided without extensive expense. It would seem to me that catching this approach of providing health services of varying types through convalescent hospitals would be advantageous to many communities because of the wide dispersion of these facilities geographically. Of course the advantages in terms of public relations are completely self evident. Probably the most difficult factor to overcome is the question of liability in an industry where liability insurance is already enormous. Perhaps the federal government could encourage the development of programs and services, both internally and externally, to the community through convalescent hospitals by establishing some clear cut guide lines and some degree of protection from unnecessary or unscrupulous liability claims.

Once again I want to thank you for the fine work that you are doing on behalf of the senior citizens of the United States through the Special Committee on Aging of the United States Senate. I hope that something I have said has perhaps sparked an idea and I would certainly be glad to expand upon anything that I have mentioned or to be available in any way through which I might serve.

Sincerely,

RAY SCHNEIDER,
Administrator.

THE CHURCH HOME,
Chicago, Ill., December 1, 1971.

DEAR SENATOR MOSS: Although the Church Home is not a Nursing Home, but rather a residential facility with intermediate care, you might be interested in some of the activities and programs that we have to keep our residents alert, interested and healthy, in mind, body and spirit.

1. Two physicians (one a psychiatrist) spending 7 hours weekly between them in the Home and on call between times.
2. Monthly visit from a licensed podiatrist, for as long as is necessary.
3. Two hairdressers three times a week.
4. Recreational therapist all day once a week.
5. Regular monthly outings by chartered bus to the zoo, plays, movies, etc.
6. Three Stereo concerts (taped) each week of a variety of types of music.

7. Free Bingo twice a month with prizes.
8. Twice a month a shopper comes in and takes the orders of those unable to get out.
9. Regularly scheduled religious services with the Chaplain available every day.
10. We have a Board of Managers and a Service Board who between them are regularly calling on everyone every six months.
11. A Residents' Council that assists the Administrator in decisions that are of concern to the residents. They arrange the special parties, etc.
12. A special Birthday Dinner each month for those having birthdays during that month, with gifts.
13. There is a wine half-hour twice a week, and free, of course.
14. We try to make the residents feel "needed"—they man the hostess desk, the closed circuit television at the front door, help set the table after meals, fold napkins, sew for others, etc.
15. Those who are blind or have difficulty reading are read to for an hour twice a week in a group, and individually at other times.
16. For those who can get out, regular visits to doctors for eyes, teeth and hearing problems. For those unable to get out, the doctors visit them here in the Home.
17. There is a weekly class taught by a dancing teacher on exercises to help arthritics.

Here is a quotation from Article 6, Section 1 of the By-laws of the Church Home. "In the pursuance of his or her duties, the Administrator shall be guided by the basic intents and purposes of the Home's Board of Trustees with regard to the operation of this Home, which are:

To provide for the comfort, happiness, health, safety, and general welfare of the residents in an atmosphere of hominess and congeniality;

To make available for members, diversions and activities aimed to contribute to the members' enjoyment, mental alertness, sense of purpose, and general well-being; and

To operate this Home in conformity to such rules and regulations pertaining to homes for the aged as may be prescribed by Federal, State, or local Government Agencies.

And as you can see from the 17 point list that the mandate of the Board of Trustees is being carried out.

As doubtless you realize, this letter is written you in response to a letter from the American Association of Homes for the Aging, but I should like to go one step further than their request, and that is, to invite you and your colleague, Senator Percy, to visit this Home at any time.

Sincerely,

THE REVEREND FRANCIS WM. TYNDALL,
Administrator and Chaplain.

OLDS MANOR,
Grand Rapids, Mich., December 6, 1971.

DEAR SENATOR MOSS: In response to your letter to Mr. Frank Zelenka we respectfully submit this report of what we think is unusual if not innovative both in the areas of retirement service and nursing or convalescent service.

1. Although Olds Manor is of Baptist origin and is Baptist owned we do not discriminate against non-Baptists either in entrance requirements or as residents once they take up residence.

2. Having the nursing service in the same building we offer a continuity of service, locale and personnel so that the resident does not experience the trauma he might if he were "taken away" when convalescent service is needed.

3. Through the plan of the life lease fee our clients are assured of life time service even if they run out of money beyond their control or if they need convalescent service. Probably the word "security" spells the difference between this and other plans when residents could or would be evicted.

4. Many people need a little more service than the average in a retirement center but not enough to be in the convalescent section. Therefore we are operating an intermediate care section with people living in their usual room arrangement.

5. We help the residents financially by arranging for them to pay in part or in whole their monthly service charge from their resources on deposit secured by a declining note at 7 percent per annum on the unused balance each month. In case of death the residue is part of the estate.

6. We offer an excellent deferred contract so applicants may choose living units and begin paying the life lease fee as much as five years before anticipated occupancy. Deposits of 20% per year earn 7% interest per annum. This arrangement freezes the life lease fee at the time of signing the contract and offers other fringe benefits. The applicants may withdraw anytime with a $600 penalty as a service fee.

7. We offer a choice of menu at every meal and cater to the medically prescribed diets.

8. A snack bar or boutique is operated by the residents. The profits are given to some project in which all the residents may participate or which all may enjoy. An example is the large color TV in the lounge.

9. There is the minimum of regimentation with options in religious exercises (ecumenical basis), crafts, games, sing-a-longs, lectures, parties, etc.

The enclosed materials may add light and color to this report and hopefully something different herein may be added to your composite report.[1]

Sincerely yours,

RAYMOND RILEY, *Administrator.*

THE BENSENVILLE HOME SOCIETY,
Bensenville, Ill., December 15, 1971.

DEAR MR. MOSS: This is in response to your recent letter to Mr. Frank G. Zelenka of the American Association of Homes for the Aging relative to services and programs to the elderly.

Our service programs to the aging are as follows:

I. Congregate Care, Residential and Nursing.—In residential care, we offer two levels of service, shelter care and "sheltered care supervised." The latter unit has been established to serve the more confused, disoriented or emotionally disturbed older person.

This has "24 hour" nursing coverage and supportive programing by the rehabilitation department which also focuses on remotivation. A rehabilitation nurse supervisor is on ½ time basis in nursing care and in charge of the rehabilitation within the building.

Nursing care is offered to all sheltered care persons for either a temporary illness or a prolonged period and a certain number of residents move between the two services.

II. Group Services, Social Development and Rehabilitation.—This program offers recreational activities, arts, crafts and remotivation techniques to all residents. Each person has an opportunity for constructive and satisfactory use of leisure time, for group experience, and to be able to develop social skills and enhance personal interests. Our Rehabilitation Center is one of three out of nineteen institutional programs in our county accredited by the Illinois Department of Public Health and is staffed by an Occupational Therapist, a Physical Therapist, a Rehabilitation Nurse, a Rehabilitation Nursing Aide, a Craft Director and an Activities Director. The program is designed to use small groups, offers a wide choice of programs and special programs for the "hard to reach" and antisocial persons. We make a special effort to reach on a regular basis the persons in nursing division whose needs are great and abilities most limited. In this program, we are presently exploring the possibility of offering "day care" to aging people in the community and along with this to effect a program of home delivered meals. This will be a joint effort of staff such as our volunteer coordinator, social workers, community consultant and group services workers.

III. Training and recruitment of Professionals and Volunteers.—Recruitment and training of volunteers is one of the major thrusts of our aged services program. We have a full time Coordinator of Volunteer Services. We use a number of individual volunteers on a regular weekly basis and approximately 60 groups of volunteers from churches and community organizations who undertake special projects.

In training of community people, we have offered a wide variety of training and placement experience, such as:

1. Student from DuPage County College for a six week practicum in group therapy techniques.

[1] Retained in committee files.

2. Two young men, college age, from "People Power" program of Elmhurst Church, Elmhurst, Illinois who worked with our staff during the summer months on a variety of assignments.

3. We are negotiating with the coordinator of nursing education of Elmhurst College, Elmhurst, Illinois to participate in training nurses in Geriatrics beginning September, 1973. We are having a senior student in Theology from Elmhurst College for a month's assignment in the Rehabilitation Center and in the Social Services Department.

4. We are providing all day seminars. The seminars are open to social agencies, other professionals and the general community. On December 3, 1971, Dr. Elizabeth Ross conducted a workshop on "Death and Dying." Over 200 persons were in attendance.

5. Within the agency, we are using clerical staff with exceptional talent and abilities, such as program secretaries, as "paraprofessionals." They are assigned to intake in the Social Service Department, statistics and some direct client contacts.

IV. Group Services Consultation to Senior Citizens, Churches and Community Organizations in the Development of Local Community Service.—One staff person is available to church and community as a consultant. The agency has sponsored the development of a "Coordinating Council for Senior Citizens" which is comprised of representatives from all the agencies and individual groups interested in Senior Citizens in our Bensenville Community. This was organized to evaluate and appraise the needs of the elderly in the area and to eliminate overlapping and duplication of services. Monthly meetings are held on or premises and in January, 1972, this organization and a number of senior citizens will meet for a breakfast meeting to discuss "Senior Citizens and Community Concerns."

In all aspects of our service programs, our goal is to help each individual and family to whom we provide service develop and function in as healthy a way as their capacity and reality circumstances permit—physically, intellectually, emotionally, spiritually and socially. We employ a variety of professional disciplines, community resources and approaches in seeking to achieve this goal. Our philosophy for those in residence is that this is their home and staff is trained to respect this and serve each person as one individual. Although at this point, our main work is with elderly in an institutional setting, we are developing programs to "reach out" in the community to provide non-residential services such as hot lunch for a nominal fee, home delivered meals assisted by volunteeer corps. We believe more services are needed and can be developed such as, preventive health care clinic, telephone assurance, home nursing, etc. Many elderly could remain in their respective communities if they had sufficient funds—larger social security payments—part time work—less limitation on yearly earnings and good supportive services.

We are concerned about our ability to maintain this quality level of rehabilitative and socialization services within the institution, as the gap between costs of service and rates paid by public aid is continuing to grow.

I would be pleased to provide any additional information or details concerning these programs which you may desire.

Sincerely,

LEROY H. JONES, ACSW,
Executive Director.

NORTH CAROLINA JEWISH HOME,
Clemmons, N.C., January 7, 1972.

DEAR SENATOR MOSS: At the request of Frank Zelenka, Director of Public Affairs, American Association of Homes for the Aging, submitted herewith is an article I have prepared for publication in our professional journals.

The article relates to some programs of service and social components of care practiced by this facility. We hope it may serve your purpose.

Please do not hesitate to call or write if we can further serve.

Sincerely,

ELBERT E. LEVY, NHA, CSW,
Executive Director.

[Enclosures.]

ACTIVATE—DON'T VEGETATE

Activate—Don't Vegetate is the watchword at the North Carolina Jewish Home at Clemmons. This slogan and its implementation have created an at-

mosphere of belonging, developing and enjoying the life ahead for many who can no longer live a proper life in the outside community. It is believed imperative to keep the resident/patients occupied as well as develop in them feelings of well-being and usefulness. The difference in a facility with full blown activities and therapeutic programs and one that does not have such programs can be likened to the differences between human beings in the average ways of life and derelicts in a weed filled vegetable garden.

It is needless to go into a long narrative in this regard but it is believed the development of a feeling of activity and usefulness together with a good preventive medicine program provides a feeling of well-being and happiness which in turn leads toward increased longevity—a longevity with a purpose instead of a rocking chair with an hour glass.

In an endeavor to share experiences, there is narrated herein some of the programs in practice at the North Carolina Jewish Home that have helped put more "Life into the Years" of those residing at that Home—a Combination Home (ECF and Home for the Aging).

To the uninitiated these programs should prove innovative—to the initiated they may prove to be "old hat"; nevertheless, they have proved successful in practice at a facility where it is believed a happy atmosphere exists and there is minimum of "turnover" as related to other facilities according to national statistical information relating to inpatient care in long term care facilities. (The present average age at the North Carolina Jewish Home is 83+ years. The average patient has 4 to 6 chronic ailments.)

GROUP THERAPY

There are four major types of group therapy used at the Home: Reality Orientation, Remotivation, Resocialization and Advanced Group Therapy. Under these headings there are sub-types such as music therapy, work therapy and other motivating and maintenance therapeutic projects.

Reality Orientation.—Reality Orientation is a technique used for the most regressed and brain damaged residents. A worker meets every day with a group of four or five residents. With the help of a Reality Orientation Board consisting of the name of the Home, the date, the weather, next meal, etc. The residents relearn information they have forgotten. Many residents who have not spoken for many months begin to speak again through this technique. The technique is based upon the theory that there is some usable portion of the brain intact even in a severely brain damaged person. There is continuity and follow-up throughout the day with other staff members who try to develop and maintain contact with the resident.

Results: The Home has had excellent results with this technique. Almost all residents involved have improved to some extent. Many have shown vast improvement.

Remotivation.—Remotivation is used for confused residents who are not regressed to the point of needing Reality Orientation. This type of group therapy aims at people who are vegetative—not taking part in programs, and therefore becoming more confused and isolated.

In a remotivation session six to eight residents listen to a story or some music. Afterwards, they are asked about the stimuli. Sometimes a subject will prove interesting to a given resident and he will begin to speak about it.

Results: There has been increased interest in other programs through this type of group therapy. The purpose of the Therapy is to remotivate residents to participate in programs and therefore become more interested in their surroundings and life in general.

Resocialization.—After a resident completes a course in remotivation he can move into a resocialization group. The purpose of this type of group therapy is to increase socialization with the other residents. Although a person might become motivated to participate, he still might be isolated from the others and not communicate with anyone. The weekly *service project* at the Home serves as a resocialization project. This project consists of making bandages for the Cancer Society and Leprosarium, making lap robes and toys for other charitable sources. During the session the residents must ask each other for materials to work with; thus conversations are stimulated. The staff remains in the background during these group meetings.

The Residents' Club is also a form of resocialization. The president of the club is a resident and he presides at the meeting. He tries to stimulate discussions

concerning the Home. Each member contributes a token dues at each monthly meeting. The money is used for special occasion gifts or it is given to charities from time to time. The Residents' Club is also a sounding board for any problems that arise among the residents. They occasionally meet with other peer groups from the community and from other Homes.

Results: The residents become aware of the needs and problems of others. They become more open-minded, find people who share the same problems; hence, solve some of their own problems. Most important, they become productive members of the Home and general community, interested in programs and most important—others.

The Social Hour.—Every day from 4:30 to 5:30 p.m. a social hour takes place near the dining area. A resident bartender serves sherry and other wines to those residents who wish a before dinner drink.

There is a 2-fold purpose for this activity. 1. The residents are able to get together and talk about the day's events. 2. The wine is medically approved as a "tonic" to increase circulation and stimulate the appetite.

The Cocktail Party.—A cocktail party is given for the residents about every 5 to 6 weeks. The reason for the party, from a therapeutic point of view, is that the party atmosphere encourages socialization.

The residents choose from an assortment of mixed drinks and hors d'oeuvres. They listen to music or sing songs and sometimes dance. Many times a community group provides entertainment during this event thus creating a "night club" atmosphere.

The cocktail party is in keeping with the philosophy of the Home. The residents are not infantilized. They are encouraged to do as much as they can in a way in which they are accustomed in earlier life. Most of the residents enjoyed cocktail parties and other social events prior to entering the Home. There is little reason for these activities to stop on admission. This is an activity the majority of the occupants look forward to—the social event of the season where most voluntarily dress and primp for the occasion.

Advanced Group Therapy.—The advanced group is for those residents who have minimum confusion and demand a more stimulating type of activity. The group is called the *Current Events Club.* Each week a different member of the group brings a topic for discussion. The topics range from politics to art with heated discussions developing from time to time among those in attendance.

Result: The residents keep abreast of what's happening in the world. They keep their minds alert through debates. During the week they read more, listen to more radio, etc., in order to prepare for the club meeting; thus developing a chain of events or activities that stimulate their life throughout the week.

Occupational Therapy.—Since the Home employs a Registered Occupational Therapist and an Occupational Therapy Assistant, the occupational therapy program is quite comprehensive. Each resident is involved in some type of occupational therapy or craftwork. Even the most regressed are worked with on a one-to-one basis. If necessary, projects for the latter are developed on the "floor".

The occupational therapy room serves as a therapeutic environment for those who need special therapy and a social and work environment for those who need minimum supervision.

The crafts made in the shop have won many awards at Fairs and Craft Shows in the area, providing stimuli for more and better products. The residents also participate in the receipt from sales of any of their products. This above is proof of usefulness, an incentive to keep active.

EDUCATIONAL AND RECREATIONAL THERAPY

Besides the regular program of games, there are two games played that would be considered innovative: *Questions and Answers* and *Concentration.*

Questions and Answers is a mind building game. It is a team game geared toward the more adequate resident. The team member chooses a question from a board which has different categories with four questions in each category. The categories range from current events to art and music. If he feels he can answer a difficult question, he can pick the 20 point one. If he feels he can only answer an easy one, he can pick the 5 point one. The team with the most points wins.

Results: The game sparks competition between teams. The individual people must really put their "thinking caps" on for some of the questions. Everyone benefits because if no one knows the answer—the group worker provides the answer and everyone learns something new. The game is stimulating and educational.

Concentration can be played with moderately confused residents. As a person ages, the remote memory often stays intact but recent memory is often impaired. Concentration helps stimulate the recent memory. It is played very much like the T.V. game of the same name.

Because this game is played for tokens, the player tries harder to remember and match the cards on the board. The recent memory can become stimulated and active through "game or play therapy".

News Letter.—The "Home News" is published bi-monthly by the residents. They have several meetings concerning the paper, deciding which events should be included. The residents who are able to write, submit articles. Others can dictate their thoughts to someone who can write.

The newsletter is therefore a reflection of the resident's views. It is not a professional paper written by the staff.

WORK PROJECTS

Wherever possible, the residents are involved in the workings of the Home in such activities as mail delivery, garden tending, bird feeding, visitor tours, receptionists for special events, hobby shop and gift shop sales, etc. An appropriate "salary" is provided for certain routine services.

There have also been "farming" projects under supervision and with the help of staff. The "fruits" of the residents' labor have proved most rewarding on the sideboard and in the dining halls. The satisfaction of seeing one's own produce being used productively is an additional reward.

