TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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CONTENTS

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(CHICAGO, ILL.)

SATURDAY, APRIL 3, 1971

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
SPECIAL COMMITTEE ON AGING,
Chicago, Ill.

The subcommittee met at 9 a.m., pursuant to call, in room 250, Behavioral Sciences Building, University of Illinois, Senator Charles H. Percy, presiding.

Present: Senators Percy and Stevenson.

Staff members present: William E. Oriol, staff director; Val Halamandaris, professional staff member; John Guy Miller, minority staff director: Gerald D. Strickler, printing assistant; and Patricia G. Slinkard, chief clerk.

OPENING STATEMENT OF SENATOR PERCY, PRESIDING

Senator PERCY. The second day of hearings on long-term care before the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging will come to order.

I will open the proceedings, in the absence of Senator Frank Moss, but again wish to extend the appreciation of both Senator Stevenson and myself for Senator Moss being with us in Chicago yesterday and personally visiting one of our homes.

At this time the committee will ask Mr. Robert J. Ahrens, director, city of Chicago Division of Aging to join us here at the witness table.

We are happy to have you with us, Mr. Ahrens, and if you would identify yourself officially and your colleague and associate, we will proceed just as you see fit.

Mr. AHRENS. All right. My name is Robert J. Ahrens and I should say that I am director of the Division for Senior Citizens of the City of Chicago, Department of Human Resources.

This is Andreé Oliver, actually Mrs. Frank Oliver, who is assistant director of the division for senior citizens.

STATEMENT OF ROBERT J. AHRENS, DIRECTOR, DIVISION FOR SENIOR CITIZENS, CITY OF CHICAGO

Mr. AHRENS. The particular problem that this hearing addresses is seen best as an aspect of an even larger problem, and one that is essentially new. The number of people age 65 and over, only 3.9 per-

cent of our State's population in 1900, is 10.1 percent today, and the numbers are growing.

As the story goes, in 1900 people worked 70 hours a week and died at age 40. Today they work 40 hours a week and are going strong at age 70.

Perhaps we need to point out that, of our people age 65 and over, only 4 percent are institutionalized in hospitals, nursing homes for the aged, and similar facilities. Fully 96 percent of our elderly are in the community. Of these, 8 percent are homebound and bedfast and another 6 percent are limited in mobility.

Changes in our Nation's Population

You know these facts intimately, but our Nation needs to know them better, to understand the changes that have taken place in our population, to have a true picture rather than a false image of aging and our elderly, and to understand and support the programs that must be gotten underway.

The problem of numbers of older people in America is relatively new. The medical field of geriatrics and the field of social gerontology are both also relatively new. This newness has, of course, important implications for community education in the problems of aging and for recruitment of professionals and other workers to these fields. Most importantly, the institutions of our society, private as well as public, have not yet adjusted their priorities to the realities of this new problem.

The elderly are, as a consequence, too often left out of planning considerations, too frequently overlooked and underserved. To the extent that this hearing can constructively affect this larger problem, it will be dealing not just with symptoms but rather with their fundamental causes, and this we need to do.

I offer for the record of these hearings two reports prepared by the Division for Senior Citizens. One, issued on January 26, 1971, proposes "Standards for Serving Older People in a Neighborhood Health Center."* Directed to the maintenance in independent living of the 96 percent of the elderly who are in the community, it has been accepted in principle by the Chicago Board of Health.

The second report by our staff, called "Impact on the Community of the Accelerated Discharge Program of Elderly Patients from Illinois State Mental Hospitals: A Statement of the Problem," was published in January 1970.** It was occasioned by the signing into State law in September 1969 of several bills which amended the Illinois Mental Health Code in relation to the elderly.

Bills Revisions in Health Code

In brief, this report points out that these bills revise the definition of a person in need of mental health hospital care in order to exclude senility; provide for the review of aged mental patients to consider the possibility of care outside the hospital; require an ex-

*Retained in committee files.
**See appendix 1, p. 1323.

amination of persons age 60 and over prior to hospital admission; and require followup care for patients placed outside the hospital by the Illinois Department of Mental Health.

It reports estimates by the Department of Mental Health that 7,000 to 10,000 elderly patients would be returned to the community by mid-1971 under the new legislation.

It notes that very few elderly are released to independent living under this program and that most require some type of protective setting such as nursing homes or sheltered care homes, and that these are already operating at near capacity.

Further: In Chicago, 32 percent of the nursing home beds were rated noncoforming and noncorrectible by Hill-Burton standards. The supply of sheltered care beds is inadequate. Enforcement of 1970 licensing standards will further deplete the inadequate supply of nursing and sheltered care beds.

Supportive followup by the Department of Mental Health is very limited. Although private agencies do offer casework, counseling and other services to the elderly, limited funding and shortages of qualified personnel restrict any significant increases in their caseloads.

Most of the elderly to be discharged will be recipients of public assistance. With limited income, these elderly will be least likely to secure long-term care beds which meet acceptable standards. Administrators of many facilities complain that payments from public aid are inadequate to meet their costs for service. Therefore, low priority is given to placement of public aid recipients.

Neither Chicago's communities nor its service systems are prepared to absorb immediate implementation of the accelerated release program. The impact of the program will be most severe on those communities whose resources are already severely depleted. These are the salient points of this report, which was given wide circulation in the mental health field and in the field of aging.

Seven months earlier, on July 7, 1969, when the legislation involved had been passed, we enclosed materials on this problem in letters directed to the chief editorial writers of four Chicago daily papers, in our continuing efforts to educate leadership to the complexities of the problem. These letters said, in part:

> The question of placement and removal of elderly patients in state mental hospitals is of concern to many, particularly now the 7,000 are scheduled to be removed from Illinois hospitals and returned to the community.
>
> The chief reason for placement of elderly in state mental hospitals has been that adequate alternative community facilities were not available. They are still not available. The problem will not be resolved, nor is it fair to the elderly simply to move them around and have "many small warehouses take the place of the large one."
>
> We do not believe the problem has yet been understood in its full complexity.

The handling of the accelerated discharge program clearly indicates the need for improvements in statewide planning for our elderly. We believe this might largely be remedied by passage of Illinois Senate bill 147, now before the 77th Illinois General Assembly, which would establish a new and more effective State unit on aging. Passage of this legislation is one positive forward step we can take.

Nation Needs System of Long-Term Care

We need also to consider some model public facilities for long-term care, perhaps similar to the new "Geriatric Living Centers" of the State of Ohio. But most of all this Nation needs to devise and finance a comprehensive system of long-term care. We need also to devise and finance a sensible system of home health care for the 8 percent of our elderly who are bedfast and homebound, and the additional 6 percent who have problems of mobility.

We need to give full support to those agencies in government which serve or could serve in an advocacy role for our senior citizens. The Administration on Aging of the U.S. Department of Health, Education, and Welfare should be encouraged to reach this stature.

The Congress has currently authorized $105 million for programs for the elderly under the Older Americans Act, through the Administration on Aging. The administration, however, to the dismay of our elderly and all who are concerned for them, seeks an appropriation of only $29.5 million. We urge that the full $105 million authorized by Congress be appropriated and spent.

We are concerned that funds for the Foster Grandparent program, which we administer in Chicago, be increased and not cut. We are concerned that continued funding be provided for our citywide nutrition program for the elderly. Chicago already puts up 50 percent of the money for this program, for which Federal funding will run out on June 28. We are concerned that funds be provided to continue and expand such programs as mini-buses for older people, homemaker services, senior centers, meals on wheels and a host of others. We are especially concerned, since the field of aging is new and lacks both personnel and experience, that research, demonstration and training programs should proliferate rather than be reduced in scope and number.

All of these programs have as their chief goal the provision of services and the stimulation of activities designed to keep our senior citizens living independently in the community for as long as it is possible and wise to do so, and to keep them out of institutions, no matter how well these might be run.

Any worthwhile philosophy will look at life as a continuum, from childhood through old age and will see a life and the community as a whole. We forget the elderly placed in institutions, or isolated elsewhere, only at peril to us all. So in our consideration of this specific problem, and of that percentage of our people to whom it is literally a question of life or death, we must be mindful that it really concerns us all, and we must begin to take up realistically the whole new problem of numbers of older people in our Nation, and of priorities and programs for them—20 million strong.

Thank you.

Senator Percy. Mr. Ahrens, I thank you very much indeed and your colleague's name is what?

Mr. Ahrens. This is Mrs. Frank Oliver, Andreé Oliver.

Senator Percy. How do you spell her last name?

Mr. Ahrens. O-l-i-v-e-r.

Senator PERCY. And Mrs. Oliver, would you care to make any comments?

STATEMENT OF MRS. FRANK OLIVER, ASSISTANT DIRECTOR, DIVISION FOR SENIOR CITIZENS, CITY OF CHICAGO

Mrs. OLIVER. I would like to make two points as a result of listening to the hearings for 2 days.

It seemed to me one question occurred which needs clarification.

The question was asked: Why was it that certain nursing homes can do a good job with old-age assistance payments while others cannot—the implication being that some homes, in effect, do a good job with this kind of payment?

OLD-AGE ASSISTANCE PAYMENTS CAUSE COST DIFFERENTIAL

I think it should be made clear that when nursing homes do a good job while serving old-age assistance recipients primarily, they do so by absorbing the difference in cost. If they are nonprofit organizations, they must identify other sources of supplemental funding; if they are for-profit organizations, then, obviously, the other paying patients absorb the cost.

I don't think it is conceivable that nursing homes could provide even minimum or acceptable service on the level of payment allowed by public assistance.

QUALITY OF PERSONNEL IS MAJOR FACTOR

The other point I think I would like to emphasize, after listening to relatives of patients in nursing homes, is that what makes the difference between acceptable and unacceptable service is the quality of the personnel.

All of our minimum standards emphasize bricks and mortar. Physical surroundings are important but what really matters is the quality of personnel serving the older people and I would like to see more emphasis on that part of the minimum standard codes.

Senator PERCY. Fine. Thank you very much, indeed.

I would like to ask you though, is it possible that public aid does not provide for adequate care?

I think our point yesterday was whether or not better care could not be provided; minimal repairs, basic repairs, basic cleanliness standards for a little more expenditure and a little more concern about it. I ask you the question: Whether, when we had the conditions as described at Kenmore, whether a man taking out of it in salaries for he and his wife, $14,000 in 1 year and $51,000 in profits on a $40,000 equity investment, in addition to that having a cash flow of $31,000 for depreciation and amortization, doesn't it seem somewhat unreasonable that the bare minimum standards were not being maintained and weren't until this investigation began?

Now, you wouldn't defend that kind of practice, would you?

Mrs. OLIVER. Oh, no, not at all. I am just suggesting that by raising the requirements for personnel qualifications we would also raise

the salaries. This would automatically change the quality of service and shift the balance between expenditure and profit. That was my thought.

Senator PERCY. Fine. I would like to say, Mr. Ahrens, I addressed the Conference on Aging of the National Council on the Aging in Washington.

Mr. AHRENS. Yes.

Senator PERCY. And I was struck by the number of young people in that work.

I am struck with the fact that both of you are relatively young and yet your perception of the problem in the statement that you have made is one of the best short summary statements that I have heard. You have pinpointed the need and focused attention on the things we are not now doing. I think is very, very admirable, indeed.

I am particularly concerned about the nutrition program that we have had as an experiment in Chicago. Funds have not been requested for the extension of this program.

WHAT WILL HAPPEN TO CHICAGO'S NUTRITION PROGRAM?

What will happen in Chicago if this program is closed down?

Are there city funds available for it, Mr. Ahrens?

Mr. AHRENS. Well, there will be——

Senator PERCY. Or will we just close the program down?

Mr. AHRENS. We just can't close the program down. The city is already into the project with a contract with the Federal Government which calls for 50-percent local funding. Some $175,000 of city funds is in the contract.

I discussed this with the mayor some time ago and I know he has strong feelings on this. As soon as we are over the events of the next week, I hope to sit down with him and others and be able to persuade them to help find some way that the city itself would be able to continue the program if the Federal Government strikes out.

Of course, we hope that the Federal Government won't strike out.

We think the clear demonstration is that the program has been most successful. The elderly will tell you this with even more effect than we can.

It has not only provided food, but is a fundamental preventive program of health maintenance.

It has also provided socialization. There are people who have found friends and activities as a result of the program.

We may well be keeping these people out of the nursing homes and other institutions.

Senator PERCY. I see.

Mr. AHRENS. It was a wise investment.

I would rather see that kind of money go into nutrition for the elderly than to some of the kind of people who run some of these nursing homes.