SPECIAL OUTINGS

There are many special outings during the year. They include Fairs, Theater Parties, Shopping Trips, tours of various manufacturing plants and other points of interest.

Since the Home has developed a van which can transport wheelchair residents, almost everyone can be included in these outings.

We emphasize that the programs listed above are only a small sample of many projects that are ongoing at the North Carolina Jewish Home. The deterrent to activity programs is the *lack* of imagination, *lack* of perseverance, *lack* of initiative and *lack* of follow through by the professional worker. It must be pointed out that well indoctrinated volunteers and sub-professional staff can do a tremendous job in this area of activity provided there is good supervision and continuity of programming. We must always remember a good patient care plan includes, with TLC, a means to "Activate and not Vegetate".

LUTHERAN SOCIAL SERVICES OF NORTHERN CALIFORNIA,
San Francisco, December 22, 1971.

DEAR SENATOR MOSS: In response to your request for information on innovative programs of care and services provided for the aged by long term care facilities, I submit the following:

A. AT ROHLFFS MEMORIAL MANOR

A housing facility for the aged, who are capable of independent living, is located in Napa, California and provides 100 apartments for 112 residents. The garden apartments are ground level and each have a patio area and front entrance and adjacent parking spaces. A central office, recreation area, library facility is within easy walking distance.

(1) Regular bus service for shopping, church attendance and recreational activities is provided.

(2) A monthly afternoon gathering "Birthday Party" is held in the recreation room for all the residents. Coffee and cake are served; games and a program are enjoyed.

A monthly potluck dinner open to all residents is held. Favorite dishes are prepared and shared with fellow residents.

(3) Weekly religious services are conducted for the residents in the recreation room. A social hour is held after the services.

They also have an afternoon quarterly newcomers gathering to introduce new residents with coffee and cake.

(4) The women residents have a sewing club that meets weekly in the recreation room. An annual boutique allows display and sale of the items so carefully made.

(5) An annual Christmas Party is held—a gala event.

(6) A newly formed Men's Group meets weekly to discuss common concerns of "the minority" (only 18 men residents out of 112). A woodworking shop and an indoor shuffle board are current requests of this group. Some lively pool games have been held since these men became acquainted and found others with a similar interest. Perhaps a pool tournament can be planned!

(7) Social work service is available to each resident. A total resident visitation was conducted by the social work staff to acquaint residents with social services and how they may be obtained. This was also a case finding program and ongoing service has been given to some residents by social workers as a result of this visitation.

(8) Social workers interview each applicant for residence. Information from the application form and the interview is used to complete an evaluation form which determines the applicant's position on the waiting list through a points system. This assures equitable handling of each application.

(9) A telephone reassurance program for residents has been initiated. Since there were more volunteers recruited to make phone calls to residents, the service is now being offered to the larger community.

(10) A Meals on Wheels demonstration dinner was served to the residents to introduce them to the program and determine whether or not there is interest sufficient to support a program. It was learned that the residents prefer to cook their own meals, so this program will not be initiated.

(11) A series of health care lectures is being presented to acquaint the residents with available health care facilities in the community and how these facilities can be used to greatest advantage in order to achieve an independent living status as soon as possible after a major illness or hospitalization. The Medicare and Medicaid programs are also being discussed.

(12) Social work staff is available as ombudsmen on behalf of residents who have difficulty with Social Security, Old Age Security or similar bureaucratic systems.

B. IN SAN FRANCISCO—MISSION AREA

Social workers provide direct and indirect services to aged in San Francisco, with an emphasis on the Mission District of the city. This area has a high concentration of aged with 1,690 persons receiving Old Age Security.

1. Services are given to help in housing needs—relocating to another apartment, a residential care home or a nursing home depending on need.

2. Every effort is made to help aged remain in their own homes through enlisting homemaker services, home health aides, visiting nursing services, Meals on Wheels, friendly visitor services and any other service available to help maintain or restore independence.

3. Many aged live in old poorly equipped hotels where rents are less expensive but facilities are poor. A reaching out program to find the aged in these hotels and to explore, with them, the needs they may have has been initiated. Small group meetings of these residents have been requested by them.

4. A drop-in center, where comfortable furniture, a coffee pot and opportunity for companionship with other "Oldsters and youngsters", is one plan in the discussion period. The center would be staffed by volunteers, most of them aged themselves and a staff person to be available to the more seriously troubled. It is anticipated that problems ranging from Social Security questions to deep psychological difficulties may be reached through a center of this type.

5. Direct financial aid, food and clothing, is available when no other resource can be used. For example, payments for medicines not covered by Medicare or Medicaid; or help with rent can be given in emergency situations.

6. Help with obtaining legal services is given.

7. Whenever possible, our staff cooperates with and provides information for class action suits on behalf of the aged. Recently, the visible labeling and dating of dairy products by supermarket chains was effected through such a suit.

We hope that the above data will be of assistance to you in preparation of your report to Congress. If additional information is needed, please feel free to contact us.

Sincerely,

(Mrs.) RUTH SAMIEE,
ACSW, Director of Social Services.

HEBREW HOME OF GREATER WASHINGTON,
Rockville, Md., December 23, 1971.

DEAR SENATOR MOSS: Thank you for your interest in nursing home problems. You have requested descriptions of positive nursing home programs. The Hebrew Home of Greater Washington is proud of its many innovative approaches and is happy to share its experiences with you and your Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging.

1. GROUP THERAPY FOR KEY STAFF

Dr. Jack Baruch of N.I.M.H. has been conducting weekly group therapy sessions with key staff with the goals of facilitating communication and understanding among staff members, and increasing understanding of residents' needs. Staff members have been able to see themselves as part of a group or team rather than a nurse, a physical therapist, a kitchen manager, etc., resulting in better agreement among key staff on goals and philosophy. Dr. Baruch is writing a paper on this experience and will send it to you when it is completed.

2. WEEKLY GROUP THERAPY MEETINGS LED BY NURSING STAFF WITH RESIDENTS AND UNIT STAFF

Supervising nurses on each 33-bed unit have been trained by Dr. Baruch to be group therapists. They have led weekly group sessions with residents and staff of their unit. Interpersonal problems, complaints, misunderstandings, feelings are discussed openly. Such topics as fear of death, sex drives in the elderly, problems of group living, are explored. Residents have used these meetings to suggest new programs in the Home such as holding monthly hot dog and beer parties and purchasing game equipment. Children of residents are invited to join the group once a month.

3. THE RESIDENTS COUNCIL

Each 33-bed wing of the Hebrew Home has selected two residents as representatives to the Residents Council which has a social worker as staff advisor. At their bi-weekly meetings, Residents ask their representatives to bring up problems of food service, housekeeping problems, etc., and they suggest better, more economical ways of managing the Home. As much as possible, resident recommendations are implemented. Morale in the Home has improved noticeably since the inception of the Resident Council.

4. FAMILY MEETINGS

Families are invited to several meetings a year at which specific programs of the Home are discussed, and families are given the opportunity to ask questions of the staff and to make suggestions for better care. These meetings have benefited family members by relieving their guilt, giving them a feeling of being involved in their parent's care, and informing them of ways in which they can help in their relatives' care. They have benefited the staff by giving staff more insight into the feelings of family members. Many suggestions coming out of these meetings have been worthwhile.

5. CLOTHING SHOPS

A ladies' dress shop and a men's clothing shop have been set up in the Home, stocked with clean, good used clothing donated by people in the community. Residents enjoy the opportunity of making purchases (the highest price for any article is $1.00) and even the most mentally deteriorated residents have been found to be interested in making selections of color, material, etc. This program is a therapeutic tool and has also had the result of residents taking more pride in their appearance. Residents assist as salespeople, stock clerks, etc., and those who had worked in clothing shops in their earlier lives have been particularly interested in continuing in their careers.

6. ICE CREAM PARLOR

Residents and volunteers manage an ice cream parlor which is open every afternoon in the Home. Residents can treat their guests, and can enjoy the con-

genial atmosphere over a cup of coffee. Most of the resident-managers had operated restaurants in their younger days and enjoy using their expertise in this field. Coffee, tea and ice cream comprise the simple but adequate menu. Together, the dress shop, men's shop, barber shop and beauty shop, the gift shop, the coffee shop, serve as a "downtown" area in the Home where residents can go for a change of scene.

7. RESIDENT VOLUNTEERS

Residents are used as volunteers in many capacities in the Home. A former postman delivers the mail. Many residents participate in a bandage wrapping program. Several men enjoy helping set up the tables for breakfast. One gentleman wheels around a cart of candy and small toilet articles which he sells for the Home. Residents man an information desk. Residents take the responsibility of daily calling sick residents who are in the hospital. Other residents take the responsibility of taking newcomers under their wing for the first few weeks. There is a sewing circle of women residents who do simple mending for those who cannot perform this task for themselves.

8. ENTERTAINMENT PLANNING COMMITTEE

A Resident Planning Committee initiates and creates several entertainment programs a months. They have put on original plays, have thought of and carried out contest programs such as, "Who Can Tell the Best Story of a Miracle That Happened to Them," a dance contest, and other entertainment. Instead of entertainment being "put on" for residents, it has proved to be much more meaningful for residents to do some of their own planning.

9. ADULT EDUCATION COURSE

A course of study has been created, using film strips created for and borrowed from the Jewish School system. This has proved to be one of the best attended programs in the Home. When people are learning new material, they are growing and not deteriorating. Their lives are expanding and not contracting. After each course is completed, participants will receive "diplomas" to add to the feeling of achievement.

10. PREADMISSION AND POSTADMISSION CONFERENCES

In addition to the usual admission procedures, the Home has instituted a conference a few days before admission with key personnel and all staff members who will be working with a new resident. Each department which has information about the new resident contributes its information. The resident's family then joins the meeting and gives as much pertinent information as possible about their parent's likes, dislikes, personality, interests. Then the new resident joins the meeting and the group has an opportunity to get a feeling of what this person will be like. After the prospective resident and his family have left the meeting, the staff discusses a treatment plan and each department tries to determine a plan of action.

Two or three months after the resident's admission, the same group meets again to investigate how successful the resident's adjustment has been. The resident's family again joins the meeting and is asked to comment on how the Home has met its expectations and the resident himself is encouraged to complain, suggest, criticize. The staff also has an opportunity to tell the resident and his family what more is expected of them.

These meetings have resulted in much better adjustments to the Home and a noticeable drop in mortality rate, as well as preventing deterioration after admission.

11. MONTHLY MEETINGS OF KEY STAFF OF ALL THREE SHIFTS

Each month, key staff of all departments and all shifts meet with the Executive Director, Medical Director and President of the Board of Directors at 10:30 P.M., to facilitate communication between shifts and to eliminate problem areas. These meetings have resulted in better patient care.

12. SPECIAL CARE FOR THE MENTALLY DETERIORATED AGED RESIDENT

The Home has studied the literature on the multitude of programs for the mentally deteriorated aged person, and has adopted an eclectic approach, using parts

of most of these programs. Many other nursing homes have adopted one specific program or another such as Remotivation Therapy or Reality Orientation, but the Hebrew Home of Greater Washington has found that using a many-faceted approach has greater success with more people. Thus, elements of Remotivation Therapy, Reality Orientation, Sensory Training, Milieu Therapy, Activity Programs, Film strip Education, have been combined together with decorating the ward with bright pictures, supplying the residents with attractive colorful clothing, putting parallel bars on the ward for frequent exercise and many other similar efforts.

13. ADOPT-A-GRANDPARENT

Families in the community have been encouraged to volunteer to "adopt" a resident with no family. They take residents to their homes for an afternoon; the children of the family are encouraged to treat this person as a grandparent; make and present gifts, tell stories, etc.

14. MUSIC THERAPY

Residents who have aphasia have responded to volunteers who sit with them and play recorded music for them. This is done on a one-to-one basis. Since no response is demanded, the person with aphasia can be relaxed in a social situation which is usually not possible for them.

15. TEENAGE VOLUNTEERS

Youngsters as young as 13 years old have been encouraged to volunteer to feed handicapped people or wheel them to activities. Some neighborhood parochial schools have sent classes of young teenagers to feed "mentally deteriorated" residents at the lunch hour to the benefit of residents, staff and volunteers.

16. IN SERVICE TRAINING PROGRAM

All new staff are oriented as to policies, philosophies and practices of the Hebrew Home of Greater Washington by an In-Service Training Director. An active, ongoing In-Service Training program consists of films and lectures by consultant physicians and pharmacists in which nursing staff on all levels attend.

These are some of the programs which have been successful in the Hebrew Home of Greater Washington. We would be most happy to have you and the other members of your Subcommittee visit the Hebrew Home of Greater Washington in Rockville, Maryland, if you are interested in a first-hand look at any or all of these programs. Please feel free to contact me for more detailed information on any program, and for an appointment to visit our Home.

Very truly yours,

SAMUEL ROBERTS,
Executive Director.

LUTHERAN SOCIAL SERVICES,
Harrisburg, Pa., December 16, 1971.

DEAR SENATOR MOSS: It is with a great deal of pleasure that I respond to your recent letter for information regarding activities in nursing Homes. Below are listed a few activities which take place in our Lutheran Homes:

I. A RESIDENTS' COUNCIL

The concept of a residents' group was introduced to the residents of the Lutheran Homes in January, 1970. The objectives of the plan were: (1) to improve the quality of Home Life; (2) to make recommendations to the administrative staff (Home Administrators, Executive Director, Board of Directors); and (3) to involve residents more completely in operating the Home and thus to develop a more independent way of living. The social worker is the only staff member at the meetings. Before the concept was introduced to the residents, it was shared with the staff; otherwise, they could have felt very threatened by residents' criticism.

The first meeting was well attended, but the residents made it very clear that they did not want to take any responsibility for "running the Home". They had entered the Home to be rid of responsibility. They liked the idea of meeting once a month. Many gripes were aired at the first meeting, but as the meetings progressed, the residents were more constructive in their criticism. Chairmen

were appointed for music, devotions, maintenance and food. The chairman and the social worker then met with the personnel of the Home who was responsible for the function that the residents wanted to change. For example, moving a bulletin board that was hung in an area where traffic was congested, putting a railing under it, wanting a box for outgoing mail, requests for favorite foods, etc. When suggestions could be carried out, they were accomplished; when the request could not be followed through, an explanation was given.

The residents became more verbal and looked forward to the monthly meetings, which have been well attended. They recognize that they have rights and that their participation is welcomed by the administration. As one resident said, "We can keep our dirty wash within the family".

The residents' council has been a good vehicle to introduce any subject when we want to know what the residents are thinking. The responses of the residents are listened to in formulating policy.

A residents' group was started in the Lutheran Home in Millersburg a year ago. One of the residents who wants and needs responsibility has been a leader in this group. The tone of the meetings in this Home are entirely different, the group likes entertainment and some of the elderly people from the town have come to the programs that the Residents' Council has planned.

Seeing the difference in these two groups, both made up of people living in institutional settings, I am convinced that an opportunity must be created for residents to be heard. In our Homes, the residents' council has been effective.

II. A TEAM ON INSTITUTIONAL SERVICES

The Home Administrator, the Social Worker, and the executive director of a multi-service agency for the aging meet monthly to coordinate the activity in the Homes with admission of new residents; as well as evaluating residents and their need for family involvement, recreation and staff services. These conferences enable all of us to keep roles clear, prevent duplication of staff function and provide a high level of care for the aging.

III. SERVICES TO THE COMMUNITY

The Home has become a center for the development of community services to the aging. Meals on Wheels are served from the Home to aging in the community, one resident teaches piano to children in the area, and day care is provided to a limited number of aging in the community. We are presently involved in trying to bring together representatives from all the agencies and Homes serving the aging in our community so we might try to present a united front with each agency serving as a spoke in a wheel of service.

I hope this is helpful to you, and I extend my personal appreciation to you for your interest in our aging.

Respectfully,

L. DAVID BOLLINGER,
ACSW, Executive Director.

THE CITY OF NEW YORK,
DEPARTMENT OF SOCIAL SERVICES,
Neponsit, N.Y.

NEPONSIT HOME FOR THE AGED—1961–71

General Background.—The Neponsit Home for the Aged, the only institution of its type operated by the City of New York, will celebrate its tenth anniversary in 1971. All other homes for the aged in the City are operated under private, non-profit or religious auspices.

Neponsit is located directly on the Atlantic Ocean at 149–25 Rockaway Beach Boulevard, Neponsit, N.Y., overlooking the end of Riis Park. Until 1959 the buildings housed a Coast Guard Hospital. They were acquired by the City as the site for a home for the aged through the efforts of then City Council President Abe Stark and the first residents were admitted in August, 1961.

Operated by the Bureau of Special Services of the New York City Department of Social Services under statutory provisions of the State of New York, Neponsit provides residential care for elderly men and women who are unable to remain in the community, but do not require constant supervision or continuing medical care.

With accommodations in 173 single and 31 double rooms in two residence buildings, the Home is now fully occupied with 235 residents, ages 65 to 102, including two married couples. Since 1961, 806 elderly men and women have lived at Neponsit.

Admission.—A 65-year minimum age requirement has been established for admission, which is limited to residents of New York City. Although applicants must be ambulatory and not in need of continuing medical care, persons needing daily medication, such as for diabetes, are not excluded. Applicants are evaluated in terms of the health of the applicant and his ability to adopt to group living.

Costs.—The full 1971 fee of $735.00 per month per resident for those able to pay is set annually by the State of New York based on current operation costs. In 1970, it was $636.00 per month, in 1969, $476.00 per month. Persons receiving only Social Security, pensions, Old Age Assistance or Aid to the Disabled, and unable to pay the full amount may also be accepted for the Neponsit Home. Such payments are applied to the total charge and the balance is supplied from Federal, State and City funds.

Staffing.—There are now 231 full-time employees, in addition to part-time medical staff, podiatrists, physicians and a dentist. These include administrative, social service and clerical staff, institutional aides, maintenance, stores and dietary staff.

Medical Facilities.—There is a nursing staff of twenty-seven, including registered nurses, practical nurses and nurse's aides, in a medical section which provides complete medical and nursing services, including medical examination, dental services, podiatry and physical therapy. Pharmacy, opthalmological, laboratory and X-ray services are also available. A nineteen bed infirmary, on one floor, provides care for minor or temporary illnesses. Residents with serious illnesses are transferred to a local hospital and readmitted upon full recovery.

Religious Services.—There are Catholic, Protestant and Jewish chapels which provide residents with opportunities for religious observance under the guidance of staff chaplains of their respective faiths.

Recreational Facilities.—The recreation building contains a large social hall and an auditorium for weekly bingo games, movies, monthly birthday parties, holiday observances and other special occasion events. Sixteen, Queens and Long Island organizations, regularly volunteer their services as sponsors of a wide variety of special programs. As a part of the Tenth Anniversary Program, a permanent plaque, listing the names of these organizations, was dedicated on May 18th, 1971.

A well-stocked library, color television sets in the sun rooms and game rooms for billiards, cards, checkers, etc. are also available. One popular activity is the arts and crafts program, with staff instructors to help with ceramics, sewing, knitting, leather craft, jewelry making and other hobbies. The recreation staff also includes part-time painting and music specialists. A fully equipped beauty parlor and a separate barber shop are also at the disposal of residents.

Outdoor facilities include shuffleboard courts, checker and chess tables, gardens, a new boardwalk along the beach with benches for residents to enjoy the ocean air and a private picnic park.

SPECIAL PROJECTS

Grandma's Boutique—(The name was chosen by the residents), has been set up on a permanent basis as a small shop where residents can leave their arts and crafts for sale to other residents and visitors. Nearly twenty different types of handicrafts—gloves, scarfs, beadwork, ceramics, etc.—are now on display.

Art Gallery-On-The-Ramp.—The bridge between the two residences has been turned into a gallery for special exhibits or the display of paintings by residents. A special Tenth Anniversary Exhibit from May 1971 to December 1971, "The Faces of Age," contrasts the faces of Neponsit residents as photographed by professional photographer John Ebstal with the faces of older people in reproductions of master painters of the Fifteenth and Sixteenth Centuries. The photographs and reproductions were chosen and arranged by Albert Bosco, art teacher at Neponsit Home.

1971 VOLUNTEER ORGANIZATIONS PROVIDE PROGRAM ASSISTANCE AT NEPONSIT HOME

American Association of Retired Persons (AARP).
American Irish Drum Corps.
Belle Harbor Garden Club.
B'nai Brith Equality Chapter.

Dalsimer Florist.
Girl Scounts of America—Rockaway Council.
Girl Scout Troops #4 and #748.
Jewish War Veterans—South Shore Post #261.
Pandora Temple—Pythian Sisters.
Rockaway Rotary Wives.
St. Camillus Band of Rockaway Beach.
Salvation Army.
Shore Garden Club.
Temple Hillel Sisterhood.
Veterans of Foreign War Ladies Auxiliary—John McLaughlin Post #8540.
West End Temple Sinai Congregation—Youth Activities.
YM–YWHA Senior Adult Activities Division—Hartman Y.

THE A. M. MCGREGOR HOME,
East Cleveland, Ohio, January 4, 1972.

DEAR SENATOR MOSS: This is a belated reply to your request to Frank Zelenka for examples of innovative programs in homes for aging. We do not claim much in the way of inovation, but some of the following aspects of our operation may be of interest.

Since ours is a life-care home, we spend considerable time on preparation for admission and orientation of a new resident. Before final acceptance, each applicant for admission spends twenty-four hours as a guest in the Home, with a resident serving as host or hostess. This provides an opportunity for two-way observation and evaluation. Following acceptance, the Home's social workers and executive housekeeper visit the prospective resident in his home to discuss furnishing of his room and details of the move. A copy of "McGregor Manners", our handbook for residents, is usually given at this time, and entries are started on our orientation checklist for new residents. This list is completed by various department heads as soon as is practical following entrance.

In order to foster a feeling of responsibility and belonging, each resident is required to perform some duty for the Home in line with his own physical capabilities. In addition to assigned duties, we encourage and provide the opportunities for residents to donate time and services to others—both in and outside the Home. Able-bodied members volunteer their services to nursing patients, writing letters and performing various other tasks. "Working parties" are recruited by our recreation director to perform such services as filling comfort kits for new patients in the nursing care section; making favors for tables for special holidays; making and filling Christmas stockings for each patient in a large county rehabilitation hospital, as well as for our own nursing care patients; making and filling bags of candy or other small favors to pass out to large numbers of children presenting Christmas programs at the Home. Many hundreds of diapers have been hemmed and bandages rolled for one of the local hospitals, and cancer dressings are made for the Cancer Society. Dolls have been dressed for Salvation Army Christmas giving. Residents sew and mend for the Home as well as for incapacitated residents. All of the table napkins for approximately 100 members are ironed regularly by resident volunteers. A small store, carrying stationery supplies, sundries and inexpensive gift novelties for sale to residents, is manned by residents themselves. A resident also operates the soda fountain which is open on Saturday evenings.

Recreational activities include programs presented by outside groups, movies, bingo games, special parties, but trips to various points of interest, pool table, talking book group, choral group, rhythm band (playing many outside engagements), "armchair exercize" class, folk dancing class.

More strenuous physical exercize is provided by four adult tricycles. This activity was sponsored by our doctor who persuaded some of his friends to donate the tricycles to the Home. Residents ride outside during the summer months. In winter, the vehicles are put up on blocks inside, providing an opportunity for exercize by pedalling in place. Our doctor also talked another friend—a cement contractor—into pouring a shuffleboard court for residents' use.

Space is alloted and the ground prepared in the spring by our gardener for individual gardens for those who wish them. Residents are also encouraged to pick flowers from the Home gardens for their own use. Picking and arranging flowers for offices and public rooms is a duty assigned to a resident.

Water color lessons for those interested have been a part of our program for a number of years. This year a new beginners class was started and members from a neighborhood senior citizens group invited to participate. Painting from both beginners and advanced classes are framed and displayed on specially lighted panel boards in the main corridor of the Home.

A large lighted china cabinet with glass shelves provides a showcase for residents' "treasures". Our consultant dietitian, who doubles as the painting instructor, arranges a new display each month featuring items collected from residents in a selected area of the building.

In our nursing unit, nurse aides are included when the change of shift report is given, and also in a monthly nursing staff meeting so that they can be aware of individual nursing care plans and so that their observations and suggestions can be heard.

At Christmas time, nurse aides have a "wrapping party" when they wrap special gifts for the annual patients' Christmas party. Patients are also wheeled or escorted throughout the building to see the decorations which have been put up by committees of residents. During the summer, patients are taken outside into a courtyard whenever weather permits. Any patients who wish to attend are escorted to Sunday afternoon church services which are conducted at the Home by ministers from neighboring churches.

Supervision and/or instruction is available in our craft shop five days a week. However, the shop is always open so that those who wish may work on their projects in evenings and on weekends.

In addition to regular medical care, the Home provides on the premises dental, eye and foot care on a weekly basis. A hearing conservation program, using the services of the local hearing and speech center, includes weekly visits by an audiologist who conducts lipreading classes, provides individual counselling for wearers of hearing aids, performs hearing tests and refers residents to the hearing center for further testing and evaluation regarding hearing aids.

In the interest of good grooming and maintenance of morale, the Home subsidizes the operation of a beauty shop. Two full-time beauticians are on the payroll and all services are furnished at a nominal charge to the resident. Particular attention is paid to nursing care patients and sufficient time allotted for regular hair and nail care for all patients.

An adjunct to our Home operation is our "Outside Aid" program through which we provide financial assistance to a number of individuals living in the community. Casework service for this program is purchased from a local agency which provides a wide range of services to the elderly. Through this program many people are enabled to remain in their own homes, who might otherwise be forced into institutions against their wishes. In addition to financial assistance, casework counselling is available to help with everyday problems and with new living plans if a change becomes necessary.

I hope some of the above will be helpful to you.

Sincerely yours,

(Mrs. W. B.) Louise W. Crane,
Executive Director.

Good Shepherd Geriatric Center,
Mason City, Iowa, January 5, 1972.

Dear Senator Moss: In response to a Memo from Frank G. Zelenka of American Association of Homes For The Aging, enclosing a copy of your letter to him requesting information on activities, programming, etc., in nursing homes and extended care facilities, please find enclosed an outline of what we call our "Program for the Whole Man Concept."

Also enclosed is a brochure describing our four facilities.* We hope they will be of some help to you in your work as Chairman of the Subcommittee on Long-Term Care.

Sincerely,

O. L. Holleque,
Executive Director.

*Retained in committee files.

[Enclosures]

GOOD SHEPHERD'S PROGRAM FOR THE WHOLE MAN CONCEPT

"For an environment of professional care with personal concern"

I. THE BODY—MEDICAL AND/OR PHYSICAL

A. Nursing care plans for each patient on his/her bed.
B. Team nursing by area with daily nurse conferences.
C. Personal visiting by dietitian to patients re food preferences.
D. Physical Therapy.
1. Home follow up visits as needed for discharged residents.
2. Homebound visitation therapy program.
E. Multiple structured levels of care.
1. Ordinary nursing care.
2. Extended nursing care and rehabilitation.
3. Independent apartment living.
F. Patient Trust Account established for each resident by the business office which acts as a bank holding "spend" money. Cash for small amounts and checks for major amounts are issued on patient request from their account.

II. THE MIND—SOCIAL AND RECREATIONAL

A. Small groups.
1. For remotivation—groups of 6 to 10 meet regularly in discussions to stimulate involvement and social interaction.
2. For environmental adaptation of the senile, regressed, and disoriented—small groups meet for simple games, singing, simple crafts, and readings.
3. Residents Relations Committee—a combination of selected residents, staff, and auxiliary to get feedback on patient interests and to welcome new residents.
B. Crafts.
1. Men's woodworking group with special adaptations according to the handicap.
2. Ladies' group.
(*a*) Short term projects—i.e., tray favors.
(*b*) Long term projects—for the Center, for personal use, or for sales.
3. Individual crafts in patient rooms.
4. Sales service for craft products.
C. Special Events.
1. Annual "County Fair" and bazaar in which all residents participate.
2. Parties—Halloween, Christmas, and monthly birthday observances.
3. Outings—Fall leaf tour, Christmas light tour, etc.—every resident encouraged to get out in the community, whenever possible.
D. Programs—varied types of programs are brought in twice each week for resident enjoyment.
E. Volunteers.
1. Auxiliary—helps program department in all official recreational and craft activities; also acts as liaison with and recruits new volunteers from the 14 churches owning the corporation.
2. Red Cross—perform direct personal services for residents; such as, reading, writing letters, visiting, and shopping.
3. Red Cross Youth—teenagers who assist nursing staff with some basic care and help program staff with special events.
F. Miscellaneous.
1. Shalom Tower apartment residents bring refreshments to the Health Center patients each day.
2. Tray and table decorations and personal favors provided for dining.
3. Home like atmosphere fostered with the patient allowed to retain his favorite possessions.

III. THE SPIRIT

A. Chapel Services (non denominational) during each week and on Sunday.
B. Bedside communion.
C. Local or home churches contacted to provide spiritual help.

THE HOME FOR AGED BAPTISTS, INC.,
Ironton, Mo., December 3, 1971.

DEAR MR. MOSS: We have been asked by Mr. Frank Zelenka of American Association of Homes for the Aging to write to you concerning what might be innovative approaches to providing for the aging in our program.

In our ministry to the aged we consider four areas of need: Physical, Spiritual, Emotional, and Social. Our doctor and staff of nurses provide the physical care which we think is as good as any, but perhaps no better than many; and in this area there is perhaps not much that is innovative.

To help meet the spiritual needs, we have staff meetings each morning for a 15 minute devotion, and the staff is constantly reminded that "man shall not live by bread alone." We have a beautiful chapel to seat all who come comfortably with headphones for the hard of hearing, and parking space for those who come in wheel chairs. In the infirmary with 55 beds we have headphones so those who feel like doing so may hear the Chapel services and programs. We have an average of three outside groups visiting the Home for some type of program each week throughout the year. These range from movies to stage dramatics to plain Gospel preaching and singing. We have a full time chaplain on our staff.

The dining rooms are gaily decorated with tables seating four and six arranged for family style dining. Three times each day they all go to the dining room who are able, with as many as 40 sometimes going in wheel chairs. If a person is able to sit up long enough to be taken to the dining room in a wheel chair, he is gotten up, cleaned up, dressed up, and taken, where he can eat with everybody else. The fellowship on the way to and from and in the dining room is worth a great deal to the individual. A beauty shop is open five days a week where each lady gets a free shampoo and set every two weeks and a free permanent twice a year.

All types of handcraft provide useful activities. Residents of the Home set their own prices on all items and they are arranged in display fashion in the sales area. This generates a great deal of pride in their work and excellent therapy.

Because of a very long waiting list, about five years ago we instituted what we term our OUT PATIENT PROGRAM. In situations where there is dire need, and there are many; when we can't make room here we will help to find a place for the person in another Home. In this arrangement we assume certain responsibility for this person, and in many cases we are paying for his care monthly in the other Home. This keeps the very poor applicant from having to live in the very lowest grade nursing home. The Home for Aged Baptists is supported by the Missouri Baptist Convention, and receives no public assistance at all; but the Home receives people whether they have money or not, and in addition is helping to pay for the care of a great many who are living in other nursing Homes under our OUT PATIENT PROGRAM. In this arrangement, of course, the local Baptist Church in the area where the nursing home is located is asked to assume responsibility for the person's spiritual and social needs. This is a foster home type program using the better nursing homes instead of the private family home.

We certainly wish you well as you lead the Subcommittee toward a better program for the aging.

Very sincerely,

JOHN H. BURNEY,
Superintendent.

UNITED LUTHERAN PROGRAM FOR THE AGING, INC.,
Milwaukee, Wis., December 2, 1971.

DEAR SENATOR MOSS: Through the office of the American Association of Homes for the Aging, I have received your request for information on programs for the aging sponsored by non-profit homes for the aging. I appreciate the opportunity to respond and commend you for your interest.

The United Lutheran Program for the Aging, Inc. is an association of 41 Lutheran Church in America congregations in the Greater Milwaukee area. Ten years ago, after careful research and planning, the first project of a 100-bed skilled care home known as Luther Manor was constructed. This home was designed and programmed to meet the total needs of the aging resident and

instituted the social components of care typical of the voluntary approach in caring for the aging. The home filled rapidly and a long waiting list soon developed. To serve those elderly people who still lived in the community, several programs were introduced. Among these programs were the following:

(*a*) *Counseling and Referral.*—This is an ongoing program designed to help aging people and/or their families cope with some of the problems indigenous to elderly people. Through the Home's Social Service Department, people who call regarding admissions are assisted in finding alternate solutions to their problems. This may involve a private counseling, appointment with the Social Worker or a simple referral to another community resource. In making referrals to other resources, through prior arrangements with the resource, we are able to refer to a specific person at a specific telephone number. This personal referral overcomes much of the frustration experienced by people who otherwise might get transferred from one department to another until they finally reach the appropriate department or person.

A complete listing of quality commercial homes is kept up to date in order that the Social Worker can make direct referrals to the appropriate commercial nursing home when required.

(*b*) *Seminar for Clergyman.*—This program is designed to acquaint the clergyman, who is frequently involved with the problems of the elderly members of his congregation, with some basic understanding of the physical, social, and emotional aspects of aging. In addition, the clergymen are made aware of the variety of community resources available to help meet some of the needs of the elderly.

(*c*) *Discussion Meetings for Multiple Generation Families.*—These are small groups made up of elderly people and one or more members of their family who are invited to participate in an open discussion on the subject of the multiple generation family. Various life situations are presented in vignette fashion and commented on by the participants. The discussion is moderated by the Home's Social Worker. Through these discussions we have found that many elderly people and/or their families recognized or acknowledged problems and that there were solutions to these problems.

(*d*) *Educational Materials for the Elderly or Their Families.*—This program consists of a packet of material made available free, upon request to any person in the community. The packet contains helpful information regarding some of the practical, day to day situations encountered by elderly people and/or their families. Through the use of this material, many elderly people have been equipped to cope with their specific problem and even find it unnecessary to enter a home for the aging.

(*e*) *Senior Centers.*—In cooperation with local congregations located in areas containing large numbers of elderly people, eight Senior Centers have been established. Professional guidance is supplied through Luther Manor as is the initial equipment and supplies necessary to establish the Centers. Through these Centers, which are programmed to fit the needs of the participants, some 2000 individuals are being served. The Centers meet from one to three days per week, provide a hot meal, activities, educational and service opportunities and recreation. This has proven to be a low cost method of providing programs which are preventive and rehabilitative in nature to people who otherwise might seek placement in an institution.

These are a few of the approaches which our agency, the United Lutheran Program for the Aging, Inc. (Luther Manor) has utilized to help older people remain independent and in the community longer. I hope the information will be of some value to you and your committee.

Again, Senator Moss, I commend you and your committee for your long standing interest in the needs of the elderly citizen of this nation. I sincerely hope that you will secure the kind of information which will help you to develop the much needed national policy relative to the needs of the aging.

Sincerely,

Rev. WILLIAM H. TRUBY,
Administrator.

RIDGECREST RETIREMENT VILLAGE,
CHRISTIAN RETIREMENT HOMES, INC.,
Davenport, Iowa, December 6, 1971.

DEAR SENATOR MOSS: To assist you in preparation of your report to Congress, and for entry in the Committee Record, the following statement is furnished, describing the care program promulgated in our retirement facility:

"Ridgecrest Retirement Village is one of the newest and most complete retirement centers in the nation. It operates under a principle of independent living with supportive care available when and as needed. We offer retirement residency in a Christian environment to individuals 62 years of age and beyond. Residents pay an endowment fee, based on the size and type of apartment, and a monthly food and service fee. In return, we provide life-time residency, and the following services:

(*a*) Three meals per day (with special diet & tray service, as requested).
(*b*) Building janitor service.
(*c*) Air conditioning service.
(*d*) Heating service.
(*e*) Electric service.
(*f*) Shuttle bus service.
(*g*) Water service.
(*h*) Group Health Insurance (optional).
(*i*) Chaplain/Administrator services.
(*j*) Ten free days in infirmary per annum, with discounted rate thereafter.
(*k*) Emergency nursing service.
(*l*) Quad-City telephone service.
(*m*) Social-recreation services, on a voluntary participating basis.
(*n*) Bi-weekly house cleaning.
(*o*) Periodic maid service.
(*p*) Other special services, as approved by the Administrator.