Senator PERCY. Can you give us or provide later for the record, the Public Aid—how much Public Aid pays on the average for nursing home care and how much is paid for medical patients on the average?*

*See appendix 1, exhibits 2, 3, 4 and 5, pp. 1335–38.

Mr. AHRENS. We can get these figures.
Senator PERCY. You can get those figures?
Mr. AHRENS. Yes, sir.
Senator PERCY. Thank you.
Are you familiar with the seven-point proposal I made last week and which I will soon introduce before the Congress.
Mr. AHRENS. I went back to my office last night and among the materials on my desk was the press release from your office. I made a note to get the full text of your statement since I had to be in Springfield and couldn't be in Washington to hear your talk.
Senator PERCY. I would very much appreciate a reaction from you with regard to one of my bills. Particularly the one calling for an Assistant Secretary of Housing for the Elderly.

HOUSING FOR THE ELDERLY IS AT CRITICAL STAGE

Mr. AHRENS. The most frequent inquiry we get from older people is with respect to housing. We know that Chicago has built more housing for the elderly than any city and yet there are still 10,000 to 14,000 elderly on the waiting list for housing.
I would like to say, while I am here, that it is a pleasure to be representing the city of Chicago, when we have two Senators from the State of Illinois who have managed to identify themselves with the aging, in your capacity as a member of this committee, and Senator Stevenson, who is on the Subcommittee on Aging of the Labor and Public Welfare Committee. It leads me to believe that perhaps Illinois can lead the way for the Nation in programs for its older people.
Senator PERCY. This is going to be and has to be a coordinated effort and I am very pleased indeed to be working with Senator Stevenson on this area and I think he would join me in saying that we are privileged to work with the city officials that have as much of an insight into the problem and devotion to it as you obviously have.

COMMENTS ON FUTURE BILLS FOR THE ELDERLY

I would appreciate very much your critical comments on the other bills. They include a bill to improve conditions in long-term facilities, to develop stricter Federal standards.
A bill to remove travel restrictions on the elderly imposed because of lack of funds, half-fares on any transportation situation that cross the State lines; buses and whatever it might be, and half-fare in nonrush hours and a seat availability for all airlines as well, which has worked so well with the young people and would enable the elderly people to travel about also.
The shocking thing is that with people over 65, only 1 percent during a year move from one State to another; 20 percent of the population changes residence every year. So we are mobile families and/or people until we get into our older years. Then mainly through lack of funds people just can't move about.
A bill to restore 100 percent deductibility of medical expenses for seniors.

A bill to include drugs under Medicare which would eliminate partial payment by the consumer.

A bill to provide employment opportunities for the elderly in a number of different ways. I want your comments and as a matter of fact, I am looking for critical comments because that is where we can improve and I will appreciate it.

Mr. AHRENS. We will be happy to supply it, but I can almost endorse all of them as proposed, just by hearing their titles.

Senator PERCY. I might add I am putting a special amendment in to the second supplemental appropriations bill which will call for the funding of all 18 nutritional programs for the elderly that now exist across the country for another year.

It is a very modest expenditure, $1.7 million, and to lose those programs and all the benefits that we have gained for the thousands of people that are benefiting from it, I think would be a national tragedy. We can take some of the money out of the SST.

I yield to Senator Stevenson now that we have saved all of that money.

Senator STEVENSON. We can do a lot of work with that money, too.

Mr. Ahrens, I just want to thank you for making what I regard as a very valuable contribution to this hearing, to this committee.

Among other things, you have pointed out that only 4 percent of the elderly are institutionalized and that the object of our policy should be to try to keep senior citizens out of our institutions, dividing them up, at least to be a part of American life and lead healthy comfortable lives and be a part of society. I agree completely on that.

I just want to say for the record, before I ask a couple of questions, that we have heard an awful lot of pious concern, self-righteous indignation expressed in these hearings and yet, as you point out, the administration which expresses concern for the plight of the elderly in the country is seeking to slash funds authorized by the Congress for the Administration on Aging.

CONGRESS AUTHORIZES . . . ADMINISTRATION SLASHES

The Congress has authorized $105 million, which in itself is a pittance and this administration is requesting only $29.5 million.

Well, let me just ask you about that nutrition program that you were referring to a moment ago. Where do the Federal funds come from for that program? Is that under title IV?

Mr. AHRENS. That Federal funding comes from title IV under research and development.

Senator STEVENSON. Title IV of the Older Americans Act?

Mr. AHRENS. Title IV of the Older Americans Act.

Senator STEVENSON. That would have to come out of the $29.5 million?

Mr. AHRENS. Yes.

Senator STEVENSON. Well, I could just suggest that there is not much chance of the administration—there is not much chance of it, if the administration only gets an appropriation of $29.5 million—of

providing you with funds for such a program, let alone such programs all across this country. I am sorry to have interrupted you, but I wanted to ask about the Foster Grandparent program also. This is a program that has been of great interest to me. I know of no other program that I have ever seen converted into action by any kind of, by any government that does so much for so many people with so little money.

It is a program which does involve elderly citizens actively and constructively in our society and they provide affection and training to needy children. The children themselves gain from this program and the real parents gain from it. What is the administration doing in this case? You didn't mention the figure.

ADMINISTRATION'S PROPOSAL FOR FOSTER GRANDPARENT

Mr. AHRENS. Well, I hate to tell you, but there is only something like $10 million currently in the Foster Grandparent program and they want to cut it back to $7.5 million. And our grandparents in the city of Chicago read the newspapers and hear these things over the news media.

I have seen what happens at places like Chicago State Hospital, with respect to youngsters who couldn't even be diagnosed, because they were both emotionally disturbed and mentally retarded. Over a period of a few months, just the work, the attention, the affection of these older people who had been trained to be foster grandparents, made the difference. In a whole ward—they were able to diagnose the youngsters in it and the ward was transformed.

It leads me to believe, too, that we ought to build on these kinds of things. We could not only do more for our elderly, but possibly for our elderly in the State mental hospitals, but where the younger people could work with them. We ought to put enough money in for the Foster Grandparent program to expand, and try it the other way around also.

PENTAGON P/R COSTS EQUALS BUDGET REQUEST FOR AoA

Senator STEVENSON. Senator Percy mentioned the SST a moment ago.

The budget requests for the Administration on Aging is roughly equal to what the Pentagon would have spent just for its public relations activities. Maybe we can save a little money there, too.

Senator PERCY. If I recall, I voted for the full amount, but they cut the $15 million out of it.

Senator STEVENSON. Mr. Ahrens, is it true that Mayor Daley has said that the city would seek Federal funding for Senior Citizens Patrol of the nursing homes.

Mr. AHRENS. Yes.

Senator STEVENSON. Could you amplify or explain that?

Mr. AHRENS. This is an idea that came about in relation to the Foster Grandparent concept.

This is a program that would take into account not only the fact that everyone wants to stay in their community, in independent liv-

ing, but that, maybe, the elderly themselves ought to be involved in the policing of these nursing homes and extended care facilities. We thought we might draft a proposal and seek Federal funding, just as we did with the local Foster Grandparent program. We would recruit, screen and place elderly people with the Board of Health and then continue to provide them with in-service training. Possibly they could have a 20-hour-a-week schedule, as our foster grandparents work. The Senior Citizen Patrol of the elderly would inspect the nursing homes and also visit the patients who are in these homes.

So we are going to get busy and draft a proposal.

Senator STEVENSON. This would be a proposal under what Federal program?

Mr. AHRENS. I don't know at the moment.

I thought possibly under title VI of the Older Americans Act, but I really have difficulty figuring out what is happening to the funding in Washington at the moment.

I have somebody researching title IV with respect to the Social Security Act and other Federal legislation to see where the money might be.

Senator STEVENSON. There is, of course, also the possibility that Congress will, in the near future, pass the Manpower Development Act, which, as you know, includes substantial sums of money for the employment of the needy people in the public sector which just might offer some opportunities for employment of elderly as well as the people of all ages to help with the care of the elderly.

At this point we don't know whether that bill will get by the White House. It didn't in the last session, but I do expect it will pass in the Congress.

Mr. AHRENS. We gave that bill study last year and we estimated some 5,000 older people could be placed in useful activity in the city of Chicago.

ARE FEDERAL REQUIREMENTS FOR TITLE III FUNDING MET?

Senator STEVENSON. Has the State of Illinois met the Federal requirements for title III funding under the Older Americans Act?

Mr. AHRENS. Well, this is what troubles us and why I mentioned Illinois Senate bill 147.

The Federal Government issued new regulations last August 5, which were to be enforced on March 15 of this year. They require that every State office on aging be either a separate agency reporting to the Governor, or if it is in another department, that it be equal to the top function in that department.

This is not so at present in Illinois. Our current office is only a section in the Public Aid Department where, in my estimation, it doesn't belong anyhow.

I have been unable to get a copy of the new State plan that was to be filed, but my assumption is that the old State plan was just refiled without any updating to meet the requirements for which the deadline was March 15.

Therefore, we are subject to withholding of title III funds for every project under title III in the State.

So the city was concerned. We knew there was a cutoff date in

April for introduction of legislation in the Illinois Legislature. Some senators—Senator Esther Saperstein of Chicago was the chief sponsor—introduced Illinois Senate bill 147, which was reported out "do pass" 2 weeks ago by the Senate Public Welfare Committee and I think is before the Appropriations Committee now.

I do have here a fact sheet on the bill which I would like to submit.*

S. 147 would set up a State office that would meet Federal requirements.

In addition, it would double the appropriation for the office which is minute in any event. It now gets only gets $100,000 a year. It will get $200,000 a year and it would enable Illinois to do a more effective job in statewide planning and evaluation. This gets back to what we were talking about on the discharge program of elderly patients, which was truly poorly planned.

A State office that was better placed and funded would have made sure that that kind of thing didn't happen.

Senator STEVENSON. We hear a lot, Mr. Ahrens, about revenue sharing and the pressure being brought to bear in the Congress at the moment to try to get the Federal Government to turn over large sums of money to the States to be spent as they see fit.

What State programs do we have now for the care of the elderly outside of our custodial care in our mental institutions?

Mr. AHRENS. Well, apart from title III funds, it would be hard to think of any programs except those funded by the city of Chicago.

Senator STEVENSON. When I was Treasurer, not too long ago, we had a rather substantial earmarked fund in the Treasury for our race horses in Illinois. I can't seem to recall anything for the care of the elderly.

Mr. AHRENS. The city of Chicago provides for my office—$0.25 million for personnel. We were the first municipal office on aging in the Nation. New York City has one that is, I believe, Federally funded. Philadelphia set up a commission 2 or 3 years ago, and I think San Francisco now has a Commissioner on Aging. The city of Chicago, through our division and other related support activities of our department, annually puts $0.5 million to $0.75 million of corporate funds into our work for the elderly. The State of Illinois apparently is putting into its work for the elderly only the $100,000 it allocates to its State office on an annual basis.

Senator STEVENSON. That answers the question.

Thank you very much, Mr. Ahrens.

Mr. AHRENS. Thank you, Senator.

Senator PERCY. Thank you, Senator Stevenson.

I think we shall excuse both of you with our gratitude and appreciation.

I am terribly sorry to have asked you to do more work when you leave, but I am certain that we will benefit from it very much, ineed.

Thank you.

The Committee will call one witness who, because of time, was unable to testify yesterday.

We will call now Dr. Jack Weinberg; and Mr. Daniel A. Slader will be the next witness to be called.

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*Retained in committee files.

Is Dr. Weinberg here?

Dr. WEINBERG. Yes.

Senator PERCY. Dr. Weinberg is director of Illinois State Psychiatric Agency and, Dr. Weinberg, we are pleased to have you here. If you have a prepared statement, we would appreciate copies of it.

Dr. WEINBERG. No, sir, I haven't.

Senator PERCY. I understand you don't have extra copies yet?

Dr. Weinberg. No, sir.

Senator PERCY. If you have a statement to be submitted, the statement as a whole will be incorporated, Dr. Weinberg, in the records of these proceedings and distributed, of course, to all committee members, and if you would care at this time, in the interest of time, to summarize your thoughts, perhaps that would be the easiest way to facilitate it.

Dr. WEINBERG. Thank you, Mr. Chairman.

First I would like to correct my title.

I am Clinical Director of the Illinois State Psychiatric Institute.

Senator PERCY. And I am saying you are Chairman of the Committee on Aging of the Group for the Advancement of Psychiatry.

Dr. WEINBERG. That is right.

Senator PERCY. It is wrong in our agenda as originally printed?