Ridgecrest Retirement Village is owned and operated by Christian Retirement Homes, Inc., a local non-profit corporation. Board of Directors consists of approximately a 50–50 apportionment between Christian laymen and pastors from the Quad-Cities. Board members and officers serve without salary. There are no stock holders; nor does the corporation propose to operate at a profit.

Currently there are 126 apartments and a 47-bed Health Wing."

Sincerely,

JOHN W. KONING,
Administrator.

THE EPISCOPAL HOME FOR THE AGING
IN THE DIOCESE OF NORTH CAROLINA, INC.
St. Peter's Nursing Center, December 8, 1971.

DEAR MR. MOSS: Your letter to Mr. Frank G. Zelinka of the American Association of Homes for the Aging has been received. In support of your work in the field of aging, I am pleased to share the program and work of the Episcopal Home with your committee.

The Episcopal Home for the Aging of the Diocese of North Carolina program is provided in the combined facilities of the Penick Home (retirement) and the St. Peter's Center (skilled nursing) for 65 older people. The two sections share common staff, food service and social-craft-recreational activities. This unique blend of services and facilities seek to keep the person suffering from chronic illness and physical-mental debilities in the main streams of life, in place of being located in an isolated, sterile environment. The following is a list of special involvements to be noted:

1. The wheel chair and walker resident is encouraged to and provided with assistance in order to eat all meals in the main dining room of the home and to participate in the weekly bingo games, Sunday evening movies, daily morning Chapel, special musical events, weekly class of Adult Education, visit to the beauty parlor and sharing in the craft activities.

2. Electric wheel chairs are provided to people who are unable to walk, thus giving them a greater sense of independence and freedom.

3. Birthdays are recognized monthly in the dining room by placing the finest linen, china and glass on the special birthday table. A cake and appropriate recognitions are made.

4. The craft program is individualized to the person's need and interest. An instructor or a volunteer is made available to the resident, to aid her in the craft development.

5. Adult Education is being provided by the Sandhills Community College, Southern Pines, in the Home one night a week. The courses are taught for college credit and averages 25 residents (both retirement and nursing) per session. Students from the community also attend the classes.

6. Transportation is provided by the Home's chauffeur to the doctor, hospital, church, social and musical events in the community.

7. A resident council composed of representatives from retirement and nursing section, plan and carry out many resident activities and social events in the Home.

8. Volunteers—are an added asset to the Home's program. All ages—teen, adult and older adult-volunteer to assist in Bingo games, movies, parties and teas in addition to working with residents on personal needs such as letter writing, walks, visits and rides.

The Episcopal Home for Aging is open to any person regardless of his racial, creedal, religious or social background. The Home provides $40,000 annually in cash for charitable support of residents, and about $40,000 non-cash charitable support plus the physical plant. The basic monthly fee includes the total cost for all residents unless some extraordinary request is made, such as private duty nurses.

I trust that the above information will be helpful and encouraging to you and your committee.

Sincerely,

PHILIP S. BROWN,
Executive Director.

MARCOTTE NURSING HOME,
Lewiston, Maine, December 2, 1971.

DEAR MR. MOSS: The Marcotte Nursing Home is located at 100 Campus Ave., Lewiston, Maine, and is operated under the auspices of the Society of Sisters of Charity of St. Hyacinth, Canada.

It is a private, non-profit corporation operating for the purpose of caring for the elderly and chronically ill residents. It is our hope that the following description of the services offered at our home will make a slight contribution to your compilation of services and programs offered in non-profit institutions.

The full-time Social Activity Program of the home began a year and a half ago. This activity is returning exceptional rewards to the residents, who participate enthusiastically, and the administrative and staff personnel are seeing tangible results of the program's primary objectives.

These results are being measured in human accomplishments and not on entries on a ledger sheet. Residents who had difficulty filling their long days are experiencing that physical limitations can be turned into personal challenges. Despair that preys upon any convalescent, infirm or chronically ill person is a difficult problem to handle in health care facilities and its solution calls for the continued attention of a well-trained and sensitive personnel.

When the Marcotte Nursing Home initiated a full-time Social Activity Program, special care was taken in the selection of a dedicated professional. A Social Activity Director was named a year and a half ago and she fulfills all the requirements for this position. An assistant director joined the program about a year ago to assist her. A few weeks ago, a certified occupational therapy assistant, Sister Jeannine Beaudette was also added to the Program.

The center of activity for the program is the newly renovated auditorium on the second floor of the home. Residents come here daily for workshop projects of all kinds, for special musical or theatrical presentations, for coffee, tea and conversation and for meetings to plan some of the year's events, such as an annual foliage trip, special summer picnic outings (a new activity added this past summer) and the home's annual bazaar.

The following are illustrations of how successful the Social Activity Program has become.

One resident, a trained secretary by profession, became the program's secretary. Once again, skills are being utilized constructively.

A wheelchair patient discovered a new sense of fulfillment in cutting yarn for bookmark cards made in the workshop sessions. She was soon "taking work home" to her room. Her world has extended beyond herself, her room and her unit.

A cerebral palsy patient learned to handle a small puncher for another assembly step in the bookmark production. His accuracy with this operation is flawless.

It's hard to say if personal victories such as these are more valuable to the patient himself, or to those around him who delight in his success and are spurred to greater efforts to make these achievements possible.

One of the surest indicators of the success of the program is the "extra effort" that many of the residents put into their projects. In many cases, the scheduled workshop hours are simply not long enough and residents frequently take work to their rooms.

There are dozens of boxes on shelves in a corner of the auditorium holding material for the wide variety of projects. More boxes are filled with completed items ranging from elaborately fashioned knitted goods to attractive bookmarks cut from old greeting cards donated by friends of the home.

Among the more unusual items are place mats and balls made from knotted plastic bread wrappers. These colorful objects serve much more than decorative purposes throughout the home. The larger plastic balls . . . very soft and lightweight . . . are used by wheelchair patients for milk carton bowling matches. And smaller golf ball sizes are used by other patients to strengthen hand and finger muscles in a program of squeezing exercises.

Many residents have found they have potential ability and can turn out useful articles far beyond their expectations. A blind gentleman works with bright-colored pieces of yarn and bent coat hangers to produce dust mops. And items such as this are always in great demand at the time of the annual bazaar.

There are more than 350 residents at the Marcotte Nursing Home. Of this number, nearly 200 take a regular and active part in the Social Activity Program. There are others who are not able to leave their rooms, but the benefits of the program reach them in different and varied ways.

Residents who have found their own horizons broadened by the program are often eager to share their experiences by visiting with those who cannot take an active part.

Regular programs of entertainment are held in the auditorium and there are also frequent informal parties or teas put on for the residents or by the residents.

A program such as this requires the services of many people. In addition to the staff, there is a loyal and enthusiastic corps of volunteers who have devoted many hours to the details that are essential to such a program. And these volunteers are all ages. Among our ablest helpers are junior high school boys and girls . . . and the backbone of the volunteer organization is, of course, the home's invaluable auxiliary group, "Les Marchands de Bonheur".

The Social Activity Program is only a small part of the overall operation of the Marcotte Nursing Home. From its beginning in 1928, the home has housed and cared for thousands of persons who have required some type of nursing care or supervision over their daily living activities.

At one time, the home had accommodations for 85 children, ages three to six, and facilities for about 200 adults. In 1965, with a decrease in the number of children in the orphanage section, it was decided that the home would devote all its time and effort to the care of the chronically sick and aged.

Many new services have been added since that time. A physiotherapy department complements the home's full-time nursing service. This department includes a consulting physiatrist, physiotherapist and physiotherapy aides.

The Social Service department assists those residents who seek advice in a number of areas of concern to the aged and ill.

The Dietary department instituted a new central feeding system early in 1971 with all dietary functions being performed in the main kitchen. Menus are circulated to the residents to make selections for the following day's meals. And these selections are carefully monitored by a dietician to be sure all meals meet the resident's specific dietary requirements.

A cooperative arrangement with St. Mary's General Hospital, just across the street, assures access to any kind of medical or laboratory service in the shortest possible time. Several other operations are shared by the Hospital and the Nursing Home.

The Marcotte Nursing Home has about 360 full-time and part-time employees. Nursing service accounts for about 60 per cent of this work force. The remainder are involved in various duties such as maintenance, housekeeping, dietary, business office, switchboard, cafeteria and central linen.

Church services are held daily at the home and the chapel is open at all times to the residents. The home's chaplain also visits daily and has regular office hours for those who wish to confer with him.

One of the most recent developments in a continuing program of modernization and renovation is the addition of resident rooms and nurses' stations on the fourth floor. New geriatric showers also have been installed there.

The administration of the Marcotte Nursing Home recognizes the value of attractive and conveniently arranged rooms for all residents. The home has private, semi-private and there are several day-rooms for conversation and games. There are also sections equipped for hair styling and barber shop which has flourished beyond anyone's expectations.

Not the least of the home's many assets is the beautiful and spacious grounds surrounding the large brick building on Campus Avenue.

The Society of the Sisters of Charity takes pride in the accomplishments of the Marcotte Nursing Home and will continue to offer the best of care to all who choose to live in their Home.

Sincerely yours,

SISTER YVETTE AUBERT,
Administrator.

NORTHFIELD RETIREMENT CENTER,
Northfield, Minn., November 29, 1971.

DEAR SENATOR MOSS: It is with a great deal of pleasure to learn that you are looking for examples of positive programs of care in nursing homes across America. I would like to tell you a little about the history of this nursing home, our philosophy and program.

The Northfield Retirement Center, Northfield, Minn., is an 80-bed non-profit Home certified by The American Lutheran Church. This Center, with very attractive surroundings in a country setting but within the city limits, has had and continues to have strong community support. The Board of Directors has representation from nearly every church denomination in the immediate area. During the past two months the community has raised over $40,000 for debt retirement through a NRC $500 Club and a NRC $100 Club in order that the heavy debt load does not have to be passed on to the residents in its entirety. Before construction the community raised $250,000.

Our philosophy is that the resident of the Center is a person who deserves our love and respect and must always be treated with dignity. And we believe the residents' needs must be met in their entirety—physical, social, emotional and spiritual. Regular staff meetings are held to promote this philosophy and to increase the skills of the staff.

Realizing the need of an individual for privacy, the Center has 52 single rooms and 14 rooms for double occupancy. The few double rooms we have work out well for husband and wife and where we can find two people who can live together harmoniously but all in all the double rooms give us problems. It is difficult for an aged person to share his entire life, 24 hours a day, with a room mate.

The nursing staff works under the direction of a Registered Nurse in her early 40's, an individual who is highly motivated not only to the physical needs of our residents but to their social needs as well. We try to instruct the entire staff to look at the whole person; recognizing special needs, these needs are directed to people who can help meet those needs. We see the need for a Social Worker but since this presently is a financial impossibility we try to meet these needs with the staff we already have.

The Dietary Department has a Dietitian Consultant and is supervised by a Food Service Supervisor who recently completed a one-year correspondence course from the American Dietetic Association. Meals are served in a beautiful spacious dining hall. The coffee pot is always on for residents and their visitors who may call at any time of day.

Occupational Therapy is given much promotion at the Center. An occupational therapist consultant comes in one morning a week. A very large storeroom has been converted into a busy activity room staffed by two highly motivated women who work a total of 48 hours a week. Although many beautiful products are made in this room, the emphasis is on the therapy for body and mind. Many volunteers from the community assist in this program. An occupational therapy kitchen has been built into an extra office room that was not being used. Most of the carpenter work and furnishings were donated. This kitchen is used not only for baking but also for small private coffee parties.

A highly organized Retirement Center Auxiliary brings many services to the Center and purchases needed equipment which we ordinarily could not afford to purchase. We do not take the support of this Auxiliary for granted. We earn this support by placing before the community a happy and contented Home situation. And the Center and its residents are loved by the community.

It is gratifying, too, to observe the community interest in that programs, 3 or 4 a week, are brought by individuals and groups. Just recently I overheard a resident talking to her daughter on the phone. She said, "We're too busy here to get lonesome. There is always something going on." Another resident who does some sewing for others "complained" that she couldn't get her work done because she didn't have time! Our philosophy is that this is not an institution, but rather a home and a home bustling with activity.

The community last summer was inspired by a resident in a wheelchair out working in his large garden on the grounds.

The spiritual needs of residents are met as adequately as possible. As Administrator-Chaplain, I conduct a 45-minute worship service every Sunday morning. I visit in rooms as I have time. The local Priest calls on his people weekly and has mass once a month; local Protestant pastors are always welcome.

We also have a rather strong program for individuals and groups through the use of the talking book record player and the cassette recorder.

We try to keep our program positive and uplifting, wanting the people in our care to live out their lives in peace and security. We don't make it a policy to move them from their rooms to rooms closer to the nurses station should they become ill. Rather we bring the service to them instead of moving them to the service. To know they will be moved should they become seriously ill causes insecurity. And to know they will be moved may cause them to hide illness in its early stages when it can be treated to better advantage.

These are just a few of my thoughts about the operation of a nursing home. I love and respect the residents and find them extremely interesting. What a rich past they have had! And they can still have rich and rewarding years ahead in a nursing home if the attitude is maintained that they have come here to live and not to die. A group of St. Olaf College students who have come to the Center regularly, exclaimed, "We have never met such interesting people as at the Retirement Center." And I admire and respect my hard-working staff; these people are working not just with the paycheck in mind. They are service-minded and highly motivated. It is great to serve in my capacity.

Sincerely,

GERHARD J. NYGAARD,
Administrator-Chaplain.

THE LUTHERAN ORPHANS' & OLD FOLKS' HOME SOCIETY,
Toledo, Ohio, November 29, 1971.

DEAR SENATOR MOSS: We have been informed by Mr. Frank G. Zelenka, Association of Homes for the Aging, that your committee is interested in knowing about programs carried on in the philanthropic homes. I hope the attached materials and following comments may be helpful.

Our Home for the Aging presently serves 83 self care and 60 skilled nursing care patients 65 years of age and over. We are planning additional facilities for nursing care since we have a waiting list of applicants from the 25 counties in northwestern Ohio and southern Michigan which constitutes our primary service area for the Lutheran Church.

In addition to the usual range of services we consider basic to provision of care, i.e., nursing, housing, dietary and spiritual care, we have tried to increase life's dimensions for those in our care with special efforts. Some of those include:

(*a*) Intensive involvement of volunteers in the Home. About 200 persons regularly come into the Home as friendly visitors, receptionists, craft workers, motor pool drivers, readers, etc. to provide new relationships and attachments for the elderly who are too often bereft of family and friends. Volunteers provide time to the individual in a way it cannot be given even by the most dedicated of staffs.

(*b*) Baking Days. Four days a week the elderly are given the opportunity to bake cookies, bread, rolls, etc. under the supervision of the Home's activities director and volunteers. The utilization of old skills and the opportunity to have a new focus for socializing is made possible through the effort. Not the least of the pleasures derived is the chance to share the baked goods with others with a happy, "Have one, I made them *myself*".

(*c*) Travel Days. Through a Foundation gift a minibus has been provided the Home which is used to transport the aged to shopping centers, places that interest them, to local community events, to the voting booth, etc. It is another

way of keeping the "outside world" open to them and counteract any real or imagined fact of isolation from the general community.

(*d*) Mobile Meals. Provision of meals to the Homebound from the Home was begun earlier this year under the auspices of the Toledo Mobile Meals program. Volunteers deliver the meals to elderly in their homes so that a hospital stay may be terminated earlier and a nursing home stay not necessitated. Efforts to keep the aged in their own homes or as independent as long as possible are of high priority to our agency.

(*e*) The Lutheran Day Center. A Day Center for the community elderly is operated on the campus where the Home is situated. Home residents are taken to the Center if they wish and are again given an opportunity to be part of the general community life. The Center features refinishing of antique furniture, crafts and games, programs, trips, parties and spiritual programming. For those in the general community participating in the Center program it serves as an introduction to the institutional services and makes possible a better adjustment for those who need to enter the Home as they experience a change in needs.

Many other activities and programs are carried out as a matter of course, such as fun time each day (exercise and games), chaplaincy services by a resident chaplain (worship, Bible study, visitation), programs from church and community organizations, and the like. In all the goal is to enable the resident or patient to best utilize his skills and self, prevent further deterioration of body or mind in so far as it is possible and to help the individual to maintain himself as an individual with dignity. Because of insufficient resources or our own human failings we do not always attain our goals, but our efforts have borne much fruit and we continue to strive for excellence.

With hopes that our contribution to your study will indeed be helpful, and with a desire that we learn from you and those with whom you labor I am,

Respectfully,

The Rev. Gerald H. Labuhn, ACSW,
Executive Director.

Hale Makua,
Wailuku, Maui, Hawaii, January 21, 1792.

Dear Senator Moss: This resume is being sent to you in response to a letter from Frank G. Zelenka, Associate Director, Director of Public Affairs, American Association of Homes for the Aging. Although we realize it is late, we hope our small contribution still may be of value.

Hale Makua, Inc., is a 124-bed nursing home certified for Medicare and accredited by the Joint Commission on Accreditation of Hospitals as an extended care facility. We are also licensed by the State of Hawaii as a Home Health Agency. Hale Makua, "Home of Our Respected Elders," is located in Wailuku, the center of government for Maui County which includes the islands of Maui, Molokai and Lanai.

Our program of care is based on three policies which are included in this paper. We feel the merit of the policies warrant consideration for their inclusion in the national policy.

If we may be of assistance in any way, we are at your service.

Yours truly,

Grace T. Lusby, *Administrator.*

[Enclosure]

Three policies, threaded through all aspects of care, are the bases upon which programs and activities are instituted in Hale Makua, Inc. One policy is that of purposeful participation in the continuity of services which cover the continuum of health needs from preventive and rehabilitative care given in Hale Makua and homes to the tie-in with care given to the acutely ill in Maui Memorial Hospital. Emphasis on the promotion and maintenance of health rather than on chronic care of the ill is epitomized in the second policy by a positive attitude toward rehabilitation which is shared by the patients and the elderly, by their families and by the staff. The third policy is the involvement of the community in Hale Makua from the minutia of daily living to the long-range planning which allows concepts of the future to merge smoothly into the reality of the present. All three of these should be essential parts of a vigorous resilient national policy for the care of the "total" aged person.

POLICY OF COMMUNITY INVOLVEMENT

Hale Makua, "Home of Our Respected Elders," is a non-profit, community-sponsored nursing home which was established as a result of community action. Since its inception, individuals, groups and organizations have repeatedly continued to demonstrate their interest and support by donations of money, equipment, sacks of fresh fruit and vegetables, refreshments for weekly parties, floral decorations and time. The community gives freely of time by regularly volunteering to visit those without family or friends or by helping the staff bring alive the traditional festivals and seasons.

A recent example was this past Christmas season. Christmas trees, wreaths, pots of poinsettias and gifts were brought to Hale Makua. Some volunteers decorated the trees. Others came to wrap presents. Carolers sang in Hawaiian or English. Each bedroom door was bedecked with greenery and bright red ribbon bows. The holiday spirit overflowed from the community into Hale Makua.

Implications

Small community-sponsored, non-profit Neighborhood Geriatric Health Centers could be established on a neighborhood basis covering a population of not more than 50,000. A Neighborhood Geriatric Health Center, governed by a Board of Trustees automatically appointed as they become members of the Executive Committee of the local Coordinating Council, or a similar organization, could become self-supporting through payments from Medicare, Medicaid or private health insurance companies.

Family and friends of the elderly within the community or neighborhood would be within "drop in" distance for frequent visits to the patients or residents. These contacts might easily be lost if the elderly persons were placed in a large institution miles from familiar surroundings.

If an elderly person was moved to the Neighborhood Geriatric Health Center before he became helpless or a cumbersome burden to the modern small, mobile family in which all adults tend to work, pleasure of visitation back and forth and a continuation of interest and expressed love might be more apparent.

POLICY OF REHABILITATION

Interest in the rehabilitation of the patient is evident in all departments of Hale Makua as each contributes towards the goal of increasing the patient's self-identity, his capability of self-care and his interest in personal activity. Rehabilitation may range from physical and mental ability to the attitudes held by the patient and his family.

Even the building plans of Hale Makua encourage the patients to move about and mix with other people through the use of multiple gardens which surround the one-story units, the individual lanais attached to each bedroom, the inviting walkways connecting the various buildings, and the large, attractive Day Rooms in each wing in which are comfortable chairs, televisions and other forms of diversions.

The Occupational Therapy Center is a hub of social activity. Enclosed on one long side by sliding glass doors, the patients stroll back and forth from the garden at will.

The Center is open from 8 a.m. to 4 p.m. every day of the week, including weekends and holidays. An Occupational Therapist directs her staff in the motivation of patients so that the patients become involved in projects and activities which interest them. The activities may include simple sewing, weaving, sanding of objects made by the patients, stringing of flower leis, etc.

As the weather permits, the physically able patients are transported by station wagons to parks or beaches for picnic lunches. Friday afternoons are devoted to parties at which special refreshments are served, often donated by members of the community. Local singers and dancers usually entertain the patients at this time. The patients may also be entertained at the monthly birthday parties held in their honor.

An interesting way in which Hale Makua seeks to stimulate those who tend to withdraw or become inactive is to put these patients on "Incentive Pay" which may run from a few dollars up to $20.00 a month. Little jobs are invented, usually in Occupational Therapy, which are appropriate for the individual patient. One patient on "Incentive Pay" may sand boards from which gifts may be made. Another, sitting in his wheelchair, may cut cloth into small pieces which will be used for cushion stuffing. Others may wheel less mobile patients around

the gardens, water a section of a garden, or help straighten dining room chairs after meals. All of these activities enhance their feelings of worth and need to others. They take their work very seriously.

The patients wear their own clothing. Even those patients who require frequent changes of clothing are dressed in their own clothes. They are encouraged to personally select replacements when needed clothing wears out. The patients are taken by station wagon to local shops where they may make their choice. If they are unable to make decisions, the Occupational Therapist buys the needed article after consulting with the nursing staff.

The patients who are clients of the Department of Social Service are allowed $8.00 a month to cover their personal needs. Those with Social Security checks are allowed an additional $11.50 for personal spending. This money, kept for the patients in the Business Office, may accumulate during the year. Some of the money may be spent for Christmas or birthday presents for them.

A part of the Social Worker's program is devoted toward helping the patients retain their self-identity. Among other things, the patients are encouraged to participate as much as possible in all holiday activities. During the different seasons a supply of appropriate cards are available so that the patients may send greetings to their family and friends who are far away. The families of the few patients who are physically able to leave Hale Makua occasionally are encouraged to take the patients home for short visits, particularly during holiday seasons.

The Dietary Department is also geared toward the rehabilitation of patients. It is the policy at Hale Makua to help the patients maintain, as much as possible, a normal pattern of living. For this reason, the patients sit at dining room tables and eat with other people. The seating arrangements, in groups of four, are made in accordance with the wishes expressed by the patients.

The patients are assisted in walking or are wheeled to and from the dining room for the three daily meals. Aides from Nursing, Physical Therapy and Occupational Therapy are assigned for this purpose and are also assigned to help within the dining room at meal time. Only those few patients who are physically unable to be moved from their beds or who are unable to feed themselves are allowed to remain in their rooms at mealtime.

The Physical Therapy Department, directed by a Physical Therapist, is open from 8 a.m. to 4 p.m. Monday through Friday. Individual therapy, as well as group therapy, is carried on regularly. The patients, who must all have had physical therapy prescribed by their physician, are encouraged to spend as much time as they wish in the department. One may see patients recovering from the effects of a "stroke" striving to regain strength in their leg muscles as they carefully walk up and down the provided rail-guarded practice steps. A member of the staff always observes and supervises these efforts.

Before a patient is discharged from Hale Makua, a Patient Planning Conference is held to consider his future needs. The conference may include nurses, Ward Aides, the Occupational Therapist, the Physical Therapist, the Social Worker, the Dietitian or a representative from Hale Makua Home Care Service. After the physician writes the order for Home Care Service, a nurse from Home Care Service visits the home to evaluate the need for equipment and family instruction. This evaluation is a basis for the preparation directed toward the smooth transfer of care from Hale Makua to the home.

Implications:

Valuable resourceful persons may be lost to the community as retired people sink into humdrum trivia of living because they are unaware of the need for their talents and abilities or are unaware of a resource through which they could express themselves.

The Neighborhood Geriatric Health Center could become a center to which all older people are drawn. They could turn past wishful thinking into actual practice. Many people, at one time or other, have felt a desire to express themselves in some art media or to "try their hand" at some activity other than that by which they earned their living. At the Center, they could try many things.

"Non-residents," the older people who live in their own homes or with their families, could be as active in the Center every day as their time, energy and interest would allow. Some might apply their talents and experience to teaching classes in gardening, knitting, art, carpentry, language, etc. Others might work in the administrative offices, raise favorite vegetables or visit "shut-ins."

Within the premises of the Neighborhood Geriatric Health Center should be a Health Maintenance Clinic. This clinic, in which physical examinations and

tests could be regularly scheduled for the "non-residents," would be a screening device to locate those persons who were developing a need for more extended medical care. The more regularly scheduled the "maintenance" physical examinations and tests, the less the deviation from the norm before its discovery and referral for treatment.

CONTINUITY OF SERVICE POLICY

Hale Makua is a vital part of the total health services available on Maui. Hale Makua and the Hale Makua Home Care Service are links between health care given in Maui Memorial Hospital and the patient's home. As transfers take place between the sources of care, pertinent information is related as needed. A patient may be followed through the continuum of health.

The Health Officer of Maui County, the representative of Hawaii State Department of Health, works closely with Hale Makua, Inc. The Health Officer is particularly interested in the care given to patients in their own home and the implications related to comprehensive health programs.

Interest is growing in all aspects of a health maintenance program which will be directed toward serving individual health needs with the familiar surroundings of their own neighborhood. This is demonstrated by a proposed extension of the Hale Makua Home Care Service to the Island of Molokai. A Home Care Service, linked with the Molokai General Hospital and the branch office on Molokai of the Hawaii State Health Department, is being planned which will be established by the Hale Makua Home Care Service personnel. When the Molokai Home Care Service unit is capable of self-maintenance, the Hale Makua personnel will be withdrawn. This program will negate the necessity to move an ill or aged person from his own background.

The same program, it is hoped, will be established on Lanai, another island included in Maui County.

Implications:

The Neighborhood Geriatric Health Centers throughout the United States could contain Home Care Service units as well as Health Maintenance Clinics and nursing home facilities.

THE SALVATION ARMY,
BOOTH MEMORIAL HOME,
Honolulu, Hawaii, November 29, 1971.

DEAR MR. MOSS: Regarding your request to Mr. Frank G. Zelenka, Director of Public Affairs, AAHA, please find enclosed description of care and services projected by the Salvation Army in Hawaii regarding a program for the aged.

Yours very truly,

(MRS.) DELPHINE EWALD, R.N.,
Administrator on Aging.

[Enclosure]

LANI BOOTH CARE HOME

1. PURPOSE AND GOALS OF THE SALVATION ARMY

A. The Salvation Army is a "church-plus" . . . an international religious and charitable movement operated on a semi-military pattern . . . a branch of the Christian church . . . evangelical in creed and practice. The motivation is love for God . . . its practical concern the needs of humanity . . . its message the gospel of salvation through faith in Jesus Christ . . . its undertaking the spiritual, moral and physical rehabilitation of all persons regardless of race or creed.

When it was known that William Booth, founder of The Salvation Army was dying, he was asked for a last message which would be sent to Salvationists around the world. "Others," replied the General, "others must always be our first concern."

To carry out its purpose of serving others, The Salvation Army has established a diversified program of religious and social services . . . family welfare services, homes and hospitals for unmarried mothers, children's homes, day nurseries, transient shelters, correctional services, general hospitals, rehabilitation centers for alcoholics, employment and vocational guidance centers, clinics and dispensaries, disaster relief programs, rural service welfare committees, summer camps for all ages, USO and Red Shield clubs for servicemen, youth group work, Bible training, street evangelism, rehabilitation centers for moral delinquents including

narcotic addicts, parolees, teen-age delinquents, overseas primary and secondary schools, hospitals, schools for the blind and many other services.

B. Purpose and Goal of the Lani Booth Care Home: 1. To provide a residential care, treatment and recreational program for 40 male and female ambulatory non-medical elderly citizens. The age distribution being left to the admissions personnel.

II. PROBLEM AND NEED

A. The Salvation Army, in attempting to meet the needs of the community, has determined that it must expand its senior citizens program and put more emphasis on care for the elderly.

B. Of our United States population, 8½ percent are now over 65. In 1900 only 4 percent were over 65. One thousand people a day join the ranks of this aging population, increasing both the number and the percentage in relation to the overall population, at a fantastic rate.

A great deal of research and study has been done on various aspects of gerontology by State and Federal governments, by industry, unions, private agencies and universities. One aspect of the findings has been most interesting to the writer. A U.S. Public Health Service report (as far back as 1959) indicated the shortage of civilian hospital beds revealed that 413,000 more beds were needed for mental patients and 261,000 for chronic patients were essential. Hence, older people who can take care of themselves all are being forced out of hospitals and into homes. The "ambulatory" are finding it increasingly difficult to get into a large percent of the homes. To provide a care home for 40 such people seems a small attempt to meet the need that is prevalent in Hawaii for adequate care home programs for are aging. It is the hope of The Salvation Army that the Lani Booth Home will serve only as the first step in our involvement with the aging. We have identified the need at three levels:

1. Care home complete with treatment, residential 24-hour care and recreational involvement.

2. An information and referral counseling center for people with problems related to the aging.

3. A vocational training program aimed at income maintenance for the aging to be phased into the Lani Booth Home in its second year of operation. This training program would be in conjunction with the Division of Vocational Rehabilitation and the Men's Social Service Center of The Salvation Army. It also would involve PAVE (Personality Assessment and Vocational Evaluation), a diagnostic testing center established at the Men's Social Service Center.

III. PROJECT PROPOSAL

The Salvation Army, in order to meet the needs of the people of Hawaii in the field of gerontology is proposing to establish a long range project that encompasses four (4) program breakdowns.

A. Care Home

A 40-bed care home will be established at 3624 Waokanaka Street. It will house non-medical ambulatory patients.

1. Physical Needs: The physical needs of the residents will be met by care aids who will help with personal hygiene when necessary, a registered and licensed practical nurse. Dietary staff, a small beauty and barber shop, volunteer cosmetologist and student aides in related fields.

2. Emotional Needs: A home atmosphere will be provided since residents have semi-private rooms, own clothing, personal articles and will be doing their own laundry when necessary. In essence, they will care for themselves when at all possible with help only when necessary. This will facilitate the idea of home living. The care home occupants will be free to come and go at will into the city for which transportation will be provided. They will visit with friends and entertain at will.

(*a*) A psychologist will donate time for those in need of therapeutic guidance.

(*b*) The staff social worker will be available for immediate needs.

3. Recreational:

(*a*) The facility will provide a library, two lounges with television and radio, arts and crafts classes with volunteers to teach pottery crafts and painting.

(*b*) A music therapist, group singing, choral and drama groups are programmed.

(*c*) Field trips to local senior citizen centers, Paradise Park, Sea Life Park, Polynesian Cultural Center, etc., are planned.

B. Information, Referral and Counseling Center for Aging

In the second year of the project an Information, Referral and Counseling Center will be established. Having gained insight into the communities' needs, the needs of the aged, and the relatives of the aged, the facility will be able to establish this center. It will be headed by the social worker attached to the facility with assistance from the administrator and a volunteer crew of four (4). We see this part of the program as essential and although other agencies are involved in giving the same information, there is much need for the service.

C. Vocational Training and Testing Program

It is hoped that ties will be established with the Division of Vocational Rehabilitation within the home's first year. The Men's Social Service Center of The Salvation Army has, within its confines, two valuable resources, (1) several training sites for the elderly and the ability to add whatever is needed, (2) PAVE, a diagnostic testing center, capable of evaluating the abilities of the referral. It is felt that income maintenance is a most helpful and emotionally fulfilling experience for the aging. This has best been seen by the Foster Grandparents Program in Hawaii. The Lani Booth Care Home, in its second year, will provide avenues of income maintenance for as many people in the community as can be handled. We hope to begin with a group of 20 as a pilot project and with the results of this, expand as necessary.

GENERAL DESCRIPTION OF SERVICES

The Lani Booth Care Home offers residential rehabilitative care to 40 male and female elderly citizens of Hawaii. Only non-medical ambulatory residents are eligible for admission. Services will be integrated to provide emotional, social, spiritual and physical needs to the aged person.

Applications will be restricted by policies now being established, but will be accepted regardless of race or religion. An Admissions Board will be formed to determine the needs and suitability of each applicant for entrance to the Home.

Provisions for emergency care will be provided. Each resident will have his/her own private physician. Where short term illness occurs and in the physician's opinion the resident may remain in the Home, nursing care shall be under the supervision of a professional nurse. Nursing care in the Home will be programmed to help each individual resident maintain optimum health and the maximum degree of self-sufficiency.

The Staff of Lani Booth Care Home will include an administrator, social service coordinator, recreation director, registered nurses and nursing assistants, office, dietary, housekeeping, and maintenance help.

Interdenominational religious services will be held regularly. Arrangements may be made for those with religious preferences to attend worship services in Honolulu churches.

The overall function of the Care Home is to provide a plan of activity adapted to the needs and abilities of the elderly resident. A program will be conceived to provide activities to fill the needs of the type of resident we are serving. For example: Arts and crafts, outings, films, art, poetry, current events, musical programs, discussion groups, parties, and resident councils.

A volunteer program will be established to supplement the work of the Staff members.

The Social Services Department will be responsible for carrying out admission procedures, counseling, orientation for new residents and social services as needed for all residents.

Residential care includes the following: living accommodations, linen service, three meals a day with supplemental nourishments (nutritionally adequate menus will be planned to provide for the dietary needs of the elderly person), minimal medical services, transportation to private physicians, churches, and activity centers in the community.

Fees range from $350.00 to $425.00 per resident per month depending on type of accommodation. Accommodations vary according to number of residents per bathroom facility.

AUGSBURG LUTHERAN HOME,
Baltimore, Md., December 1, 1971.

DEAR SENATOR MOSS: I recently received a letter from AAHA Public Affairs Director Mr. Frank G. Zelenka urging us to list some of the programs we provide here at Augsburg Lutheran Home.

Listed below in sketch form are just a few of the programs and services we think are innovative and noteworthy.

Arts, Crafts, Activities.—Our Activities Director has recently instituted a "Talking Book" program through cooperation and assistance of the Maryland State Library Assn. She develops the talents and motivates our people to useful service through a regular arts and crafts program.

Spiritual Development.—Regular Worship Services are conducted in our chapel; Mid-week Bible Class is conducted; Religious movies are shown; A Chaplain makes visits to sick and infirm; Large-Print religious materials are provided by our church body.

Volunteer Program.—Various church and civic groups provide entertainment, make visits to our guests, and provide refreshments. A Women's Auxiliary has set up a Monthly Eentertainment Night at which they provide a night of enjoyable entertainment for our guests. This month, for example, a band from the Social Security offices here in Baltimore will come out to play.

Transportation.—The home provides transportation to local shopping areas twice a week; also makes arrangements for day trips to points of interest making use of our home-owned bus.

Medical.—A program of training with special reference to care of the aged was instituted for our Aid and Practical Nursing staff under the guidance of our Medical Director; A merit promotion program was recently set up for all Nursing personnel.

Orientation of New Employees.—New employees are required to listen to a recording made by an aged resident titled: "What It's Like To Grow Old." Gives them a better appreciation of problems as well as joys of our aged guests.

We hope the above notes will give your committee some indication of the type of programs and activities carried on here at Augsburg.

We happen to feel that we are doing a far superior job at caring for the aged entrusted to our care than most of the profit orientated long-term care facilities. We need the support and financial help of the State and Federal government in our work. We could do a lot more if this sort of help would be forthcoming.