Dr. WEINBERG. Yes, I wanted to correct the statement, that I am not the director, but the Clinical Director of the Illinois State Psychiatric Institute, which is a training and research institute for the Department of Mental Health and therefore, I come to you both as a concerned citizen, as a psychiatrist within the Department of Mental Health, as Chairman of the Committee on Aging of the Group for Advancement of Psychiatry and a member of the Task Force on Aging of the American Psychiatric Association.

STATEMENT OF DR. JACK WEINBERG, CLINICAL DIRECTOR, ILLINOIS STATE PSYCHIATRIC INSTITUTE

I cite the above to indicate that I have been involved in the area of aging for even a longer period of time than Mr. Ahrens who is the same age as I am, only I show mine, having been greatly concerned with the problem.

I am grateful to the Senate Special Committee on Aging for having come to the State of Illinois, not so much to investigate, I hope, nor to put the finger on anyone because we are all culpable, but rather to shed some light on the problem and to see what it is that we can do about improving the quality of life of our elderly citizens.

I am not going to catalog the ills of the nursing home industry and of related facilities.

We have all heard of them, and only too often, and only yesterday you have heard a number of people who presented their feelings as well as their findings about their relatives in nursing homes.

HUMAN RESPONSIBILITY IS IMPORTANT ISSUE

Throughout I have heard and continue to hear the need for very respectable aspects of fiscal responsibilities both on the part of the

Government and on the part of the nursing homes, but what gets lost is the human responsibility which I think is much more important and which brings me to an important issue.

I think that the great uproar about nursing homes must be seen not only in the context of what happens to individuals in that situation, but also in the context of the entire philosophy of the concept of a nursing home.

Other aspects, expectations that we set up for individuals when we state that they are going to go to a nursing home must also be considered.

The appelation, the very words "nursing home" are misnomers in many instances.

They seem to make a promise and, I believe, an implicit contract with the individual who comes into the nursing home, that this is going to be a home. And the very word home conjures up a host of feelings, a constellation of concepts of what it should be like.

No matter how bad, one's own home, that which one calls home might be. When at the end of the day we all say "I am going home," we imply that we are going to a place where we are going to be understood, taken care of, given warmth, food, shelter, and even love.

Is this given to the elderly when they enter a nursing home? The word nursing, too, implies the promise of providing nursing care—the type of nurturing that a mother gave to the infant when she nursed the infant.

These implied concepts and exceptions are lost and are not fulfilled when an individual enters a home called a nursing home, a facility for their long-term care.

I think also that it is important for us to realize that when we speak of programs to return people to the community, then we again conjure up a new concept fraught with emotional connotations.

What does a community mean?

Are we returning many of the people who go to nursing homes to their community or communities?

The fact is that many of the elderly are placed in nursing homes which are located in communities far away from the families of the old and certainly far away from the place where these people spent most of their adult and mature years. We are creating communes for the sick elderly within communities in which they have had no roots.

Criticizes Department of Mental Health Program

Here I address myself, of course, to the criticism that has been leveled at the Department of Mental Health, for having released so many elderly people into the communities.

I must state that I am one of those who criticized the program severely. I criticized it not because of its philosophical concept, but rather because of the notion, the idea of transferring inordinately large numbers of people into nursing homes from mental hospitals.

I was amazed when, about 2 years ago, the new Governor of the

State of Illinois, Governor Ogilvie, announced that he was going to release 7,000 elderly patients into the community.

I didn't know who made the important clinical decision that these 7,000 peoople were not mentally ill. To my mind it echoed something that had occurred in 1941 when I initiated a program in the State of Illinois, for the foster home placement of psychotic individuals into the community.

At that time too, it was announced that these people would be released into the community through an accelerated program and the figure that was announced then was also 7,000 and it strikes me that this 7,000 is some kind of a magical number of people that the State feels do not belong in the State hospital system.

I would like to, if I may, Mr. Chairman, to read from a paper of one of my favorite authors—meaning myself—a paper that I have presented before the American Psychiatric Association describing this system which I had started in 1941 to release individuals into the community.

I call attention to this to indicate that I am philosophically not at all opposed to placement of the ill in appropriate situations, if it were to be done on an individual basis. A basis concerned with the needs and the dignity of the individual person, and not with the cold needs of a monolithic system.

I stated in the paper that:

I am convinced that a more liberal policy of the release of patients would have important psychiatric and human values.

The superintendent of hospitals in consultation with the central control authorities adopted a policy that the State's resources should no longer be thrown into the building of additional wards and the provision of new beds, but rather in the direction of an enlarged extramural mental hygiene and supervisory service, a liberal release program, longer and more careful supervision after release and the establishment of mental hygiene facilities for the community adjustment of patients who would otherwise be committed.

This was in May of 1941 and in July of that year I had established the Chicago Community Clinics, now known as the Illinois Mental Health Clinics, and the technique is described as follows:

At that time the equivalent time of four additional psychiatrists and 11 psychiatric social workers was added to the staffs of the several hospitals to carry out the new program.

In addition, other people of the medical and social workers staff devoted more time and effort in seeking out releasable patients, preparing them for discharge and assisting with their subsequent supervision.

New Clinic To Supervise Released Patients

Since the large majority of the patients at the Elgin, Chicago, Kankakee and Manteno State Hospitals, all of them should be familiar to both of you, were committed from Chicago and Cook County, a new clinic, the Chicago Community Clinic was established to supervise the patients released from these four hospitals to Cook County.

The number of 1-day monthly clinics for the supervision of newly released patients throughout the State was increased from 12 to 22 days, thus a more careful coverage of the State by the clinics brought the extended extra-mural service closer to the many communities and permitted the release of larger numbers of patients requiring careful supervision.

A diagnostic and consultative service to patients about to be committed was established in the full-time Chicago Community Clinic and the twenty-two 1-day-per-month clinics which I had staffed and where judges, physicians, social workers and relatives used this precommitment service and are given protections for the vocational, social and home adjustment of the patients for whom the precommitment study reveals that institutionalization is not required.

Thus we had started a method of stopping the influx of patients into the mental hospitals by providing alternative care and by providing an assurance to them that we would follow their progress and if need be, they could be readmitted into institutions.

The members of the clinics gave information to the community as to what the State hospital can and cannot do for the different types of personality maladjustments.

During this 18-month period—I reported on this in 1943, at the time when I entered service and during the 18-month period that we had run this clinic—340 patients were removed from the State hospitals and placed with families other than their own under a foster home placement concept.

A majority of this group became self-supporting or was supported by relatives. A minor faction was supported by old-age assistance and only a small number was supported by State hospital funds. In some instances, although the patient did not live with his own family, several of his relatives contributed small amounts so that his placement in the community was possible.

Because of the many legal, physical, medical procedures about which the social workers seemed to have special knowledge, a social service manual on the family care of a mental patient was developed.

Staff meetings were held to discuss the possibility of release of borderline cases and to prescribe the kind of community care needed.

I describe this to you in detail so that you will see what care was taken to effect proper placement.

A form was devised and distributed among the physicians, entitled "Physicians Release Recommendations," to be used at the staff meetings deciding whether or not the patient could be released and subsequently by the physician and social workers supervising the patient after release to the community.

Senator PERCY. Dr. Weinberg.

Dr. WEINBERG. Yes, sir.

Senator PERCY. I would like to remind you that the focus of our investigation and hearing and study is largely confined to problems of the aging as they relate to nursing homes.

Now, all of this material is pertinent, as it relates to the release of mental patients to nursing homes and what effect it has on them. That portion of your large body of experience and testimony relat-

ing to the problems of the mentally ill, I think we can just incorporate into the record,* but we would like to focus your experience and attention this morning on the problems of nursing homes as it relates to release of mental patients. That is really our function and duty and we have just 3 hours left here this morning for a number of witnesses.

So, we would like to question you as much as we can on your knowledge in that particular field, which is our direct and immediate responsibility.

Dr. WEINBERG. I understand, of course, and I am sorry to be so lengthy.

Senator PERCY. But very interesting and very helpful in the general sense but our charter is somewhat confined in the nature of these hearings.

THE ISSUE OF MENTAL HEALTH ELDERLY PATIENTS

Dr. WEINBERG. Right. I will therefore proceed directly to the issue of the release of mental health elderly patients into the community—which was announced 2 years ago.

At that time I was asked by a deputy of the then-acting Director of the Department of Mental Health, who, by the way, was not a social scientist or a psychiatrist, but someone who was recruited out of management in order to determine the fiscal responsibilities of the department.

I thought it was a good move to have someone look into the budgetary activities and whether the finances of the department were judiciously spent.

However, one of the early programs initiated was the release of these elderly people from the State hospitals to overcome crowding. However, I believe that the Governor was ill-advised in announcing that 7,000 patients would be released, in 1 year.

I was then approached and asked by the Special Assistant to Mr. Briggs at that time, to supervise the method of release of these patients from the State institutions.

My first reaction was a negative one, but then I accepted because I felt that this would permit me to carefully evaluate the individuals who would be released into institutions, and to monitor their progress.

For I was not at all convinced that all 7,000 were individuals who were not mentally ill.

I suggested at that time that a committee of known, proven gerontologists, be formed. I submitted the names to the department suggesting that these individuals be the ones who would determine, on a case-to-case basis as to who was to be placed out of the hospital, in consonance with the person's needs.

PRESSURE APPLIED TO SPEED-UP PROGRAM

Soon I felt that pressure was put upon me to move ahead more rapidly with the program despite the fact that I knew that many of the nursing homes were not acceptable nor ready to accept our pa-

*See appendix 1, item 2, p. 1339.

tients; yet these were the facilities where most of our patients were to have been placed.

This prompted me to write a letter, of which you are aware, to the department, stating as follows:

After a few restless nights I feel that I must again reiterate my stand on the proposed discharge of 7,000 old people from the state hospital system to the community. I am principally opposed to such a sweeping pronouncement which is then to be implemented as rapidly as possible. I do not know how the Department of Mental Health arrived at this important clinical decision, a decision which has proven to be untenable in other states. I believe that we are approaching the problem backwards.

When you asked me to provide you with some general statements on policy I had indicated my philosophy and that is that we can stem the influx of aged patients into the hospital through the screening process; that the insert of these people into slots in their communities while the community is still a viable place for them, is tenable and desirable. To discharge patients to nursing homes, boarding homes, halfway houses, et cetera, is not to discharge them into their communities nor do I feel that we will actually be able to provide follow-up services despite our best intentions.

Furthermore, I believe that the Department of Mental Health has done a creditable job in the gradual reduction of patients within the state hospital system during the past decade. Even at present Chicago State is making every effort to place patients in various alternative living arrangements. I honestly believe that a concerted accelerated drive will bring about some disastrous results.

I am fully aware that I may be irked because I was not consulted on such an important issue and then am asked to assume responsibility for the supervision of the same. It is obvious, of course, that I am not at all comfortable and my honest reservations about the totality of the program would make it seem as if I am dragging my feet.

Now to the central issue. You asked me to head up the review team. I was, as you know, reluctant and accepted against my better judgment. I have indicated to you that it may be a tedious job and a prolonged one. If we are honest about the program then we ought to call upon experts in the field of aging rather than other psychiatrists from other facilities who have not worked with the aged to make judgments on this target population. What I am saying is that I would be satisfied only if those who have worked in the field review the case load. The procedure then seems to be simple, the staff at Chicago State Hospital should provide the team with the culled patients to be placed and the team would then go over it one by one.

It was for this reason that I wanted to indicate the criteria that I had established earlier for release of mental patients from a mental hospital. They were direct, clear, important, and bear directly on our issues. I would like to introduce the paper into the record as an appendix to my remarks.

(The paper follows:)

This obviously would slow down the impetus that you would like to generate. I have indicated to you that I trust the Chicago State Hospital staff in their efforts but if you feel that someone else ought to do it, then the above may be the most feasible plan. To have other than recognized geriatricians, i.e. psychiatrists from other facilities, to review the recommendations of the Chicago State Hospital staff is offensive to that staff and thus resentments and resistance may arise.

This leads me to the conclusion that to a certain extent the team that I would propose, and I, would be used as a shield against any criticism of the thrust. I honestly do not mean to ascribe to you any ulterior motives, I just do not like the pressures of rapid and indiscriminate implementation of a program which to me is unpalatable.

That was written September 5, 1969.

I am fully aware that the State of Illinois had, in November, instituted a pilot program in Chicago State Hospital.

I had hoped that my letter would have some meaning and would decrease the impetus, would slow down and provide a more careful review of the patients who were released, something which I think has been done. However, some of the places to which they were sent were not of the best, even though they were licensed, for licensing is not enough.

May I be permitted to make a few suggestions as to what I think should be done?

Senator PERCY. Yes.