Sincerely,

REV. FLOYD P. DUFF,
Administrator.

LENOIR MEMORIAL HOME, INC.,
Columbia, Mo., December 3, 1971.

DEAR SENATOR MOSS: We recently received a communication from Frank G. Zelenka asking that we submit a résumé of our program giving emphasis to that portion which we might consider innovative.

May I, first of all, describe the type of facility which we have. We have apartments and private cottages for independent living. The occupants of these units are responsible for their own housekeeping, meal preparation, laundry, etc. We provide building maintenance, lawn care, insurance, transportation if needed (they can and many do have their own car) and answer emergency calls twenty-four hours per day. We have an M.D. on call and have a licensed nursing section with space held in reserve for all our ambulatory residents in order that they can feel secure in the knowledge that they will be adequately cared for in case of illness. These people participate in the total program of Lenoir and hold office in the Family Council.

We have an ambulatory unit for persons who are able to occupy a private room, dress and bathe themselves; go to the dining room without assistance. Many go shopping in town (we furnish transportation on a daily basis) go to Church and any number of social and educational functions.

Our nursing section is divided into two units, one for those who need a minimum amount of care and/or supervision but who are able to go either to the main dining room or to a small dining room located in the nursing section, the other unit is for those who need the maximum amount of care.

The above statement describes our physical facilities and their various uses. Now let me share with you something of our philosophy of operation.

"Retirement in health, honor, and dignity is a worthy objective after years of positive contribution to a community and nation". (The Many Faces of Aging by J. Edward Moseley.) This statement expresses the hope of every person who gives any thought to the retirement years. It is the purpose of Lenoir to provide an environment where people can retire in health, honor and dignity, and continue to make a positive contribution to society. The scriptural passage that best expresses the philosophy of the function of Lenoir is taken from the words of Jesus as recorded by Matthew, "You have my Father's blessing, come, enter and possess the kingdom that has been ready for you since the world was made. For when I was hungry, you gave me food; when thirsty, you gave me drink; when I was a stranger you took me into your home, when naked you clothed me; when I was ill you came to my help, when in prison you visited me". (New English Bible)

Hunger and thirst is not always of a physical origin. A person can become hungry for the followship and social contact with others of like mind and interest. It is possible to be a stranger in the midst of many whom we know. Every person needs to feel that he belongs to and is a vital part of the group in which he lives. He needs to be accepted by his peers. Each person needs to be clothed by the warmth of the love and concern of those about him. Each person needs to feel secure in the knowledge that when illness comes either to the mind or body there are those who stand ready, willing and ably equipped to render whatever assistance is needed. There are occasions when we find ourselves locked inside our private prisons and we have the need for the love, devotion and understanding of those whom we respect and in whom we have confidence.

As we recognize the dignity of each individual we are readily aware of the responsibility to preserve and maintain this dignity in order that he may be a whole person.

With the use of our facilities and our philosophy as a base we endeavor to employ program functions to the ultimate end that each person may have the opportunity for continued growth and enrichment of life. The Lenoir Family Council is a most important part of our program. This serves two distinct purposes for our residents. The first purpose is to let them plan the kind of program they want and the other is to use their own planning ability as a part of their therapy. The enclosed information sheet gives somewhat more details relative to the functioning of the Family Council.

We operate on the basis that each person should do for himself all that he can and that our staff do for each individual according to his needs and ability. Each person (patient) needs the therapy of self care (within his limitations). This may be nothing more than walking to the bathroom with the help of two attendants, but this is better than using a bedpan.

We use dutch doors on rooms where the mentally ill are located. This gives them freedom within the room, the attendants can check on them each time they pass the door, the patient can see into the halls and is able to converse with those who come by. By the same token they do not wander out of the area nor do they disturb others in the section.

Each patient in our nursing section is removed from the bed at least once each day and when possible taken out of the room to another location in the building. We have a part-time director of activities who helps in the planning and execution of the many types of programs and this is always done in cooperation with one of the committees of the Family Council. A brief statement of the "Leisure Activities at Lenoir" is enclosed.

As an individual seeks suitable surroundings in which to live the later portion of his life the most important ingredient is a sense of security. By this I mean that they can live with the knowledge that they can continue to be as independent as their physical and mental state will permit and at the same time know that whatever needs arise that they cannot meet will be cared for by competent, concerned and trained personnel.

Thank you for the privilege of sharing the philosophy and program of Lenoir Home with your Committee.

Sincerely,

JACK P. BODARD,
Administrator.

[Enclosure]

LEISURE ACTIVITIES AT LENOIR

Leisure can be a friend for those who know how to use it to add to the meaning of their lives. Leisure activities of the residents of Lenoir take many forms from individual project to group activities; and from those focused on self-improvement to those dedicated to the service of others.

The resident self-governing body, the Lenoir Family Council, keeps many active with a variety of projects and committee plannings. The Council has four officers including a historian who is compiling a complete history of the Home. The worship committees include Vesper Service, Morning Devotions, Communion, and Table Grace. Other Committees are Library and Education, Programs, Music, Service, Publicity, Social Affairs, Hospitality, and Record Concerts.

The Program Committee invites guest speakers, educational lectures, and performing groups of individuals to the Home. We try to have this type program twice a month depending on the available time of the guests. Popular program areas in the past have included music, dance, travel, international political scenes, and school children. New interest has been shown in science areas such as geology and astronomy. The Program Committee also schedules series of classes with guest instructors. A popular series last year to be continued this Fall deals with Shakespearean literature.

The Social Affairs Committee organizes all social activities that occur at Lenoir under the guidance of Lenoir staff and residents. This includes three birthday parties a year (alternated with three birthday dinners), the wedding anniversary party, holiday parties such as Thanksgiving, Christmas, Halloween, etc., and special parties like the Watermelon Feast, and home-made ice cream on the 4th of July.

Every Saturday there is an evening of entertainment on record with selections made by the Record Concert Committee. Small groups gather among themselves for an afternoon or evening of cards, scrabble or other activities. The Boone County Regional Library sends a representative to Lenoir twice a month which adds a variety of reading material to the Home's own library. The Regional Library checks out between three and four thousand books a year to the residents, so it is easy to see that reading is a popular leisure activity. The Home library has recently added an aid for readers with failing eyesight. This machine magnifies the book print on a small television type screen with a minimum of mechanical operation by the reader.

In addition to a large group of readers, Lenoir has a representation of writers. Most well known at the Home are a writer of verse and a writer-director of skits. Musical talent is in abundance among the residents. In addition to the organized choir, there are many residents who fill the living room with piano or organ music on a regular basis. Two residents have pianos in their own rooms for private playing. This leisure fun not only is pleasant for the ones who sing and play, but also offers leisure listening for the appreciative audience.

Painting is another dilettante area for several of the residents. Last year classes were offered in watercolors and this year these art students are working with oils. The classes are taught by a volunteer local artist. Several of our artists were experienced in art before coming to Lenoir. One of these can captivate her audience while she does inspirational chalk drawings to a sermon or music.

Puzzles of all types are very popular among the residents. Many work jig-saw puzzles and crossword puzzles continuously on their own. They collect word puzzles by the books and newspapers often are void of their puzzle before being thrown out. Jigsaw puzzles have also become a group project in the TV room. A puzzle is out for anyone to help put together and when completed, it is glued into a picture for the hobby room. Many individuals have an art of their own to which they devote much of their time. Such talents are crocheting, embroidering, sewing and tailoring, weaving, tin can craft, photography, wall hanging paintings, flower pressing for pictures, and quilting. These talents are often shared with others within and outside of the Home. One of the most far-reaching projects is the making of quilts for Indians in the Southwest. New skills are being learned all the time. Some of the residents take classes from the Columbia Older Americans Klub and classes are starting at Lenoir in Macrame' and seed mosaic.

Volunteer work is a rewarding activity for many of the residents. Volunteers manage and operate the Home library and assist the Regional Library repre-

sentative. A volunteer assists with mail pick-up and delivery for the main building. The picture gallery is supplied and changed weekly by a volunteer resident. The nursing unit staff is supplemented by a retired nurse volunteer resident. Outside the Home, several volunteers work at Woodhaven School for Exceptional Children. Many of the residents are active with their own church activities. They participate in their circle groups, fellowship dinners and other church related functions. The three local colleges provide cultural activities for several of the residents. Musical performances and the theaters draw the largest representation from Lenoir.

Not all of the leisure activities take people inside. Walking is one of the most popular activities. Adult tricycles are privately owned by cottages and two are fixed inside the main building for exercise. The Home also has several gardeners. The size of the productions vary from enough to serve the entire dining room to a few tomatoes. A wide variety of flowers are grown by residents and during the growing season most of the tables are decorated by these home grown beauties. Fishing and golf provide outdoor enjoyment for other residents. This past summer outings took groups to the Ozarks for a boat trip, and to visit a gladiola producer's garden in Ashland.

A list of Lenoir leisure activities is quite expansive as well as varied. Also as new residents come to the Home and old ones become better acquainted, new talents and interests are discovered. The happy atmosphere that prevails at Lenoir combined with the variety of leisure activities sought by the residents offers support to August Heckscher when he stated, "Happiness is the exercise of the individual's powers along lines that he deems significant".

Purpose of the Lenoir family council embraces the following objectives:

1. Promote fellowship among the residents and administrative staff.
2. Encourage group and individual activities of those residents who desire such.
3. Plan, develop and present programs of general interest and value to residents.
4. Provide opportunities for self-improvement.
5. Relieve the administration of such activities and plans in order that their time may be fully devoted to the many problems of administration.
6. Support the program of the NBA and the Christian Church (Disciples).

Functions carried out by committees shall include:

1. Worship Committee under chairmanship of the Vice-president with four subdivisions:
   a. Vesper services, providing speakers, either guest or resident, and conducting these services each Lord's Day evening.
   b. Morning devotions with selected leaders appointed for a week at a time, to read Scripture and offer prayer within five to seven minutes from 7:30 a.m. midway of pre-breakfast musical devotions.
   c. Communion to be served each Lord's Day evening to those unable to attend church.
   d. Assign a person to give Thanks for dinner and supper on a one day basis; corporate prayer being sung in Doxology before breakfast each day.
2. Library Committee to supervise the Dr. I. N. McCash Memorial Library and Picture Gallery.
3. Program Committee to secure entertaining programs.
4. Musical Program Committee to schedule musicians for daily morning devotions, music of weekly Vesper Services, programs for special church days such as Easter and Christmas.
5. Service Committee to distribute hymnals for services, arrange seating, set up film equipment, prepare trays for communion.
6. Publicity to report items of interest to Columbia papers.
7. Hospitality Committee to greet visitors (more than 3000 annually) provide guides for tours of the Home . . . express appreciation for the Church support provided.

MAGNOLIA MANOR,
Americus, Ga., January 14, 1972.

DEAR SENATOR MOSS: Mr. Frank Zelenka of the American Association of Homes for the Aging passed along a copy of a letter from you requesting reports on "new and imaginative approaches" to the care of the Aged. It has never occurred to us here at the South Georgia Methodist Home for the Aging (better known by our Trade Name, Magnolia Manor) in Americus, Georgia that we may have a somewhat unique approach. However, at the White House Confer-

ence on Aging several representatives from H.U.D. were surprised, and possibly disappointed, to find that they did not have to go to Europe to find a Comprehensive Complex for Aging. This prompted our conclusion that possibly we have stumbled onto something here which may be of interest to you and your Committee.

Magnolia Manor is a Methodist Church owned complex for the Aging serving approximately four hundred fifty (450) persons. It is located on three hundred seventy-eight (378) acres of land just inside the city limits of Americus, Georgia, a South Georgia community of approximately sixteen thousand (16,000) population. The complex, under one ownership and management, provides multilevels of care.

The primary advantages of this approach are, once a person enters the complex at any level of care: (1) He may be relocated according to his need with a minimum of the trauma usually associated with relocation of the aged. By the same token it is not necessary for a well, active person to be confined to an often depressing unit with costs and services designed for the helpless. (2) The admission paper work necessary which to most seems simple, appears staggering to the aged whose minds simply have ceased to function as efficiently as previously. The single admission to all levels of service eliminates worry and reassures the oldster that he will be dealing with the same people, operating within previously understood policies. (3) The resident has available to him many services which could not be economically provided in one segment. Some examples of this are: (a) medical attention (b) free bus service to shopping areas and churches as well as recreational trips (c) educational, social and activities programs (d) security personnel (e) more variety in food service (f) pharmacy services at reduced cost (g) chaplaincy services (h) therapy and rehabilitative programs.

Senator, we appreciate your concern for the people whom we serve. I am in Washington several times each year and if I can supply you with further information about our approach to services for the Aged please call upon me.

Sincerely,

GERALD A. BISHOP,
Administrator.

RESURRECTION REST HOME,
Castleton-on-Hudson, N.Y., December 7, 1971.

DEAR SENATOR MOSS: First, let me tell you how happy I am that someone is sincerely interested in seeking-out what might be positive in Nursing Homes. Mr. Frank Zelenka urged those of us who administer nonprofit homes to relate to you our concept of total nursing care and how we try to implement it.

Individuals we care for vary in their needs. We begin by trying to maintain a dedicated staff to give good nursing care. Women like to look their best and the elderly are no exception, so we put a lot of emphasis on good grooming and care of hair. An attractive hairdo will go a long way to lift the spirits of any lady!

They say that "the way to a man's heart is through his stomach". We find the same principle holds true for our female residents. It takes a lot of dietary planning, but home cooking and especially home baking goes a long way. This is a frequent topic of discussion. The patients do not hesitate to stop by the kitchen to say how good the meal was.

"Not by bread alone does man live" says the Lord, so the spiritual needs are considered. The chapel is crowded with wheel chairs, walkers, and a devout nursing home population, especially on a Sunday. We welcome Ministers of all denominations to serve the people of our home. Death is no stranger to any of us. When someone dies, the other patients plan a simple memorial service. They care about each other and it does matter to them when one of them is called to their Maker. They know that they, too, will be remembered after they are gone.

To maintain physical and muscular function as long as possible, we have a daily program of physical therapy. A registered Physical Therapist comes once a week and his instructions are carried out by a Physical Therapy Aide on a daily basis. Patients do not just sit in their chairs all day.

An important part of our program of care is social and recreational activity. This involves a great deal of planning because our patients differ in their capacities. Our planned activities take in:

Arts and Crafts.—The articles the patients make under guidance are really lovely and useful. We sell them and use the revenue to purchase more supplies.

Movies.—These range from educational, to religious, to musical entertainment, to travelogues.

Slides and Discussion.—An interesting development—Occasionally a guest speaker comes with slides from a trip to Europe or the Orient. The residents enjoy the slides along with the comments. One local Castleton resident showed some valuable slides of Castleton which were taken back before World War I! Some of our patients are quite elderly so they were able to identify some of the landmarks, and found the speaker's comments very interesting.

Music, Concerts, Singing, Dancing.—Many such events are put on by volunteer clubs and other groups.

Games.—Bingo is loved, not only for the prizes won, but for the thrill of anticipation of possibly being a winner.

Entertainment.—Many and diversified programs are put on by outside groups including groups of children.

Parties and Celebrations.—Dress up and costume parties. All this takes place in the home. To get those patients who are able, out of an institutional setting, at least once in a while, we plan trips like: seeing a garden in full bloom in Spring or Summer; a Memorial Day Parade; a barbecue dinner prepared by Kiwanis Members; a covered-dish luncheon with Senior Citizens from the area; any number of outings which we can plan within their limitations.

To help us with all these activities, we were able to mobilize a core of volunteers and recently a group of Senior Citizens, still able to maneuver outside a Nursing Home. We also found that youngsters are a delightful source of help if supervised. They love the old people and the old love to have them around. They help transport patients, serve refreshments at parties, help shaky hands partake of them. One of the volunteers comes once a week just to read to a smaller, interested group, anything from the "Courtship of Miles Standish" to other poetry and stories. The patients love it as it provides topics for discussion and keeps brain cells from atrophying.

We find that volunteers are extremely important for our program of activities. All ages can and do serve. Ours range in ages from 10 to 75. Each brings in a willingness and a desire to serve and each has her own talent to offer. Diversified activity would be impossible without them. In this way, we also involve the community and we are proud of the response we are getting from the Castleton Community.

Another technique we use and want to further develop,—especially with patients with chronic brain syndrome, is the Remotivation Technique. This consists of a series of twelve patient-meetings, lasting thirty minutes to one hour, held once or twice a week with a nurse as the leader. In each group, there are about ten patients who are encouraged, but not required to attend.

The nurse begins an objective discussion by using as conversational material current events, natural history, national holidays, etc. It is hoped that something in the discussion or visual aides used will spark the interest of even the most regressed or confused patient. The nurse or leader is not teaching the patient nor are these classes, but are group discussions in which the sharing of ideas promotes personal interaction between nurse and patient, and among patients.

Remotivation is a structured program with five specific steps. These steps are: creating a climate of acceptance for the patient, building a bridge to the world, sharing the experiences of the world, discussing the work of the world and showing appreciation for the patients' participation in the session. I might add that this segment of the Nursing Home population is the most difficult to care for. They do respond, however, to love and kindness.

Now, for example, most of our activities are being planned around the Feast of Christmas. With guidance from the activity leaders, our patients made Christmas center-pieces, Christmas tree decorations, Christmas knick-knacks. There will be carols, music, a concert of sacred Christmas organ music in the chapel, special Christmas films, groups of carolers like: a third grade chorus (the children love to come); The Fire Co. Auxiliary with gifts; the 4H girls, Girl Scout Troops and finally the gala Christmas party the patients are planning for the staff, volunteers, Senior Citizens and any visitor who may be around. Usually things are done for the patients, but this time they are "throwing the party" with help from their leaders.

The residents wrote out the invitations and made the room decorations. One volunteer wrote a poem which will be used as a surprise entertainment. A resident will be Santa Claus and give out the gifts; another will play the piano while her fellow residents sing and entertain. For a change, they are "doing" rather than being "done for". They are very involved in these preparations and it is turning out to be a family affair. If all the planning goes well, it should be the event of the year!