Dr. WEINBERG. The Group for Advancement of Psychiatry has formulated a policy toward the elderly, which has been published, a booklet which I took the liberty of sending to both you Senators, Percy and Stevenson, the receipt of which both have been gracious enough to acknowledge.

Senator PERCY. I would like to say that that is considered by professionals that know a great deal more about it than I do as a layman, as an excellent report, and I think the report issued under your chairmanship, the entire group should be commended for this report. You have contributed to the body of understanding that we have in this field.

Dr. WEINBERG. Thank you.

There, most of our recommendations have been stated. I would like to add this possibility for consideration for legislative action.

I have recently returned from an extended tour, having been awarded a senior stipend by the National Institute of Mental Health, to study the delivery of services to the elderly in Europe and the Middle East.

UNIQUE PROGRAM FOR ELDERLY IN THE NETHERLANDS

I saw one program in The Netherlands which, to my mind, was way ahead of anything that we have done.

Despite the fact that they had, throughout the years, excellent programs for the aged, they have recognized that not enough has been done for long-term-care patients.

They have, therefore, 2 years ago, passed a law that all employed, and self-employed people were to be taxed.

One percent of their annual income up to 18,000 guilder, which was about $5,000 American.

This 1 percent went into a special fund which was to take care of long-term illness solely.

So far their experience has been that this has been more than enough to pay for the percentages of those who were in need of long-term care. I don't know whether this could not be incorporated into the Social Security Act or if not whether we in some way could institute a similar program.

It was made more palatable for the citizens of Holland by having the employer pay the 1-percent tax rather than the employee, but those funds went into the provision for care of the sick elderly as well as for those with long-term illness.

I cannot emphasize enough the need for a community program for the elderly in order to move away from the institutionalization of these individuals by preventive social action.

A great deal can be done, as has been done in Europe, to stem the influx of patients, of sick elderly into the institutions.

Senator PERCY. Dr. Weinberg, you mentioned in your report——

Dr. WEINBERG. Yes?

Senator PERCY. Under the care for the elderly, the tremendous boom in issues on the stock exchange in facilities for the care of the elderly.

In other words, Wall Street and LaSalle Street look upon this as—and Market Street in San Francisco look upon this as—a big business.

What are your general observations and recommendations with respect to whether, as we go from 25,000 to 50,000 homes for the elderly, whether we should continue on the same course of having about 90 percent of them organized for profit?

PROFITMAKING HOMES FOR ELDERLY—NOT BEST WAY

Dr. WEINBERG. I suppose it would be un-American on my part to state that the capitalistic system is not a desirable one. It would also be injudicious on my part to indicate that some of the places with a profit motive have failed to provide good services, but, I do think so many of them have seen a way of making what you have yesterday termed "a fast buck."

It is impossible for me to visualize how an institution that is going to provide the humane care which a human being ought to have, that we piously state should have concern, that we eloquently sometimes address ourselves to, and yet be able to make a profit.

It is impossible to visualize how any nonprofit organization which runs the better types of places can do it on a profit basis. They usually come to the public and ask for funds to take care of their deficits.

I think there are good places that can show a profit. The costs, however, would be exorbitant—and only the affluent could possibly afford it—but the vast majority of our people cannot, and therefore so many tragic placements.

Senator PERCY. Don't you imagine that there is the possibility that the operators of these nursing homes organized into an association and an officer of whom we will have before us in a few minutes, put pressure on the State and other government officials to release patients so they want to fill beds?

They have got stockholders' reports to make and dividends to pay and profits to show. They have got empty beds and they are going to fill them with bodies and maybe those bodies are going to have to come out of the mental institutions.

Don't you think that sets the pressure up then to fill those beds?

BRIBERY ATTEMPTED BY NURSING HOME OPERATOR

Dr. WEINBERG. It certainly does. May I reveal something personally, that when I was asked to supervise this program and it was announced, someone in my family was approached by a nursing home

operator, asking my brother to be exact; to approach me to direct patients into his home and that he would offer me a stipend of $100 per head.

This actually happened and appalled both my family and me.

Senator PERCY. And $100 a head is double the rate charged by what were humorously referred to 25 years ago as the 5 percenters in Washington. Is it true that operators many times feel that their standards should be $1,000 profit per year per head or per bed or per patient in a nursing home and that is what they shoot for?

Dr. WEINBERG. Yes.

Senator PERCY. So that 10 percent is a reasonable kickback, I suppose?

I appreciate your revealing this very much, indeed, and should you wish to provide this committee with any further details on that, we would be happy to put an investigator behind it. I think that exposure of this kind of wrong-doing and the frank admission by you, is the best way that we can get to the heart of these problems.

I imagine you must have been shocked and——

Dr. WEINBERG. Indeed.

Senator PERCY. You mentioned in your report that standards, the Government has an obligation to impose standards now that will be adequate, and I wondered if you feel that standards that have now been established are adequate, Dr. Weinberg?

In other words, do we have adequate standards at the local, State and Federal level now, or do we need to go back to our homework?

ADEQUATE STANDARDS—INADEQUATE ENFORCEMENT

Dr. WEINBERG. I think that there are adequate standards.

The difficult issue, as Mrs. Oliver had pointed out, that while we can legislate standards, the width of doors, bars on the halls and the lighting, fire escapes, et cetera—we cannot legislate as to the human elements that are involved in providing the care——

Senator PERCY. Well, now——

Dr. WEINBERG. For these individuals.

Senator PERCY. When you say the human elements, aren't we then specifically talking about the enforcement of those standards, not only self-enforcement of those standards. Money that we pay for that, inspection which is not resulting in good patient care, is coming out of your tax dollars.

So that it is really a question of the enforcement of those standards rigidly by a sampling inspection at every level of government that is involved, but also a policing at the level of the home itself?

Dr. WEINBERG. Yes, indeed.

Senator PERCY. Fine.

Dr. WEINBERG. And I think one of the concerns that all of us working in the field of geriatrics have had, is that there isn't enough trained personnel to provide the care within those facilities; that provision for training has been cut back by our Federal Government; provision both for research and training, and just this morning I was shocked to read in the press that cuts in Medicare are being considered.

Senator PERCY. Yes.

Dr. WEINBERG. Rather than providing more care.

So that obviously the situation might get worse if you gentlemen permit it, you and those who feel like you, permit it to get out of hand.

QUESTIONS RAISED BY RELEASE OF STATE PATIENTS

Senator PERCY. Dr. Weinberg, the question of releasing patients from State institutions to nursing homes is a policy that I am not familiar enough with all of the facts to really be able to evaluate and judge.

I just really have begun my initial investigation of that by talking to some of these mental patients yesterday in their thirties who were housed with the elderly there in their seventies, eighties, and nineties and it is a problem that I think, because of the devotion of our own staff and deep interest that they have; we are going to direct our activities as Senators to that to do everything that we can to see what the best policy is that can be established.

However, I want to be certain that when you raise the question, and I think it is phrased something like this:

How was the decision made that the persons transferred from the mental hospitals were not mentally ill?

I raised the question:

Is it possible through your experience that we could have, in past years and maybe presently, been dumping a lot of the elderly in the mental institutions who, in effect, are not really mentally ill—and we had direct testimony yesterday from the family of a woman who was not mentally ill, who was dumped into a State institution to get rid of her; and if that is true—how many do you think, if we carefully went back over and reviewed or reaudited to see what could have happened through some rehabilitation, how many could we find in our State institutions that might be transferable, and might find rather than a huge institution, a better life in a smaller properly run nursing home?

Dr. WEINBERG. Well, I think you phrased it very well, Senator Percy, and that there is no question but that we might find individuals there who should not be there and who should never have been admitted in the first instance.

Studies, however, have indicated that in many areas of the country, that there are very few who are admitted to State institutions because of mere old age.

What we find is that many people who are physically ill, manifest mental problems also.

The need then is to have them medically well examined and treated in general hospitals and in other satellite institutions prior to an admission to a mental hospital, if not to preclude it.

Many of them might have had an intercurrent infection which produced a toxic state with confusion and symptoms that might well be considered to be psychiatric in nature. These symptoms could rapidly pass once the individual entered the institution, was treated medically; hydrated or dehydrated et cetera, as the necessity arose. They may have been overmedicated or undermedicated.

Some of the elderly have trouble remembering, therefore, they don't remember when they take their medication, fail to take it, or frequently take medication more than once and overdose themselves.

Once the medication is removed, the symptoms lift; and, once they clear up, it doesn't seem to be necessary to place them in institutions.

My feeling is that we can stem the influx of these people into institutions by providing medical care in general hospitals for the removal of all medical and physiological illnesses if possible, until we are able to determine whether one is really psychiatrically ill or not.

Senator PERCY. Thank you, Dr. Weinberg, very much, indeed, for your most interesting and helpful testimony.

I yield to Senator Stevenson.

Senator STEVENSON. Dr. Weinberg, I think it would be helpful if you would make a copy of that letter available to the committee for inclusion in the record, the letter of 1969 which you wrote about accelerating discharge.*

Dr. WEINBERG. Yes.

Senator STEVENSON. Thank you.

Is there any clinically accepted way of drawing the line between senility and mental illness?

WHAT DIFFERENTIATES SENILITY AND MENTAL ILLNESS?

How do you differentiate between what we commonly regard as senility and on the other hand, illness of the mind which does or should require custodial care in our public institutions, mental institutions?

Dr. WEINBERG. This is not an easy question to answer because it has vexed many people, and there are divergent opinions about it.

By psychotic, if we were to define it clearly, it would mean that the individual manifests a thought disorder added to the memory defects, poor judgment and confusion. But to my mind—and there are many of us in the psychiatric field who believe—an individual who suffers from a chronic brain syndrome, which many define as senile, is suffering a mental illness. Senility is a wastebasket category in which we place elderly people who are confused, have memory difficulties, lack of judgment, misidentify people; but, who are not bizarre in their behavior, who don't have delusions, who don't have any thought disorders—usually harmless—but may be self-destructive.

Yet to my mind, they are mentally ill people and often in need of protective and medical care.

I believe further that many of our mental institutions, even though some of them may be snake pits, are better places than some of the nursing homes in view of the fact that they, at least, have such necessary items of care as 24-hour coverage by a nurse, a fire alarm system and the food in the State hospitals is nutritionally adequate; and some facilities for some minimal activities is also present in most mental institutions of the States.

OTHER MOTIVATIONS HELP CLASSIFY PATIENTS?

Senator STEVENSON. In 1969 or whenever it was that the accelerated discharge program began, were there, in addition to differences of opinion over who should be classified as a mental patient and re-

*See p. 1217, for text of letter.

tained as such in the mental institutions, other differences, other reasons for discharging patients such as, oh, just simply saving money in the Department of Mental Health or the opportunity perhaps, to get a larger share of the Federal pie perhaps through Medicaid for the care of the elderly?

Dr. WEINBERG. Yes, there have been other differences of opinion because there are two populations in the State hospitals. Those who were psychiatric patients admitted in their youth or midlife, diagnosed as schizophrenics who have lived and aged in the institutions. Some of them who have been there 30, 40 years and have considered the institution as their home and who, through the years, have become so docile that it was felt that they could go out of the State hospital, and be placed somewhere else in the community where no rehabilitation is provided for.

I for one—for humane and psychological reasons—questioned the propriety of the release of these individuals. Those who have been in institutions for 40 years—and call it their home—to another strange place, with no resources available to cope with a new environment.

Senator STEVENSON. Well, was specifically, Medicaid one of the inducements to the authorities in the Department of Mental Health at that time?

It did offer, I suppose, more Federal funds in the State of Illinois through the nursing homes which care for the elderly?

Dr. WEINBERG. I would avoid stating that this was the motivating factor. It could be, of course, but I would not ascribe it to people in the Department of Mental Health.

My difference of opinion and my fight were purely on a psychiatric basis and on my knowledge of what the nursing homes were like. That many were not proper places for our patients to go to; and that we could provide—even under the worst of circumstances—better care than some of the nursing homes to which patients would be destined to move.

Senator STEVENSON. Just for the record, you are not suggesting that all the problems of the nursing homes in Illinois or Cook County are solely due to this program of accelerated discharge of mental patients?

Dr. WEINBERG. No, I do not. They had problems prior to the discharges of the mental patients.

Senator STEVENSON. Yes.

Let me just ask one final question. You referred to the delivery system for extended care in the Netherlands. How are those delivery systems structured?

Are these nonprofit, private institutions or are they public institutions or what?

Dr. WEINBERG. Yes, they are public institutions.

Most of the elderly in Holland and in European countries are covered by pensions. There is the National Health Insurance program.

There are a few voluntary places, but on the whole, they are mostly public.

I found an interesting situation in Sweden where 40 percent of the people of 65 and above choose to go to homes for the aged.

That, indeed, is a startling figure in contrast to what happens here.

I found delivery of services in the Scandinavian countries, in Scotland, in England, and in Israel superior to what we are doing here.

Senator STEVENSON. All of them provide, as a result of—I don't know whether you would call it insurance——

Dr. WEINBERG. National Health Insurance programs.

Senator STEVENSON. As part of the comprehensive national insurance——

Dr. WEINBERG. Correct.

Senator STEVENSON. Program?

Dr. WEINBERG. Correct.

Senator STEVENSON. Extended care for the elderly is provided?

Dr. WEINBERG. Yes.

Senator STEVENSON. I think that the committee would be well advised to look into that.

Dr. WEINBERG. The thing to remember is that Holland, which still has a National Health Insurance program, still saw fit to pass a law for the care of the long-term ill patient. This is what is so lacking in our Medicare and Medicaid programs because it is the chronically ill who have suffered most.

Senator STEVENSON. Thank you very much, Dr. Weinberg.

Senator PERCY. Thank you very kindly, Doctor.

The committee now calls Daniel A. Slader as administrator of Melbourne Nursing Home.

Would you identify yourselves and your colleagues?

SWORN STATEMENT OF DANIEL A. SLADER, ADMINISTRATOR, MELBOURNE NURSING HOME; REPRESENTED BY THOMAS SULLIVAN AND ALLEN METZ, ATTORNEYS

Mr. SLADER. My name is Daniel A. Slader and I am administrator of Melbourne Nursing Center located at 4621 North Racine Avenue in the city of Chicago.

On my immediate left is Mr. Thomas Sullivan of the firm of Jenner & Block, attorneys at law, and on his left is Mr. Allen Metz, associate counsel with the same firm.

Senator PERCY. It is your intention, Mr. Slader, to testify directly yourself and on occasion, where you need technical advice and counsel, to confer or will you ask your colleagues to directly testify on your behalf?

Mr. SLADER. Well, I will testify, Senator, with respect to matters of which I have knowledge.

As to any matter that they may have knowledge, that I don't have information on, I would ask the Senators if they would allow them to testify.

Senator PERCY. All right, fine.

And in any case where they testify and in which you yourself have no personal knowledge or cannot certify to the accuracy and truth of it, would you so then indicate to us?

Mr. SLADER. Yes, sir.

Senator PERCY. The subpena requesting your appearnace will be entered at this point in the record.

(The subpena follows:)

UNITED STATES OF AMERICA

Congress of the United States

To Mr. Daniel A. Slader, Administrator, Melbourne Nursing Home, 4621 North Racine, Chicago, Illinois, Greeting:

Pursuant to lawful authority, YOU ARE HEREBY COMMANDED to appear before the Special Committee on Aging of the Senate of the United States, on April 2, 1971 ~~XXXXXX~~ at 9:30 o'clock A. m., at ~~their committee room~~ University of Illinois Circle Campus, 250 Behaviorial Sciences Building, then and there to testify what you may know relative to the subject matters under consideration by said committee.

The Committee requests your appearance along with financial records relating to the operation of the above named nursing home for years 1966 through 1970.

Hereof fail not, as you will answer your default under the pains and penalties in such cases made and provided.

To Val Halamandaris, Professional Staff Member to serve and return.

Given under my hand, by order of the committee, this 30th day of March, in the year of our Lord one thousand nine hundred and seventy one

Chairman, ~~Committee on XXX~~ Subcommittee on Long-Term Care

Senator PERCY. Would you rise, please and be sworn in?

Mr. SLADER. I, Daniel A. Slader, in the testimony that I am about to give before this committee will tell the truth, the whole truth and nothing but the truth, so help me God.

Mr. SULLIVAN. May I make a brief statement, Senator Percy?

Senator PERCY. You certainly may.

Mr. SULLIVAN. First I would like to say that I am pleased to be here with both of you Illinois Senators.

Mr. Slader, who, as he says, is the administrator of the Melbourne Nursing Home, has attempted to cooperate with the committee, Senator Percy.

An inspection was made by Mr. Halamandaris and a man from the Better Government Association.

However, the inspection was delayed for a few minutes while Mr. Slader called me to get my okay because I had given him instructions not to have people going through there after the unfortunate experience he had with the Chicago Tribune reporter, to which I will refer later.

We have produced the documents requested by the committee well in advance of this hearing so that you would have an opportunity to go over them.

We have also cooperated with other agencies, State and Federal. We have produced documents for the Federal Grand Jury and we have submitted to continual investigation and interviews by the Chicago Board of Health, which has the immediate supervision of the home.

BASICALLY NOT HOME FOR AGED

This home may fall within the category that you, Senator Percy, said, is outside of the purview of the purposes of this committee because it is not basically—basically it is not a home for the aged but rather for patients who have—who are indigent and who have been finally discharged from State mental institutions and most of the patients are not considered in the aged category.

The home is supervised carefully. There is an employee of the Illinois Department of Public Health who spends 80 percent to 90 percent of her time on the premises, Miss Brock, a social worker, and there are frequent inspections of the home by the Chicago Board of Health, Nursing and Sanitation Division, building inspectors, Fire Department inspectors, and so forth.

In addition to that, there is a committee of physicians who are attending the patients who are on the premises, each week.

Mr. Slader and his home got into the public press through the story of Pamela Zekman in the Chicago Tribune and shortly after that he came to our office.

We attempted to identify the nurses aides and nurses who were referred to in this story and Mr. Metz, who is working with me, took statements from three ladies at the home who apparently were the nurses or nurses aides referred to in this story.

Senator PERCY. The story you are referring to is the one by Pamela Zekman?

Mr. SULLIVAN. Yes.

Senator PERCY. March 1?

Mr. SULLIVAN. Yes.

Senator PERCY. Thank you.

Mr. SULLIVAN. And as I say, we interviewed them in great detail and I have their interviews here and they are available to testify here and as a matter of fact, in some respects, it is unfortunate that they will not have a chance to tell their stories in public.

But, even if they did, it is unlikely that the Tribune would print them.

If, what the nurses aides tell us is true, this story is not only terribly exaggerated, but in many respects, downright false.

Now, you will observe by reading the story, that much of it is hearsay or double hearsay. It is what somebody said she said somebody told her, Pamela, so if she were here and I could cross-examine her, which I would very much like to do, she would not be able to back up a great deal of what is in here because it is based on hearsay.

BOARD OF HEALTH REPORTS SEEM FAVORABLE

However, the harm that a story like this can do is incredible. The inspection reports that this nursing home has received from the Board of Health, while they are far from perfect, I mean there are items continually complained about and conditions asked to be corrected, on the whole they seem to me to be favorable reports.

For example, the food reports, the inspections conducted on the food a few days ago gave them a score of 100 percent, a perfect score.

Senator PERCY. Mr. Sullivan, it would be really the preference of the committee that Mr. Slader testified on his own behalf.

These are matters that he has firsthand knowledge of and you have secondhand knowledge of and we would be very happy and are anxious to make certain that the record is clear.

We could incorporate in the record any affidavits that you have and if necessary, we will see that in open hearings, if we can then, if there is a conflict of testimony and perjury has been committed and a reputation defamed because of such perjury, we would be happy to refer these matters to the Justice Department and I think all of them should be sworn, just as Mr. Slader has been.

Mr. SULLIVAN. I agree.

I don't believe that perjury has been committed.

All Pamela Zekman did was to write a newspaper story, but as you know, people assume the truth of these stories and this woman has not testified or subjected herself to the cross-examination which is the ultimate test of the truth.

Senator PERCY. That is the truth.

Mr. SULLIVAN. Mr. Slader is here and available and ready to testify.

DANIEL A. SLADER

called as a witness herein, after having been first duly sworn, was examined and testified as follows:

EXAMINATION BY SENATOR PERCY

Senator PERCY. All right. I would like to clarify, Mr. Slader, the dual relationship which you have.

You are the owner of Melbourne Nursing Home and you are also the treasurer of the Metropolitan Chicago or the Chicago Metropolitan Nursing Home Association, is that correct?

Mr. SLADER. Not entirely.

Senator PERCY. Pardon me?

Mr. SLADER. Not entirely. I would like to clarify that if I may. I am one of the owners of the Melbourne Nursing Home.

Senator PERCY. And what percentage ownership do you have?

Mr. SLADER. 25 percent.

Senator PERCY. You have 25-percent ownership?

Mr. SLADER. Yes, sir.

My wife has another 25 percent. Together we own 50 percent.

Senator PERCY. And has that been the lowest or has that been the highest amount that you have ever held in ownership in the Melbourne Nursing Home?

Mr. SLADER. That is the highest I have ever held in the Melbourne Nursing Home, yes, sir; with my wife together, 50 percent.

Senator PERCY. But in effect, you have 50 percent?

Mr. SLADER. Yes.

Senator PERCY. And that is controlled and that you do manage it yourself?

Mr. SLADER. Yes, sir.

Senator PERCY. You do?

Mr. SLADER. Yes, sir.

CONSIDERED RESPONSIBLE FOR OPERATION OF HOME

Senator PERCY. So that you would consider yourself fully responsible, more responsible than any other individual or group for the operation of the home?

Mr. SLADER. Well, as the administrator of the home; I don't control the board of directors of the corporation, having only 50 percent with my wife.

Senator PERCY. Yes.

Mr. SLADER. But in a general sense, I think your statement, sir, is correct.

Senator PERCY. And do I understand that the property, the land, the building, the equipment, is owned by the same corporation that operates the facility and that there is only one corporation that we are talking about?

Mr. SLADER. No, sir, that is not correct.

Senator PERCY. Now, how many corporations are we talking about?

Mr. SLADER. One corporation, sir.

Mr. SULLIVAN. And one partnership.

Senator PERCY. Well, if Mr. Slader understands, it, I would rather that he would explain it.

Mr. SULLIVAN. Go ahead and explain it, would you, please?

Mr. SLADER. Yes, sir. I am trying to clarify this, Senator, if I may. There is but one corporation as a corporation is defined.

There is the land, including the building, of course, and the personality. The personal property is owned by what I, as a layman, call a partnership—the Melbourne partnership.

The land is held by the Oak Park Trust & Savings Bank as trustee under a trust agreement.

The same people who own the corporation are the same people who are participants in the trust to the same extent, so in effect, sir, it is all one and the same.

I just wanted the record to show that.

Senator PERCY. And the proportions are the same in both entities?

Mr. SLADER. Yes, but strictly speaking, the corporation, legally speaking, sir, the corporation does not own the land, the building and the personalty.

Senator PERCY. Yet the corporation operates it?

Mr. SLADER. Yes.

Senator PERCY. Now, in the corporation operating statement then, there would be a rent?

Mr. SLADER. Yes.

Senator PERCY. Which would be paid to the partnership?

Mr. SLADER. Yes.

Senator PERCY. Which is taking it out of one pocket and putting it in the other?

Mr. SLADER. Yes.

Senator PERCY. Because it is the same people involved?

Mr. SLADER. Yes.

WHAT IS PURPOSE OF THIS TYPE OF ORGANIZATION?

Senator PERCY. Can you tell us what the—just so that we better understand how nursing homes are organized—what is the purpose of having it established in that way?

Mr. SLADER. Senator, I honestly don't know.

Senator PERCY. In that case, you can certainly seek counsel if you would like.*

I mean, how is it explained to you, Mr. Slader, as to why it was done that way?

(Mr. Sullivan is speaking with the witness off the record.)

Mr. SLADER. Senator, if I may explain: We have to go back.

Senator PERCY. Yes.

Mr. SLADER. To about 1960, I believe, when the corporation that we are talking about was first organized.

My counsel at that time was the firm of Hoffman & Davis. They did the legal work in setting up the corporation and were largely instrumental in determining the financial structure, the legal structure, et cetera, as to what should be owned by the corporation and what should be owned by the trust. They set up both the trust and the corporation, the legal documents, the structure.

*See appendix 1, item 3, exhibit H, p. 1350, for explanation of organization of Melbourne partnership.

I am not sufficiently cognizant of the legal and accounting and tax implications and therefore, left it entirely to them and proceeded on their advice.

I don't know what reasoning went into this, I have no idea. I assume it was sound legal reasons, good business judgment, but I really don't know what their reasoning was.

Senator PERCY. Are most homes set up this way or a very small percentage of them?

Mr. SLADER. To the best of my knowledge, and I haven't checked into every nursing home, there are many who are so structured.

Now, I made no examination of records, et cetera; this is based on conversations primarily, Senator, and if I am in error, then I am sorry, but it is just my impression that this is the way it is done.