It is so difficult to describe the whole of a program of a Nursing Home which tries to make a home away from home for its residents. All this is not exactly innovative, but the contented, happy patients prove it is effective.

May I take this opportunity to wish you and yours a joyous holiday.

Sincerely,

Sister THERESE SLONSKI,
Administrator.

WESLEY NURSING CENTER,
Charlotte, N.C., December 3, 1971.

DEAR SENATOR MOSS: We are very much aware of the work your Subcommittee has done for the U.S. Senate Special Committee on Aging over the past several months on long-term care. We, likewise, are aware of the fact that there will be a prepared report submitted to Congress based on the Hearings that have been held and the various materials which have been accumulated by your Committee Members. We appreciate your several public expressions that it was the Committee's intent to emphasize the positive in relationship to the care being given to our wonderful senior citizens and leave the negative approach to others.

Wesley Nursing Center, here in Charlotte, was inspired by men and women of the same mind as you and your Committee Members! After two years of careful planning and with the co-operation of Federal, State, and Local Government, in early 1961, the final plans for this facility were placed out for bid. In November of 1963, the doors were opened and currently we can share with you the following statistics and programs which we feel have contributed to the very best in patient care. Likewise, these procedures and programs have resulted in our being mentioned quite often throughout the nation as a facility that emphasized the total components of care as opposed to seeing with how little we might get by.

The building was a joint venture by us as a denominational sponsor along with Hill-Burton Funds. We were the first long-term care facility to be constructed with this Federal aid in North Carolina.

Wesley Nursing Center has national accreditation or approval by the following: The Joint Commission on Accreditations of Hospitals; all 277 beds are certified for Medicare-Medicaid patients through North Carolina State Board of Health; full certification by The Certification Council of The United Methodst Church.

We maintain an unusually high ratio of employees to patients and currently such is 1.2 employees to each patient.

Among the featured services or opportunities for total patient care might be listed: our Beauty Shop, Barber Shop, Snack Bar, Seamtress, and Library. The Library actually operates a book truck on wheels which makes all six floors on regular schedule. We then have a store or trading post which also operates a mobile unit and runs on regular schedule to where the patients can purchase anything from greeting cards to personal care items. We have a Physical Therapy Department as well as an adequately equipped Dentist and Podiatry Room. These services may be rendered to our patients by the professional of their choice in any medical speciality. Each patient is under the care of his own personal physician. With this open staff policy each doctor must comply with frequency of visit requirements.

In planning the physical plant, a large courtyard enclosed by an attractive brick serpentine wall with proper furnishings gives the patients an opportunity to enjoy the out-of-doors even when there is need for a certain amount of supervision. The beautiful wooded areas near the building contain a paved pathway lined with benches. Patients in wheelchairs or those ambulatory may be taken by personnel and/or loved ones to enjoy shaded areas in the summertime without fear of traffic and the other hazards sometimes prevalent in non-beautified areas.

A large occupational therapy department with decided emphasis on creative crafts has three and one-half full time employees which stay busy five days a week teaching and assisting in weaving, ceramics and a variety of other creative hobbies.

Regular devotion and worship programs are held in a most attractive Chapel with ample space for wheelchair patients. This program is under the over-all supervision of a full-time, trained Chaplain.

Emphasis is placed on small and large parties and special occasion observances both by staff and by the staff encouraging loved ones and visitors to participate

on the occasion of such social events. Short movies, especially travelogues, are scheduled in a way that they are appreciated and well attended. Group participation in games is encouraged and a Bingo afternoon almost weekly attracts the attention of many patients (no one pays, almost everyone wins a unique prize). Under the guidance of the Special Services Department such activities as the Rhythm Band, particularly among those who may have degrees of senility. This group has amazed everyone by their attentiveness as well as their over-all enjoyment of such activity. Remotivation groups have met from time to time and the results of such programs have been most encouraging.

A small but important thing is the procedure to keep the patients, loved ones, and visitors informed—along with the employees—of what is going on prompted the erection of an attractive bulletin board with a calendar of the week's activities being posted regularly. Birthday cakes are always provided by Dietary Department for all those individuals having a birthday in a given month.

The policy of recognizing years of service among all employees by awarding service pins in years divisible by five has contributed to lessening the per cent of turnover in employees. It is our opinion that in long-term care the patient being familiar with the employees adds to their feeling of security and whereas a general hospital might only have a patient stay seven or eight days, the long-term care facility like ourselves have the same patients for three, four or ten years. Constant changes in faces are frustrating to many.

Senator Moss, whereas your Committee Members may be interested in some particular phase of operation or procedure that contributes to first class care, we feel that it takes *all* of the things that we have mentioned and then some to really render *quality care*!! We feel that our positive approach has benefited many people, yet we realize that there are those nursing home owners and operators who would criticize us for giving too much care for too few dollars.

In spite of the wide variety of services and the inclusiveness of our "plus factors" a fairly comprehensive survey indicated that our rates were very much in line with homes that have the physical plant that we are fortunate in having and are in an area where the demand for quality professional personnel is high. We enclose one or two pieces of material about The Center for your interest and records.*

May we use this opportunity to express our appreciation for your individual efforts and the efforts of several of your Committee Members. We have heard a few of your colleagues speak on occasion and know they are all dedicated to the matter of seeing that our aging *are not* neglected or exploited but *are* afforded the finest care that can be delivered in a reasonably economical manner.

Very truly yours,

WILLARD S. FARROW, N.H.A.

ST. THERESE NURSING HOME,
Minneapolis, Minn., December 7, 1971.

DEAR SENATOR MOSS: We hope that the following inventory of our programs of care and service to the aged at St. Therese will exemplify the positive action taken by dedicated administration and staff to meet the needs of the elderly in a long term facility.

St. Therese aims to care for the total person, highlighting the satisfaction of the spiritual, social and psychological needs, while meeting the physical needs. We aim to have each resident see himself as important, needed, and loved.

St. Therese opened in 1968 and continues its care to essentially four communities of living. These communities interact but are different groups operating within a larger community. These communities or levels of care are:

Residential.—For the quite independent.

Residential Nursing Care.—For the quite independent but needing guidance and care.

Infirmary.—For the physically ill—the acute nursing.

Ambulatory Nursing Care.—For the mentally dependent.

Our daily census shows our two hundred bed capacity filled and a long waiting list.

We feel proud that our continually full house and waiting list reflect the reputation for an excellence of care we have in the community.

*Retained in Committee files.

Thank you for this opportunity to describe our approach in caring for the total person in a long term facility.

Sincerely,

JAMES WALL,
Administrator.

[Enclosure]

Program	Description	Rationale
Department of Nursing Service: Department head, Mary Shurson, R.N., 3104 Kentucky Ave. S., Minneapolis, Minn. 55426.	1. Observes, guides, supports, assists residents in meeting physical and psychological needs.	1. (a) To assure that patient care is provided in accordance with the regulations of the Joint Commission on Accreditation of Hospitals and Nursing Homes and the Nursing Practice Act and in accordance with the Standards of the American Nurses Association, (b) staff ratio 2.9 hours per day, per resident, of skilled nursing.
	2. Coordinator system (supervising nurse). R.N. on each 8-hour shift who is responsible for (a) evaluating medical needs of resident, (b) contacting physicians, (c) expedites physicians orders, and (d) contacts resident's family regarding all medical problems.	2. Continual detailed communication between coordinators to provide 24 hour continuity of care, (a) charge nurses report all complaints, signs, symptoms, inquiries, requests, to coordinator who personally checks resident to gather diagnostic information, (b) all calls and correspondence to physician are performed by coordinator to establish uniformity of communication between nursing home, physician, laboratories, and hospital, (c) directing and supervising all medical orders, and (d) to keep family informed and to help maintain close family ties.
	3. Report of individual resident's condition is passed from charge nurse going off duty to charge nurse and nursing care team coming on duty, at beginning of each 8-hour shift.	3. (a) Total team care, (b) evaluation and planning of duties, and (c) continuity of care.
	4. Schedule medical committee meetings. Medical committee consists of each department head, Dr. Gregory Schissel and D. Kump.	4. (a) Discussion of medical policies as need for change arises; (b) medical direction in planning new programs.
	5. Conducts team conference once a week. Each department is represented. 10 patients assessed.	5. (a) Review and evaluation of patient care plan, (b) to meet individual resident's changing needs, and (c) patient report sent to family.
	6. Schedules utilization review meeting once a month. Each department head attends, as well as 1 physician from medical staff, and administration.	6. (a) Medical charts are selected at random for review and evaluation; (1) medical care given, (2) care given by total team (departments).
	7. Written work assignment sheets containing complete information regarding daily physical and mental needs of each assigned resident given to nursing assistant.	7. Aid in fulfilling goals of patient care plan.
	8. R.N. students, North Hennepin Junior. College; L.P.N. students, suburban Hennepin County Vocational affiliates with home.	8. (a) Provide education setting in geriatrics, (b) educational setting sharpens in-house staff to greater proficiency.
	9. Unit manager of each nursing station is responsible for providing material needs of station.	9. Relieve medical personnel of secretarial duties, (a) ordering supplies, (b) scheduling of personnel.
Department of in-service Education: Department head, Dianne Crawford, R.N., 8008 Yates Ave. N., Minneapolis, Minn. 55443.	1. Orientation of all new personnel, volunteers, and affiliates.	1. Indoctrination of uniform philosophy, objectives and skills to help employee feel comfortable in his new job role which in turn will promote better job performance.
	2. Continual development of policy and procedure book, e.g., developing a procedure for a medical problem new to the home, (patient with a tracheotomy).	2. (a) Guide for teaching, (b) resource, (c) uniformity of skills, (d) better staff performance, and (e) job satisfaction.
	3. All house learning programs (minimum of once a month).	3. Educate and challenge staff, (b) better job performance, (c) job satisfaction.
	4. Schedules professional education opportunities for entire staff, e.g. (a) nursing, (b) inservice, (c) administration, and (d) pharmacy.	4. To name only a few: (a) Kenney Institute for Rehabilitation Nursing, (b) Minnesota Nursing Home Association meetings on development of inservice departments, (c) University of Minnesota; (1) Nolte Center for continuing education, (2) seminar on aging; (d) American Society of Hospital Pharmacy; (e) Minnesota Hospital auxiliary.
	5. Volunteer commitment to recommendations of satellite program.	5. Maintaining high level of care as satisfied the satellite approval committee.
	6. Establishing medical library	6. Source of reference material for staff and affiliates.

See footnote at end of table, p. 1966

Program	Description	Rationale
Dietary: Mrs. Craig Ensley, 8924 Northwood Parkway, Minneapolis, Minn. 55427.	1. Juice and coffee served on all stations from rising time until breakfast (also throughout the day).	1. (a) To promote socialization before breakfast as aides are often busy with cares, (b) to follow a familiar life style pattern of some residents who partake, and (c) to encourage fluid intake.
	2. 5 meal a day plan with tray service	2. The greatest advantage of individual tray service is that each resident is receiving nutritionally the food his doctor has prescribed. The 5 meal day plan provides smaller feedings for older people whose capacity requires that they have smaller feedings more frequently during the day. It also promotes more frequent socialization. It gives residents an opportunity to have a late breakfast and go directly to activities.
	3. Rehabilitation kitchen	3. Available to residents with special equipment to make area accessible for all types of limitations.
	4. Coffee shop facilities open to residents and employees all day. Beer available daily to residents at no cost.	4. Gives residents an opportunity to snack outside of a dining room situation in the very pleasant coffee shop surroundings which is part of their home.
	5. Attends all staff and department head meetings, team conferences, Intake meetings, utilization review.	5. To provide and glean information which will give better total care to the individual.
	6. Interview residents on admission	6. To acquaint new residents with the food service available at St. Therese and to become acquainted with his individual dietary needs.
	7. All house cocktail parties, holidays. Daily 4 p.m. beer hour.	7. Socialization, appetizer, reduction of medications.
Department of Physical Therapy: Department head, Mr. Kay W. Roberts, physical therapist, 660 South, St. Paul, Minn.	1. Gives medically prescribed treatment to prevent disability, relieve pain, develop, improve, or restore motor function.	1. To maintain maximum performance within each individuals' capabilities.
	2. Reviews each resident on admission without charge.	2. (a) To determine their physical capabilities, (b) inform physician of need and possibilities of a physical therapy program, and (c) to report information to intake meeting and assist in formulating patient care plan.
	3. Acts as resource and taching person to staff.	3. (a) Aid in development of programs: (1) OT projects to increase ability of hand function, (2) OT exercise program; (b) evaluate and improve transfer techniques: (1) adding to comfort and ability of resident, (2) safety and comfort of staff; (c) assista in writing procedures for procedure book; (1) ace bandage for amputee.
	4. Participates in weekly team converence	4. (a) Reevaluating patient care plan to meet residents changing needs, (b) communicate to staff their responsibility for treatment.
Department of Social Services: Department head, Sister Bernarda, OSB, 8000 Bass Lake Rd., Minneapolis, Minn. 55428.	1. Revised handbook of personnel policies to meet changing needs.	1. Distributed to all personnel for uniformity of performance.
	2. Visit to residents before admission to home.	2. (a) Evaluation of care needed, establish good relationship with individual and and his family.
	3. Make arrangements for admission	3. (a) Inform staff who will welcome and assist, (b) expedite recording information.
	4. Identification cards issued to all residents.	4. Cards carried on person with emergency information, (a) security for resident when leaves home to walk, shop, etc, (b) expedite necessary care, and (c) community better able to assist in recognizing, directing, and calling us.
	5. Welcome party scheduled the evening of admission day.	5. (a) Introduce and welcome. (b) help feel a part of family atmosphere.
	6. Social history obtained and distributed to all departments and placed on chart.	6. Better understanding of person as individual for more affected care.
	7. Conducts intake meeting on each new resident.	7. (a) Each department is represented, adding their evaluations for development of patient care-plan.
	8. Counsels residents and families	8. To help resident and family adjust to new role in nursing home, and to meet continuing needs as they arise.
	9. Evaluates and directs interhouse transfers.	9. Uniformity decisionmaking and direction in conjunction with other department heads.
	10. Visits residents who have been transferred to hospital.	10. To represent home and convey concern.
	11. Schedules family night 4 times a year	11. (a) Educate families to programs within the home, (b) hear group concerns, and (c) family becomes integral part of team.

See footnote at end of table, p. 1966.

Program	Description	Rationale
Department of Activities: Kathie R Crema, B.A., activities director, 4016 Louisiana Ave., Minneapolis, Minn. 55427. Laura Blenkush, C.O.T.A., activities director, 1810 E. 28th St., Minneapolis, Minn. 55407. Mrs. C. E. Popp, activities director, 8300 33d Pl. N., Minneapolis, Minn. 55427. Lana Jones, C.O.T.A., activities supervisor, 4632 Winnetka Ave. N., Minneapolis, Minn. 55428.	1, Resident is interviewed on adminission as to his interests. Evaluation is made of physical, social, and psychological needs.	1. For the purpose of encouraging him andl gradually getting him involved in as many activities as are meaningful to him.
	2. Daily exercise program throughout the home.	2. Emphasis is on physical activity to maintain physical fitness.
	3. Specialized exercise program with adapted exercises and equipment.	3. To work with specific limitations: (a) CVA—stroke, (b) arthritis, and (c) limited range of motion.
	4. Individual craft clinics for various levels of care, (a) confused, (b) infirm, and (c) guidance and support.	4. Enables more specific programing for individual needs and skills.
	5. Small group crafts	5. Allows for a higher level of craft opportunities, (a) ceramics, (b) painting.
	6. Social work projects, (a) cancer pads	6. Allows opportunity for resident to do something for someone else in need.
	7. Patio gardens, at elevated level	7. Allows wheelchair as well as ambulatory resident to work, (b) fulfills work need, (c) provides residents opportunity to get outside.
	8. Diverse recreational activities at least 5 days a week, (a) hootenany, (b) films, (c) rhythmn band, (d) shopping trips, (e) attending ball games, and (f) ice cream socials.	8. To promote well rounded resident—mentally, physically, and socially.
	9. Rehabilitation kitchen adapted with special equipment.	9. To make area accessible for all types of limitations.
	10. Resident newspaper published once a month.	10. (a) provides communication within home, (b) gives resident opportunity for creativity.
	11. Resident council meetings	11. Allows them to voice areas of complaint and improvement potential.
	12. Resident library developed and maintained by residents; 4,500 books, mostly donated.	12. (a) Provides mental stimulation, (b) keeps them in touch with current world happenings.
	13. Remotivation techniques	13. Intellectual stimulation through reading groups, educational films, special interest groups and music appreciation, (a) to encourage good communication and coordination with other members of department, (b) encourage professional stimulation and continuing education of staff members, and (c) to recognize the diverse education and skills of other members of department to meet the needs of different levels of care.
O.T	Meetings of activity staff; daily, weekly, and monthly.	

[1] Departments: physical therapy, dietary, occupational therapy, volunteers, religion, social services, and pharmacy.

Program	Description	Rationale	Systemic implication for sound national policy
Volunteer (in a nursing home): Mary E. Raker, director of volunteers, 1925 Glenwood Parkway, Golden Valley, Minn. 55422.	Volunteers are those interested in serving the elderly through the direction of the volunteer director under the supervision of the department in which she serves. In our nursing home volunteers serve in the coffee shop, drive residents to doctors and special events, iron, mend, make beds, read, write notes, feed, take for rides or walks, visit, help with grooming, assist to chapel and other events, assist with crafts and recreational events, play games and cards, tidy rooms, pass trays, help at information desk, type, give tours of home, shop for and with resident and develop special interest in resident.	After being interviewed by volunteer director, the volunteer is given in-service training before being assigned to station where she will serve. Adult volunteers assume tasks that releases the professional staff for duties which require special training and provide that human touch to make a more home-like atmosphere for the resident.	Under proper supervision and cooperation of staff and administration—volunteers can serve in a nursing home in a way that paid personnel cannot, because of need of nursing care and time that the staff must devote to the medical needs of the residents. If a volunteer chooses to serve in a nursing home she can devote as much time as she is able to give to serving the elderly.