Senator PERCY. How do you establish the rate of rent that you pay yourself for the building and facilities?

Mr. SLADER. That also wasn't done by me. We have accountants and I have no idea as to how it was arrived at. I know what it averages, though.

Senator PERCY. Is he a certified public accountant?

Mr. SLADER. Yes, sir; and he is available for examination.

Senator PERCY. Has he been your accountant for some time?

Mr. SLADER. Yes, sir.

Senator PERCY. For how long?

Mr. SLADER. Well, to the best of my recollection, Senator, my present recollection, I believe he was engaged somewhere around 1963, 1964, somewhere in there, in one of those years.

I may be off a year or so.

Senator PERCY. And when did you purchase Melbourne Nursing Home's physical facilities, should we say?

When did the partnership purchase these physical facilities and from whom?

Mr. SLADER. Now——

Mr. SULLIVAN. When is the question, Dan, and it calls for a year.

Mr. SLADER. I believe it was 1959.

Mr. SULLIVAN. And from whom?

Mr. SLADER. I don't recall. We handled it through an attorney. I really don't know who the owners were. I don't recall who the owners were.

Senator PERCY. Since 1959 you have owned it?

Mr. SLADER. I believe that is correct, sir.

Senator PERCY. On June 30, 1959 the guarantor of the deed for this property was a Phillip Goldman and the Oak Park Trust & Savings Bank is listed also. Does that name ring a bell?

Mr. SLADER. Yes, sir.

Senator PERCY. Do you know who Phillip Goldman is?

Mr. SLADER. Well——

Senator PERCY. Maybe it might be well for you to tell us, at this point, who owns the other 50 percent of the partnership as well as the operating corporation.

Mr. SLADER. Yes, sir.

Dr. Arthur J. Wolski and his wife, Virginia B. Wolski, own the

remaining 50 percent of both the corporation shares and what I call the partnership.

Senator PERCY. I see.

Mr. SLADER. What I have referred to as the partnership.

Senator PERCY. All right.

INTERRELATIONSHIPS IN MCNHA

I would like to come back to the corporation itself and the partnership but first I would like to establish for the record and for my committee's better understanding the interrelationships here.

You are the treasurer, then, of the Metropolitan Chicago Nursing Home Association.

How long have you been treasurer?

Mr. SLADER. I believe it dates back 2 years, perhaps three. I am not certain.

Senator PERCY. But——

Mr. SLADER. Two or three.

Senator PERCY. But you have been treasurer for several years?

Mr. SLADER. Yes, sir.

Senator PERCY. And you are quite familiar with the operation.

Rabbi Yampol is listed as the executive secretary, is that right?

Mr. SLADER. No, sir, executive director.

Senator PERCY. Executive director?

Mr. SLADER. Yes, sir.

Senator PERCY. And do you have any knowledge at all through conversations with him or other knowledge that he is also the secretary of the following homes: The Inglewood Rest Haven; St. Michael's Rest Haven; Mid-West Rest Haven; North Shore Rest Haven?

Mr. SLADER. I have no knowledge, Senator, as to what you are just stating—as to what you have just stated, no knowledge whatsoever.

Senator PERCY. You haven't?

Well, he is listed, according to our committee staff, as the secretary of those homes and I am sorry that time did not permit, and he had to leave before we called him yesterday afternoon.

Are you familiar with Mitchell Macks?

Mr. SLADER. I am familiar with the name, Senator. I do not recall ever having met anyone with that name.

Senator PERCY. Do you know Mr. Benjamin Cohen?

Mr. SLADER. Yes, sir, I do.

Senator PERCY. You do?

Mr. SLADER. Yes.

Senator PERCY. Do you know that Mr. Mitchell Macks is the brother of Benjamin Cohen?

Mr. SLADER. I learned that yesterday, Senator.

Senator PERCY. I see. And are you familiar with the fact that Benjamin Cohen has been the owner of Kenmore House and you must have heard yesterday that a Mitchell Macks was also an officer or a director of Kenmore House up until February?

Mr. SLADER. I heard that, Senator.

Senator PERCY. Right. Do you know Mr. Frank Williams?

Mr. SLADER. Yes, sir, I do.

Senator PERCY. And in what capacity do you know him?

Mr. SLADER. Well, I know him as a friend. I know his wife. We have had active dealings with the Metropolitan Chicago Nursing Home Association as fellow directors from time to time.

I converse with him frequently. I meet with him socially. I know Mr. Frank Williams.

Senator PERCY. And do you know that he is an owner or investor in a number of nursing homes?

Mr. SLADER. I believe he is, Senator.

Senator PERCY. Yes. We have indications that he is financially involved in investments or in investing in seven nursing homes, and do you know also that he has been the past president, former president of the Metropolitan Nursing Home Association?

Mr. SLADER. Yes, sir; I know that, too.

Senator PERCY. So that the Metropolitan Nursing Home Association is an association whose officers are operators and knowledgeable, for the most part, in nursing homes and should and do apparently know them quite well?

Mr. SLADER. Sir, if I may comment on your statement.

Senator PERCY. Yes, of course. I would like very much to have, as treasurer, your statement because we do not have the executive director here.

Mr. SLADER. Yes, sir.

Senator PERCY. I would like to have a brief statement as to the function and purpose of this association.

MAKEUP OF BOARD OF DIRECTORS OF ASSOCIATION

Mr. SLADER. Yes, sir. Well, I would like to say this:

That the board of directors of the Metropolitan Chicago Nursing Home Association is made up of both administrators, per se, who are employees of others in the administration of nursing homes, along with what I think we could agree on, would be called owners or investors in nursing homes. It is a combination sort of board of directors.

I don't recall the proportion, sir, of owners, using my definition and, per se, administrators, but there are many administrators who have no financial interest in the homes that administer, or stock interests, who are also members of this board and who can be quite persuasive at times during deliberations of the board from time to time.

I am trying to be helpful, Senator.

Senator PERCY. In the functions of the Nursing Home Association, I understand that it does offer programs which are understandable and perfectly standard procedure for associations, to help improve the training and education of its membership.

I wonder if you are familiar, as treasurer, with the fact that a course is offered for rehabilitation nurses?

Mr. SLADER. Yes. sir.

Senator PERCY. You are familiar with a course instructing nurses in rehabilitation techniques?

Mr. SLADER. Yes, sir, I am.

Senator PERCY. And as treasurer, can you give us an idea as to what the fee is?

It it true that a 3-week course costs about $1,200?

Mr. SLADER. Sir, I am not that familiar with the fees charged for that course, but I am of the opinion that the amount is grossly exaggerated.

I believe it to be somewhere in the area of $300 to $350, or something along that line.

Senator PERCY. Some of which is refunded by the State of Illinois?

Mr. SLADER. A portion. It is a sharing program as far as the costs are concerned.

I don't believe it is anywhere near $1,200.

Senator PERCY. The information——

Mr. SLADER. But I may be in error.

Senator PERCY. The information that I have is that the State course costs $55, which the State pays and I just wondered, even if it is $350, what the disparity is here?

Mr. SLADER. I don't know.

HOW ARE FEES SET BY THE ASSOCIATION?

Senator PERCY. How are fees established by the association?

Mr. SLADER. Generally the board of directors of the association establishes the fees to be charged, but in certain areas, and it may include this area, Senator, the executive director has been empowered to establish fees which are later submitted to the board of directors for conformation or rejection or modification.

At this point I cannot honestly relate to the matter of the amount of fees because I just don't know.

Senator PERCY. As treasurer, can you indicate whether the association or its officers or members engage in political activity of any kind?

Mr. SLADER. They may engage on their own.

Senator PERCY. As individuals, of course?

Mr. SLADER. As individuals.

Senator PERCY. Of course.

Mr. SLADER. I do not believe the association has ever at any time participated in political activity.

Senator PERCY. Has the association at any time made political contributions?

Mr. SLADER. I have no knowledge as to that; none whatsoever, Senator.

Senator PERCY. Have any of the employees of the association, while in the employ of the association, participated actively in political campaigns for any candidates, Republican or Democratic?

Mr. SLADER. Not to my recollection, Senator. I can't remember anything like that and therefore I do not believe it happened.

Senator PERCY. Your purchase of Melbourne, I assume this is just two families, your wife and yourself and your partner and his wife?

Mr. SLADER. Yes, sir.

Senator PERCY. The purchase was made in 1959.

Had you been in the nursing home business before that, Mr. Slader?

Mr. SLADER. No, sir.

Senator PERCY. You had not?

Mr. SLADER. No.

Senator PERCY. Would you mind telling the committee how you happened to go into the nursing home business; what brought you into it?

Mr. SLADER. Yes, sir.

WHAT MOTIVATED ENTRY IN NURSING HOME BUSINESS?

Senator PERCY. And what your objective and purpose of going into the nursing home business would be, and I am not in any way discouraging a man who says, "I made an investment as a sound good investment."

There is nothing wrong with that in the American system that I know of, whatsoever, and I hope there never will be, but I think it would be helpful to us to know what motivated you as an individual to go into the business?

Mr. SLADER. Well, first of all, Senator, I would like to say that one of my motivations was what you just stated, to make a good investment. That was one of my motives.

I had been in the real estate business for some time prior to 1959 and in the course of that occupation, I came across this building.

This building was being occupied and operated as a hotel and not as a nursing home or any similar type of facility.

It was rather run down. It appeared to me, and in the opinion of professional advisors, structural engineers, and people who had more knowledge as to the thing than I did, that it was financially—rather, it was—I beg your pardon, that it was structurally sound, it was a solidly built building.

It was the Melbourne Hotel and at the time it was built, I believe it dates back to, oh, 1919, 1920, perhaps, somewhere in that area. I don't know the exact date it was started or completed, but I believe it to be about that time.

It was considered one of the finest buildings of its kind in the north part of the city of Chicago.

I had the idea at that time, along with my associate, whose name I previously identified, of attempting to operate this property as a hotel; in other words, to rehabilitate the property, it being in our judgment, structurally sound, as I said before.

Senator PERCY. And from the operating statements that you had seen from the previous owners, had it been operating as a profitable hotel at the time?

Mr. SLADER. No, sir; not at all.

Senator PERCY. It was not?

Mr. SLADER. No, sir; no, sir. I don't believe that it would be possible to operate this property in its then state of repair and furnishings at a profit by anyone. That was my opinion, Senator.

We did, thereafter, purchase the property, I mean after our examination of the premises, operating records which were made available to us, having obtained the advice of people proficient in the area of appraising property of this type, structural engineers, et cetera, we did consummate the purchase.

Thereafter, we operated the hotel as a hotel in the same manner as previously.

Would you like me to continue, Senator?

Senator PERCY. Yes, sir.

Mr. SLADER. Now——

Senator PERCY. I would like an answer to the question as to what motivated you to get into the nursing home business?

Mr. SLADER. Yes, sir.

Well, up to that point, there was no motive, because I wasn't going into the nursing home business. I was going into the hotel business and did go into the hotel business.

Now, shortly thereafter, when we started, my partner and I, I am trying to be specific, started to go over the figures, the estimates and the bids and the quotations, et cetera, with respect to what it would actually take to rehabilitate the property, together with the costs of furnishings and further taking into account the anticipated gross income, estimated expenses and resulting net income or loss, we decided that this was a retroactive appraisal situation—we decided that we had erred, that it probably would not work. It might work out, but it didn't look like it would after getting the figures.

ACTUAL CASH INVESTED BY EACH PARTNER

Senator PERCY. And how much money are we talking about that you and Mr. Wolski each invested, 50 percent each for your families?

Mr. SLADER. Yes, sir. The actual cash investment, as I presently recall it, was in the neighborhood—was either $40,000 or in the area of $40,000, give or take——

Senator PERCY. That was $20,000 apiece?

Mr. SLADER. No, sir.

Senator PERCY. $40,000 each?

Mr. SLADER. No, sir; it was a combination of $40,000 as I recall.

Senator PERCY. Well, what proportion did you put in and what proportion did Mr. Wolski put in?

Mr. SLADER. I don't recall just what it was at this time.

Senator PERCY. Dr. Wolski.

Mr. SLADER. It seems to me I put in around $10,000 and Dr. Wolski put in $30,000. At that time it was disproportionate, then, and later on we straightened it out.

Senator PERCY. But the intention was that you would be 50-percent owners?

Mr. SLADER. Yes.

Senator PERCY. Even though he put in a disproportionate amount?

Mr. SLADER. Yes. He advanced funds for me, as I recall.

Senator PERCY. What was the total purchase price?

Mr. SLADER. As I recall now, this goes back to 1959, but on this date, at this table, and at this time, I believe it was a $100,000 total purchase price.