Program	Description	Rationale
Department of Junior Volunteers: Department head, Mrs. Patricia S. Gozola, 5936 Jersey Ave. N. Minneapolis, Minn. 55428.	1. Organization of youths between ages of 13½ and 16, who volunteer their time and talents on a regular assigned basis. Orientation to home, philosophies, and skills is provided.	1. (a) To relieve staff members of specific nonprofessional duties, (b) provide additional help to residents, (c) acquaint youth to needs of elderly, (d) create good attitude for future working force, (e) provide purposeful activity for youth, and (f) expose youth to volunteer work and community and social involvement.
	2. An award ceremony is held once a year. Mothers and guests are invited to attend. Pins are awarded for hours of service.	2. (a) Recognition and appreciation of contributed time and talents, (b) Encourage future volunteer work.
	3. 2 teen parties given each year	3. Thank you from home for service.
	4. Students from Cooper Senior High School, 12th grade social science classes visit individual resident on regular basis.	4. (a) To meet class requirement of social involvement with elderly, (b) acquaint youth with needs of elderly, and (c) to give resident opportunity to share memories, knowledge, and experience with youth.

Business office	Description	Rationale
Mrs. Delaine Schmidt, 7910, 59th Ave. N., New Hope, Minn. 55428	These are services offered residents in addition to the usual accounting work:	
	(a) Cashing checks, (b) keeps resident's funds for those unable to manage more than a few dollars, and (c) sign medicare forms for all supplies.	(a) A convenience for residents, (b) to prevent loss or theft of large sums of money to those unable to keep a record of their account, and (c) an added service to residents families.

WEBER COUNTY HOSPITAL,* ROY, UTAH

[George E. Goodell, Administrator]

*Information complied by: Inservice Education Department, Weber County Hospital, Mary Ann Anderson, R.N., Director.

Weber County Hospital, a 198-bed chronic disease and rehabilitation hospital located in the Salt Lake Valley, Roy, Utah, has an 11-year history of service to the chronically ill. It has the distinction of being the only hospital for chronic illness in the State of Utah and has a constant patient census with frequent waiting lists that verify the need for such an institution.

This hospital's goal of patient rehabilitation for the chronically ill is enhanced by the physical setting of the building. The structure itself is a total of 196,840 square feet which is all located on one level. Consider the relief felt by a patient in a wheelchair or on crutches when he sees that there are no stairs nor elevators for him to struggle with during his initial rehabilitation phase. The "all-on-one-level" concept definitely allows for more patient mobility.

The grounds at the hospital complex are also in tune with the rehabilitation concept of chronic illness in that there are two beautiful rock gardens, five large patio areas, three closed-in flower gardens, and 4½ acres of grass, trees, and sidewalk specifically for patient use.

Another aspect of the building itself is the interior decoration style used throughout. The once beige walls are now a variety of shades of yellow, orange, and green. In appropriate areas such as the nurses' stations, patient sitting areas, and the television rooms, there is bright, floral-print walltex that may seem somewhat too large and too colorful to a visitor; but to the aging patient with dimmed vision, it is appropriately pleasant. Another major addition made by the hospital's interior designer was the black door frames. Black door frames may sound strange; but actually they are merely another method of breaking visual monotony and, thereby, make a long hallway look shorter to the hemiplegic or amputee. The hospital also has wheelchair guards and handrails in every hallway for patient convenience. And, as has been mentioned, there are dining rooms, T.V. rooms with floor-to-ceiling windows, and homey patient sitting areas.

As a chronic and rehabilitation institution, Weber County Hospital admits a wide variety of patients. The average age is between 55 and 60 years, with the youngest patient of 1971 being fourteen years old and the eldest ninety-nine.

The general hospitals in the area as well as private physicians transfer to Weber County Hospital post-acute stroke and head-injury patients, as well as diabetics, amputees, and other logical candidates for chronic disease and rehabilitative nursing care.

A patient being admitted to this hospital must be under the care of a physician who is on the hospital medical staff. After arrangements for bed space and medical care have been made, the patient and his family are taken to the hospital admitting clerk where the actual care for the person being admitted begins.

During the admission process, the clerk gleans from the patient and family pertinent telephone numbers and names such as those of the family, patient's clergyman, and some close friends. These numbers are then used throughout the patient's hospitalization to keep the patient in touch with his at-home world.

The philosophy of patient care at Weber County Hospital places primary emphasis on maintenance of the optimal state of health and body function of the patient. Much effort is directed toward motivating the patient to increase his ability to function as independently as is possible.

PHILOSOPHY OF PATIENT CARE AT WEBER COUNTY HOSPITAL

> The philosophy of patient care is based upon the respect for dignity and worth of the individual. We feel each patient has the right to receive effective nursing care which is a personal service based upon his needs as they relate to him as an individual and to his clinical condition, in-so-far as the hospital facilities permit. We wish to carry out the therapeutic measures ordered by the doctor with intelligent application to the individual needs of the patient. Patients who are becoming increasingly ill or are dying have the right of support, understanding, and companionship as well as physical care. Last, we wish to help to restore the ill patient to the best possible state of physical, mental, and emotional health and to maintain his sense of spiritual and social well-being through cooperation and coordination of the paramedical personnel and the family.

Weber County Hospital's 198 beds are divided into six distinctive patient care units. Each unit or division is part of the total plan of progressive patient care. There are two 20-bed acute-care units that are used for evaluation of newly-admitted patients and for the care of those needing isolation nursing, continuous oxygen or intravenous therapy, or other types of acute nursing care. From these units, a patient may be transferred directly to, or through physical improvement, work his way to any of the next four 40-bed divisions. These areas are a custodial or maintenance division, a rehabilitation division, and a self-care, behavior-modification unit. The sixth patient care area is the State Tuberculosis Unit.

Along with the patient units themselves, Weber County Hospital has a variety of departments that adhere to the patient care philosophy as well as individual patient goals. One such department is Social Services. Within 24 hours after a patient's admission, the Director of the Social Services Department makes initial contact with each patient. She does this by means of an interview that is recorded on a standard form and is left on the chart after its completion. This information—referred to as a social service history—is used constantly by the personnel who give patient care as a means of understanding and assessing patients as individuals.

The Social Services Department is responsible for patient activities—an aspect of patient care that has been found invaluable in this chronic disease hospital. The building has a large auditorium equipped with movie screen, microphones, and a stage that is constantly used for these patient activities. The psychological effect of "going out" is met this way by having the patient leave his division and "go out" to the program held in the auditorium. Meeting this psychological and social need plays a vital role in preparing patients for eventual discharge.

The programs that the patients attend have a great deal of variety! Church Services are held weekly and bi-weekly for many different denominations. Also, there are often such programs as weekly movies with popcorn; weekly sing-a-longs with a professional singer as the leader; and regularly held ceramic and clay modeling classes. The Social Services Department also sponsors a monthly birthday party where patients with birthdays-of-the-month receive corsages and special treats.

Seasonal activities are indeed prevalent. Patients may be seen carving pumpkins, decorating Christmas trees, or hiding Easter eggs. The patients also have available daily reading groups, quilting sessions, and gardening projects in the summer. As has been said, the activities are devised to not only meet the patient's immediate social needs, but to help him in the difficult adjustment from hospitalization to home by perpetuating facets of home living.

The hospital's arts and crafts area is under the jurisdiction of the Social Services Department. For some patients, their projects in arts and crafts are as important as a job is for someone outside the hospital. One female stroke patient likes to make feather dolls and, therefore, spends four to five hours each day making a doll. This is indeed a "day's work" for someone with the use of only one hand! The arts and crafts areas provides a great deal of opportunity for patient socialization as well as a vital feeling of self-worth that comes from completing projects. Patients go to arts and crafts without needing a physician's order. Once there, they are allowed to choose the project on which they want to work and then proceed with it under the supervision of a member of the Social Services staff. The arts and crafts room accommodates approximately 25 patients for any one activity.

This department has yet another major responsibility—that of being the concrete liaison between the patient, hospital, and family. This aspect of the department is one that is used constantly. By providing someone to handle family complaints and problems, it is felt that the hospital prevents much of the unhappiness that can be caused by patient-family misunderstandings. Other responsibilities related to this are: the courtesy of keeping families informed of the patient's condition, and relating to the family needs of the patient that only they can fulfill.

Another department in the hospital that is essential for quality patient care is that of Nursing Service. This department is led by two qualified registered nurses in the positions of director and associate director of Nursing Service. Also, each of the six patient care areas has a registered nurse as the division coordinator, and each shift has a registered nurse supervisor. Besides these supervisory nurses, there is 24-hour, 7-day-a-week, registered nurse coverage for each clinical area. Working in conjunction with the registered nurses on the staff are the licensed practical nurses. Desirable staffing calls for a registered nurse and licensed practical nurse on each division for the day shift and a professional nurse on *each* unit for the other two shifts of duty. Weber County Hospital has found that by having professional nurses on duty the high standards of care required to meet the needs of the geriatric and long-term patient are met.

The majority of the Nursing Service personnel assistants, both male and female. These people do much of the direct patient care under the supervision of the nurse. Prior to anyone's being employed in one of these vital positions, he must have successfully completed the hospital's six-week nursing assistant training program or have had at least one year of work experience. Currently, the hospital is attempting to institute a nursing assistant step-level program that will allow the more experienced nursing assistants the prestige and privileges of their seniority.

Upon the admission of a patient, the professional nurse takes information for a nursing history from the patient and his family. The immediate performance of this task enables the nurse to establish realistic patient care goals within the first few hours after admission. These goals are then shared by two distinct methods with whoever assists in giving the patient his care. The first method is a chart-sized form that has room for a brief patient history and the patient care goals. This detailed nursing care plan is then placed directly on the patient's chart where it is available to the medical, nursing, rehabilitation, and paramedical personnel.

The second method used to "share" patient goals is on the 48'' by 42'' master care plan board found on each nursing division. Listed on these boards are the 40 patients on the division according to room number. Then in columns reading from left to right are such important and individual details as the patient's bowel and bladder program, ambulatory ability, appointments for occupational therapy and physical therapy, and other essential items that should be considered while giving patient care. The use of these two tools promotes goal-centered, patient-oriented care for each person from his first 24 hours after admission.

The Nursing Service Department at Weber County Hospital constitutes slightly more than one-half of the entire employee population. With this number of personnel to supervise and coordinate, there obviously is a need for a governing body; and Weber County Hospital has one! The Administrative Council of Nursing Service is led by the Director and Associate Director of Nursing. Other members include the division and shift coordinators, the Rehabilitation Clinical Specialist, and the Coordinator of Educational Services. This group of interested professional women meet every two weeks; and in these meetings, they compliment, comment on, and if necessary, criticize the quality of care being given to patients. For the most part and with administrative approval, this council makes the decisions that govern nursing care. This action avoids the pitfall of having non-nursing "experts" tell nursing how to function.

Another group of patient-oriented professionals is the rehabilitation team. This group consists of the Chief Physical Therapists, the Occupational Therapist, Rehabilitation Clinical Specialist, Social Services Director and Associate Director of Nursing Service. These people meet monthly in an effort to assure close interdepartmental cooperation, as well as sameness in terms of patient goals. This is one major way that the hospital assures its patients of the best service possible from each department. This unity creates an atmosphere where suggestions can be made and new ideas tried all in the name of improved patient care.

The Rehabilitation Clinical Specialists is a registered nurse with an extensive background and experience in rehabilitation.

Although the hospital has one 40-bed unit designated specifically for rehabilitation, the Clinical Specialist is not assigned to that unit alone. Instead, she floats from division to division assessing patient needs, devising care plans, and teaching rehabilitation techniques to all personnel. The full effect of this specialist can be felt when she is allowed to seek out rehabilitation patients from the entire hospital instead of limiting herself to just one work area. This nurse also does a great deal of patient-family teaching and family counseling.

The Clinical Specialist shares office space with the hospital's Occupational Therapist; and according to them, this close proximity helps keep both people informed of patients they should be seeing. The Occupational Therapy Department is contained in one medium-sized room. In this room there is equipment for teaching activities of daily living such as a tub, toilet and wash basin; adaptive devices for patients with physical defects; and fine-coordination exercise equipment used to promote an overall physical therapy program for the patient. The availability of this wide variety of equipment is one of the major reasons for the success of the department.

The Occupational Therapist sees her patients after a physician's order has been written. She does a complete evaluation of the patient and then makes appointments for 3 to 5 times a week. All patients are seen on a one-to-one basis for at least the first 30 minutes of the time they spend in occupational therapy. Then after this individual work, the patient may wish to proceed to some other activity with only limited contact from the therapist. Another aspect of the Occupational Therapist's responsibility to the patient seeking rehabilitation is the skill of teaching dressing techniques. This may sound peculiar to someone unfamiliar with rehabilitation; but for the patient with a disabled arm or a paralysis that affects both an arm or a leg, dressing can become a very frustrating chore. The therapist makes rounds each morning to assist the patients who need instruction in dressing. The ultimate goal of this task is to teach the patient to be as independent as possible, and it does seem to be working! Patients with chronic diseases are often in need of splints, slings, and individualized adaptive devices. The Clinical Specialist and the Occupational Therapist work together devising new methods, and trying out new products in an effort to make the most functional and practical splints, slings, and devices possible. All splints and slings used in the hospital are made by the therapist; thereby, the patient can be assured of the adaptability and quality of the equipment.

With occupational therapy assuming the care of fine motor coordination needs, there is obviously a need for someone to assist a patient in controlling his gross motor activity. The Physical Therapy Department does just that. There are three registered therapists, two assistants, and a secretary employed in the essential, patient care area. Patient visits to this department also require a doctor's written order and result in a complete physical evaluation made by the registered therapist. Physical therapy for all patients is done on the one-to-one basis that is used throughout the hospital.

Equipment in this department ranges from small sand bags to the huge 750-gallon Habbard tub. There are two tilt tables, pulleys, restorators, and nearly as much exercise equipment as can be found in any small gym. And it gets used! Patients receive either active or passive exercise to the affected muscle groups as a warm-up; then the real exercise begins. Often patients in acute need are seen for an hour, two or three times a day. Then as they improve, their physical therapy activities gradually and skillfully decrease. Without this concentrated physical therapy, there would be no significant rehabilitation of any kind.

An interesting idea that has been used by the rehabilitation team as well as Nursing Service is that of involving family members in the actual care of the patient. If it seems to be beneficial for the patient, family members are invited to team or care-planning conferences. At that time, the family is encouraged to voice opinions, and relate information that will in any way assist the personnel in meeting the patient's needs.

An essential aspect of any hospital is the Dietary Department. The department at Weber County Hospital employs two dietitians, and approximately 30 dietary supervisors and aides. The task of preparing 200 meals three times a day for patients who have the same dietary problems as those in general hospital, plus the special problems that exist for geriatric patients, patients on bowel and bladder training program, or one of the many other dietary problems peculiar to chronic disease, is a monumental responsibility. Some of the methods by which these problems are handled include regular patient-dietitian-family conferences, or dietitian-nurse sessions that are geared toward individual paients and their dietary personalities.

The dietary staff works with the Social Services Department in preparing outdoor barbecue dinners during the summer. These gala affairs involve various patients who do planning, some cooking and generally much "fussing." These dinner parties are held once a week during the summer months and rotate from patient division to patient division.

The Dietitian and Rehabilitation Clinical Specialist work closely together in planning diets for the patients on bowl and bladder training programs. One simple idea that has resulted in sending glasses of water on the food trays assures patients of receiving adequate fluid intake for their bowel and bladder program. The Dietitian also alternates the necessary juices and salads that are vital to any retraining program.

One factor that assists patients in having their social as well as dietary needs met is the patient dining rooms. These areas are established in pleasant, brightly-lighted rooms that have a "wall-of-window" and a view which looks out on a lovely garden area. The tables in these rooms are not dormitory type, but instead are small tables for four, covered with tablecloths, and adorned with centerpieces of a variety of styles.

Most hospitalized persons are allowed to pick their own food for each meal. These selective menus have been available to patients for nearly two years. The professional dietary personnel are always available to do individual or group diet teaching for patients and families. This teaching is yet another way the hospital tries to prepare its chronically ill for a return to family and society.

An area of the hospital that does not deal directly with patients, yet is vital to quality patient care is the Education Department. From this department, comes the detailed six-week nursing assistant training program that is required prior to employment for most nursing assistants. Continuing education for nursing assistants involves classes in professionalism, hospital safety, specific disease entities, anatomy and physiology, interpersonal relationships, and a wide variety of other pertinent, related topics. Classes for all personnel are repeated several times during a week, and on all three shifts so that everyone has an opportunity to attend on duty time.

Besides teaching philosophies and skills to the nursing assistants, the department reaches out to the registered and licensed practical nurses on the hospital staff. Refresher courses, sanctioned by the State Department of Registration are offered as needed. There are also classes such as medicine administration, I.V. therapy, and parenteral injection techniques; rehabilitation nursing concepts; interpersonal relationships and team management; patient care planning; and a variety of others taught to keep the professional nurses "On Top" of nursing practices.

The Education Department, which consists of one registered nurse and a secretarial-assistant, also offers classes to every other department in the hospital. This philosophy is based upon the precept that everyone in the hospital must know his job well in order for the standards of care given at this institution to be maintained.

An example of this is the behavior modification training program that was introduced into the hospital care system two years ago. At this time, not only nursing service personnel were taught the techniques and theory of the concept of patient management, but so were the inhalation therapist, housekeeping supervisor, the admission clerk, dietitian, PBX operator, and many others who needed to know about and support the program so that it could be successful. Now, behavior modification is used extensively on all nursing units and is supported by each hospital department.

The Education Department not only teaches in-hospital programs to personnel, but it coordinates out-of-hospital workshop sessions. This method of sending personnel out of the hospital for training and then bringing them back with new information and techniques has proven itself to be very successful. Employees go to workshops both in and out of the State of Utah, and thereby, continually reinforce the already existing patient care standards.

The Education Department also prepares and coordinates an annual program for stroke patients, their families, and the general public. These are evening programs held once a week for a month wherein rehabilitation experts, the hospital medical director, and other health professionals teach concepts of home care for the stroke patient. This program is one more way Weber County Hospital prepares patients and families for eventual discharge.

With an eleven-year history of long-term care to the aged, this hospital dedicates itself to a continuance of that care.

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