Senator PERCY. $100,000?

Mr. SLADER. Yes, sir.

Senator PERCY. Of which roughly $40,000 was provided in cash and $60,000 financed by a mortgage presumably?

Mr. SLADER. Purchase money mortgage.

Senator PERCY. Yes.

Mr. SLADER. Yes, sir.

Senator PERCY. All right. Go ahead. You have reached the point now where you have realized that your capital is not wisely invested in a hotel.

Had your partner been in the nursing home business before that?

Mr. SLADER. No, sir.

Senator PERCY. He had never been?

Mr. SLADER. No, sir.

Senator PERCY. So how did you happen to get into the nursing home business?

Mr. SLADER. Well, we had this investment. We had several choices, Senator.

We could continue to operate it. As I recall, we were not losing a great deal of money, but it was some.

We had the alternative of possibly reselling it and hopefully recouping our investment or most of it or perhaps some of it, or using the property for another purpose and we determined that we would try to find the best answer to this question.

I don't remember at this time, Senator, just what got us into the nursing home end of it.

We met with many people. I made many phone calls, visited many people, and it was a sort of an osmosis decision, if I may use that expression, but it seemed to center on nursing homes.

We thereupon made the decision to convert this property, as it could be done, into a nursing home, and we proceeded to do it.

Senator PERCY. All right.

I would like to suggest to Senator Stevenson, because of the desirability of having a continuity in flow here that we simply proceed this way, but invite him and encourage him, if you would not mind, to break in at any point, and I would be very happy to yield if there are points that you feel, Senator Stevenson, that you need clarification on with respect to the chronology of the story that would help supplement my own line of questioning.

Senator STEVENSON. Fine.

Senator PERCY. I would like to have your assertion, as I surmise, since 1959, when you—and what year did you go into the nursing home business, by the way?

Mr. SLADER. In 1961, Senator.

Senator PERCY. 1961?

Mr. SLADER. Yes, sir.

Senator PERCY. So that you started for 2 years as a hotel. It did not work out and then you decided to go into the nursing home business?

Mr. SLADER. No, sir, no, sir. That isn't entirely correct and if I gave you the wrong impression, Senator, I am sorry. I didn't mean to do that.

Senator PERCY. That is all right. Just clarify the record, then.

CORPORATION ORGANIZED IN 1969

Mr. SLADER. All right.

I don't remember the exact date that this took place, but I remember the year 1960 as the year in which the corporation was organized. I believe it was May of 1960, but I may not have the correct month, but I am rather certain it was 1960, which is prior to the year 1961. I didn't want to leave the impression——

Senator PERCY. The corporation was organized, though, then, for the purpose of operating a nursing home and getting ready for that?

Mr. SLADER. I am of that opinion.

Senator PERCY. So that the basic decision by the partners had been made?

Mr. SLADER. Prior to 1961, yes, sir, and not too long after the——

Senator PERCY. Not too long after the operation of it as a hotel, an apartment hotel?

Mr. SLADER. Yes, sir, in 1959 or 1960, or somewhere along in that area, but I can't pin down the date at this time, Senator.

Senator PERCY. Yes.

Mr. SLADER. That is about as close as I can get to it.

Senator PERCY. And is it true, then, that since then, since you went into the nursing home business, that as the—you might say the operator and controller of 50 percent of the stock and having a close relationship with your partner was really—in a sense is he a silent partner in effect?

Mr. SLADER. No, sir.

Senator PERCY. Does he get into the operation? Well, I don't mean a silent partner, is he an operating partner, does he operate in any respect help run the home? Does he draw a salary from the home?

Mr. SLADER. Yes, sir.

Senator PERCY. He does.

Mr. SLADER. Yes, sir.

Senator PERCY. And what are his duties and what have been his duties for the past 11 years or 10 years in the operation of the nursing home?

How do you divide the responsibilities?

Mr. SLADER. Well, as directors and fellow officers of the corporation, we must, needs be, consult with each other and we do.

To say that he controls me would not be a statement of fact. It wouldn't be true.

Mr. SULLIVAN. Tell him what he does, not what he doesn't do.

Mr. SLADER. He is fellow director and we consult with each other. He is an officer of the corporation.

We meet frequently and we discuss the operation of the nursing home.

'Silent' Partner Never Assumed Responsibility

Senator Percy. But from the standpoint of establishing and maintaining standards, has he overruled you when you have said, "We have got to invest in this. We have got to paint and repair. We have got to improve. We have got to put more money into staff. We have got to improve the quality of food."

Has, at any time, he assumed the direct responsibility for reversing a management decision of that type?

Mr. Slader. At no time.

Senator Percy. At no time. So that then we can state, it is not necessary to have him here, that you are fully and solely responsible, then, for the operation of the nursing home, for its standards and its procedures.

I will ask one question and then I will yield to Senator Stevenson.

The State record will show that Melbourne House has a record of violations and complaints from patients and their relatives dating back to January 1965. This is what we have been able to get for our records.

Would you care to comment on what happens when violations or complaints are cited, and why has there been now a period of 6 years where these complaints have been filed or registered.

Mr. Slader. Well, I don't recall at this moment, Senator, just exactly what you are referring to.

I have nothing in front of me and I don't recall.

Now, there were violations of standards from time to time during the entire period that this home has been licensed.

In my opinion, Senator, they are largely minor housekeeping matters but not entirely so.

Mr. Sullivan. I might interject, Senator, there.

I have a report and I assume you have it of March 25, 1971, an anonymous call, complaint about four different items that were supposed to be wrong at the home, check it out on that date with the detailed report concluding this complaint was not justified at this time.

That is a complaint.

Senator Percy. Yes.

Mr. Sullivan. But it is not a justified complaint.

Cites Recent Violation of Standards

Senator Percy. Well, suppose I cite, then, some in fairly recent history—not since this investigation, let us go back to 1970—but recent enough to certainly remember.

On July 14, 1970, Melbourne House was fined $110 for violations —for "violations on the failure to correct the violations."

Proceedings began on March 19, 1970, when the Bureau of Investigation of Institutional Care, the Board of Health, brought suit action against the home for the violations.

Violations were first reported in a city inspector's report dated January 5, 1970, and between that date and July 10, 1970, a period

of a little over 6 months, eight inspections were conducted and turned up more than 50 violations of all types including mice in the food storage area, peeling paint and plaster, rat and mice poison in open boxes in the kitchen, inadequate food given to the patients, roaches, accumulated dirt, waterbugs in the dining room, broken plumbing, et cetera.

During these hearings the home's State license was not reissued, however, its city license was reissued after the fine was levied because, "The city inspector found the majority of the violations had been corrected. Consequently its State license was renewed."

Would you care to comment on that and indicate why, when violations were cited, there was apparently insufficient effort to correct those and court action had to be brought?

Mr. SLADER. Senator, I don't know if the court action which you are referring to is the same matter to which you have previous reference citing the items.

Now, there are two charges, two counts, as I recall it for which we were cited in the court action. Now, you listed more than two, so I am somewhat confused at this moment.

Now, the two actions, the two counts, that were listed were alleged violations of chapter 136 of the Chicago Municipal Code, if I recall correctly at this time, not having anything in front of me.

The maximum fine on each count, I believe is $200, or a total of $400 claimed.

The judge reduced the fine, as I recall it from the $200, from $200 maximum to $50 in each count by reason of the showing made in court as to the efforts made to correct the violations.

Two $50 fines, as I recall it, was the total fine, and I believe the $10 may well have been court costs.

HOME RETAINS LICENSE AND STILL OPERATES

Senator PERCY. Now, there is some contradication here in that the license was renewed following these violations but had been cited and a surprise inspection team from the County Board of Health, State Department of Mental Health and the State Board of Health made an inspection on August 24, 1970, and found:

> The overall picture of the third floor to be in deplorable condition. Urine saturated beds and floor areas. The stench permeated the area. This team also found broken plumbing, peeling plaster, inadequate food.

and nevertheless your home retained its license and are you still operating?

Mr. SLADER. We are still operating, Senator.

Senator PERCY. Can you explain why, when these imposing numbers of imposing boards found this condition, you still continued to operate as a person to which the Federal Government pays a large part, two-thirds, possibly, of all of the costs and I wonder what happens when we have these investigations and these kinds of statements and apparently no correctional action.

(Consultation between Mr. Sullivan and the witness.)

Senator PERCY. While you are conferring, I would like to put in the record, a report dated September 4, 1970, from Dr. Murray C. Brown to William Prendergast, city collector of the city of Chicago.

Advised that on July 14, 1970, suit action was instituted against the above-named facility, Melbourne Corporation for violation of Section 136–15 of the Municipal Code of Chicago and a fine of $110 was levied against the Melbourne Corporation.

Return visits to premise on August 8 and 24 revealed repeat violations of Section 136–15 of the Municipal Code.

Would you care to comment on why, when violations are officially cited, correctional action is not immediately taken.

Mr. SULLIVAN. May I consult with him?

Senator PERCY. And if there are inadequate financial resources, or whatever the reason might be, I think we would like to have that.

(Discussion off the record between Mr. Sullivan and the witness.)

Senator PERCY. May I say to Mr. Sullivan who represents one of our most distinguished firms in Chicago—you are from Bert Jenner's firm?

Mr. SULLIVAN. Yes.

IF STORY INJURED CLIENT'S REPUTATION

Senator PERCY. Both you and Mr. Metz.

I am pursuing this line of questioning in response, not that I might not have otherwise, in response to the fact that the statement has been made that Pamela Zekman's story was exaggerated and has been injurious to the client's reputation.

The only difference seems to be that Pamela Zekman's story was put in a public record and whereas all of these files, records, and court proceedings were not known to the public before, but when disclosed right now would seem to be injurious and damaging and very consistent with what was found by the team of BGA investigators as well as news media investigators.

Mr. SULLIVAN. If I may respond to that, I do not think that that statement is at all accurate.

Pamela Zekman's story recounts different kinds of things, a different quality of abuse, not a clogged drain or some urine in the bedclothes or something like that, but this is a story which is emotionally charged, an emotionally charged story and it is not of the same kind or character as the complaints to which you have made reference.

The reason I consulted with Mr. Slader just now was to try to get him to give you a responsive answer.

He does tend to become loquacious and get over onto irrelevancies and I would like him to respond to this point, and the purpose of my consulting with him was to help get on with this.

I would like him to explain what happens to these reports after they are made; he gets a copy and I would like him to tell you what happens.

Senator PERCY. Very good, because I think we are almost at the stage where we are trying to find out the case history as to what really happened.

Mr. SULLIVAN. That is right.

Sentor PERCY. We can all generalize.

Many times the heads of departments and agencies come in and say what they think is the policy and how it is implemented, but we never seem to find out until we get down to the nitty-gritty part of a situation, any enlightenment when the violations are filed.

Are they fair or unfair.

Why aren't they followed up?

If you could explain that, that would be very helpful to the committee.

Mr. SULLIVAN. I do not think that you can fairly say that the kind of violations that you referred to are the same as the things that Miss Zekman reported in her story. I think they are very much different in kind, but you go right ahead.

Senator PERCY. We will come back to the story later, then, but we will see what we can develop from official documentation as to the conditions, and we would be happy to have a reply.

Mr. SLADER. To the best of my knowledge, Senator Percy, we receive a copy, and this is the kind of copy that I am talking about. this green form.

Mr. SULLIVAN. I have given him the August 8th and August 24th inspection reports to which you have made reference, Senator.

Mr. SLADER. This is headed, "Institutional Inspection, City of Chicago Board of Health."

Generally we receive these.

Now, there are reports that we do not receive, but with respect to this particular report, and I believe you had reference to this type of report.

We receive a report listing alleged violations, including minor things, which this one disclosed, loudspeaker broken, that is a violation.

Subsequent to the date of the inspection, a revisit is made, sometimes immediately thereafter, sometimes a month later, at which time each and every one of the alleged violations are reinspected.

If the violation has been abated, regardless of what kind of violation, a notation is made in the right-hand column indicating the date of the reinspection and the initials of the inspector.

This indicates that the violation has been abated; whether it be a minor violation, a major violation, irrespective of the type of violation.

Now, that is the manner in which violations have been followed down.

Now, in connection with violations from alleged violations, which may not have been corrected as of the date of the first reinspection, this matter is then followed down during subsequent inspections.

In other words, the inspecting nurse, the registered professional nurse who is the inspector, follows these things down until they are taken care of.

Now, if they are not taken care of, then action is taken by the Chicago Board of Health and we have many courses of action open to them as was indicated yesterday.

Senator PERCY. Senator Stevenson, do you have any comments?

Senator STEVENSON. I would like to get back to Dr. Wolski, Mr. Slader?

Mr. SLADER. Yes, sir.

Senator STEVENSON. You indicated that he was paid a salary and you were a little vague about the nature of the services that he performed.

Mr. SLADER. I am sorry about that, Senator.

Senator STEVENSON. That is all right.

Mr. SLADER. I didn't mean to be.

Senator STEVENSON. I just wanted to ask whether those services include the treatment of patients in the nursing home?

Mr. SLADER. Those services do not include treatment of patients in the nursing home.

PARTNER ALSO TREATS PATIENTS . . . BILLS SEPARATELY

Senator STEVENSON. Does he treat patients in the nursing home?

Mr. SLADER. Yes, he does, but he is not paid for that service or those services by the corporation.

Senator STEVENSON. How is he paid for those services?

Mr. SLADER. He is paid for those services by the State of Illinois.

Senator STEVENSON. You mean through Medicare funds, Medicaid?

Mr. SLADER. Well, I don't see the bills and I don't have anything to do with it except that I have knowledge of the fact.

I mean, I have knowledge of the fact that he does treat patients and he does, I believe, bill and collect.

I mean, I don't become involved in that process.

Senator PERCY. Well, he is the house physician, you might say?

Mr. SLATER. No, sir.

Senator PERCY. He is not?

Mr. SLADER. No, sir. He is not a physician. He is a dentist.

Senator STEVENSON. Oh.

Senator PERCY. He is a dentist?

Mr. SLADER. If I gave the impression, Senator, that he was a physician, I am very sorry. I didn't mean to do that.

Senator PERCY. Well, does he then confine his activities to dental work?

Mr. SLADER. Yes, sir. I didn't say that he was a physician.

Senator PERCY. Only dental work?

Mr. SLADER. Yes, sir.

Senator STEVENSON. He does render dental services to the patients in the Melbourne Nursing Home, is that correct?

Mr. SLADER. I am sorry, I didn't hear that. [Question read.] Yes, he does.

Senator STEVENSON. Does he also maintain an office outside of the nursing home?

Mr. SLADER. Yes, sir.

Senator STEVENSON. For the practice of dental medicine?

Mr. SLADER. Yes, sir, dentistry.

Senator STEVENSON. Dentistry?

Mr. SLADER. Yes.

Senator STEVENSON. And can you describe the nature of his practice, the kind of patients he treats as a dentist on the outside?

Mr. SLADER. No, sir.

Senator STEVENSON. Do you have any knowledge of his referring patients, dental patients, to this nursing home?

Mr. SLADER. I don't believe he has ever done that, Senator, or attempted to.

Senator PERCY. Does he do the principal dentistry work for the patients in your home?

Mr. SLADER. Yes, sir.

Senator PERCY. He does?

Mr. SLADER. Yes, sir.

Senator PERCY. And the fees for the work are established by the Department of Public Health?

Mr. SLADER. No, sir.

Senator PERCY. By who?

Mr. SLADER. State agencies.

Senator PERCY. Medicaid or Medicare—how is he paid by the Government for these services?

Mr. SLADER. Well, I don't know that he is paid by the Government, Senator. I think he is paid by the State of Illinois; if by the Government, you mean Federal Government.

Senator PERCY. No, the State of Illinois would be government.

Mr. SLATER. I see.

Senator PERCY. There may be Federal funds and they are probably back of the State's money?

Mr. SLATER. No, I don't know how he is paid. I don't know.

HOME CERTIFIES PERFORMANCE OF SERVICE

Senator PERCY. Is there any certification by the home required as to the performance of services?

Mr. SLATER. Yes, sir; with respect to dental treatment for patients who are paid for by the Illinois Department of Mental Health but not with respect to any other patients.

Senator PERCY. Does he treat such patients?

Mr. SLADER. Yes, sir.

Senator PERCY. Is it wise to have a partner on one hand to treat patients, a partner who holds a 50-percent ownership in an operating company, the employees of which must certify as to the work being done.

Is that a sufficient arm's length transaction for the State to accept certification?

Mr. SLADER. Well, I can only give you my opinion, Senator.

Senator PERCY. Yes.

Mr. SLADER. I see nothing improper in it and I also think I see a good deal of merit in the idea, he being interested in the welfare of the patients in the home.

Senator PERCY. Right.

Mr. SULLIVAN. Perhaps we should find out who does the certification.

Senator PERCY. I think we should, and could you furnish for the record then—we could, of course, call him, but it would be easier if you would simply indicate that you would provide for this committee not only the procedure followed in the certification, but also, since you became operators of the nursing home, what the annual fees per year were charged by Dr. Wolski and paid by patients in your home, divided by private, if you have those records, but certainly you have the public records.*

Mr. SULLIVAN. Could I ask a question.

Senator PERCY. Certainly.

Mr. SULLIVAN. Do you mean private patients as against ones that are there as State-aided patients?

Senator PERCY. Right.

If he has records of the private patients, that he has had, but certainly he has records, and we would insist on records for any patients paid for by the government.

Yes, Senator Stevenson.

STATE EMPLOYEE SPENDS TIME ON PREMISES

Senator STEVENSON. Mr. Slader, I understood you to say, and I may have misunderstood you earlier in your testimony, that a department of mental health, State Department of Mental Health employee spent about 80 percent of his time on your premises.

Mr. SULLIVAN. I said that.

Senator STEVENSON. Is that correct?

Mr. SLADER. Well, it is Miss Brock and in my opinion she spends at least 80 percent of her time in the premises overseeing the patients generally, particularly those for which she has a special charge, they being the bulk of the patients placed there by the State Department of Mental Health.

It is her job to see these patients.

Senator STEVENSON. And how do these patients get there? Are these the patients we heard about today as discharged from the State mental institutions?

Mr. SLADER. As I recall the testimony, as I was sitting a little earlier high up in the room, I may not have heard it exactly, but the doctor was referring, I think, to the placement of elderly patients out of State hospitals, 7,000 patients or so.

We don't participate in that program and never have. To the extent that they are elderly patients, I have no knowledge of these people.

Senator STEVENSON. I don't quite understand who these patients are that are your patients and what their ages are.

Are these the mental patients?

Mr. SLADER. These are the younger people, primarily.

These are people who have been adjudged mentally ill at one time, I assume mentally ill at one time in their lives and were in State mental institutions.

Senator STEVENSON. They are mentally ill?

*See appendix 1, item 3, exhibit A, p. 1345.

Mr. SLADER. Yes.

Senator STEVENSON. But you are operating a licensed nursing home?

Mr. SLADER. Yes.

NURSING HOME FOR CUSTODY OF MENTALLY ILL?

Senator STEVENSON. And in that licensed nursing home you have custody of the mentally ill?

Mr. SLADER. No, sir. I would like to explain that if I may.

I say at the time that they were placed in the State institution, I believe they were either mentally ill or mentally retarded.

I didn't complete my statement.

Upon discharge from the State institution to a facility such as we maintain, they must undergo a certain examination by a psychiatrist, physicians, social workers and other people familiar with this type of patient and they are then generally discharged with what is known as an absolute discharge.

In other words, they are adjudged no longer mentally ill, no longer in need of hospitalization in a State mental institution and require custodial care, oversight by reason of the fact that they may require some medication, that they may or may not be incontinent and are unable to live alone.

They do need some supervision involving nursing, but they no longer require hospitalization in a State institution because they are not mentally ill.

Now, some of them may not, may never have been mentally ill, I don't know, but they certainly come in with a clean bill of health as far as mental illness is concerned.

Senator STEVENSON. Well, then, why does the Department of Mental Health maintain this continuing responsibility for the care of these patients and has an employee of the Department in the nursing home? Does it reimburse you for the custody of these patients?

Mr. SLADER. Yes, sir.

Senator STEVENSON. Are you saying that the Department of Mental Health is then paying you for the custody of patients who aren't mentally ill?

Mr. SLADER. Yes, sir, I am; and these, I would like to point out, these are indigent patients who are unable to pay their own way and who require the type of care that an institution such as ours provides.

Senator STEVENSON. How much does the Department pay you per month or per day for the care of these patients?

Mr. SLADER. The amount varies with the patient depending upon the amount of care required.

The amount paid is determined by the representative of the State of Illinois, not by ourselves.

There is a rather complex, complicated point system which has been alluded to in previous testimony, which is used as the basis to determine the amount to be paid by the State.

Mr. SULLIVAN. Senator, may I—Senator Stevenson, just to clarify this, as I understand it, part of his patients come from the Department of Mental Health and part from the Department of Public Aid.

Mr. SLADER. Public Aid.

Mr. SULLIVAN. Public Aid. So there are two agencies involved, and you have only been talking about one of the two.

DEPARTMENT OF MENTAL HEALTH PAYMENTS—AT LEAST $260

Senator STEVENSON. Right. The basis, as I understand it, for your compensation by the Department of Mental Health, is $260. That is the rock, that is the bottom figure, and that figure is augmented, depending upon the degree of disability and the number of points?

Mr. SULLIVAN. That is right.

Mr. SLADER. Basically that is correct, Senator.

Senator STEVENSON. Has it ever been suggested to you by any official of the Board of Health or the State Department of Mental Health or any other public agency that you should be also licensed as a mental institution?

Mr. SLADER. I don't recall any such suggestion. It may have been done, but I don't recall it.

Senator STEVENSON. You have never thought about that, or considered it necessary?

Mr. SLADER. No, sir.

Senator STEVENSON. Or advisable?

Mr. SLADER. No, sir, for the reason that these people are adjudged as not in need of hospitalization. They are not in need of that sort of care.

The Department of Mental Health, and our home have participated in this on-going program since its inception which, I believe, dates back to 1961 or 1962, and to the best of my knowledge, there hasn't been any question raised. If there had been, I don't recall it. I have no idea at this time.

Senator STEVENSON. Let me get back 1 minute, also, to the Metropolitan Nursing Home Association.

Could you identify the other officers of that association? You may have already done it and if so, I apologize, because I didn't hear it.

Mr. SLADER. No, I didn't identify them. I don't believe I did.

The present president of the Metropolitan Chicago Nursing Home Association is Mr. Roland Chabot.

I am the treasurer, as I stated previously, as was stated previously.

I believe the vice president is a Mr. Kallner, and I don't remember who the secretary is.

Senator STEVENSON. You said you didn't, or the association didn't engage in any political activities. Does that mean that it doesn't represent the interests of the nursing homes at the State legislature?

Mr. SLADER. No, sir, it doesn't mean that at all.

Senator STEVENSON. You don't have a legislative representative registered with the Secretary of State in Springfield?

Mr. SLADER. I have no knowledge of that.

Senator STEVENSON. Is there a State association of nursing homes?

Mr. SLADER. Yes, sir, the Illinois Nursing Home Association.

Senator STEVENSON. Can you tell us who the president of that association is?

Mr. SLADER. No, sir, I cannot tell you who the president is. We have no relationship.

TWO ASSOCIATION MEMBERS ON STATE LICENSING BOARD

Senator STEVENSON. Do any of the members of your board, the board of the Metropolitan Nursing Home Association, or any of your officers occupy position on the State licensing board for nursing home administrators?

Mr. SLADER. Yes, sir.

Senator STEVENSON. How many and who?

Mr. SLADER. Two.

Senator STEVENSON. What are their names?

Mr. SLADER. Herbert Kellner and Daniel Halpern.

Senator STEVENSON. And can you tell me how many members there are of the State licensing board for administrators of nursing homes?

Mr. SLADER. I cannot tell you that, Senator.

Senator STEVENSON. You don't —or do you know any members of the board of directors or who are officers of the State Nursing Home Association and are also members of the State licensing board for nursing home administrators?

Mr. SLADER. I have no knowledge of that.

Senator STEVENSON. Thank you.

. . . NURSING HOME VOTING IRREGULARITIES?

Senator PERCY. Senator Stevenson mentioned voting.

Do you have any knowledge that there have been any allegations, charges, rumors, whatever it may be that inquiries are now being made into a possible vote fraud connected with alleged voting irregularities for voting held at your nursing home and if so could you give us the details of that?

Mr. SLADER. Well, I have heard this. It was in the public press.

Senator PERCY. Can you tell me and the committee how voting is handled for patients at the nursing home?

What procedures are followed?

Where is the voting precinct of polling place physically located in relationship to the home and what assistance is given to the patients?

Mr. SLADER. Yes, sir; I would be glad to.

The political party representatives in the area, including representatives of both of the major parties, send people into the nursing home prior to elections.

These people are, I believe, although I am not certain, precinct captains or assistant precinct captains or people who have that duty with respect to certain duties of the major parties. They include the two major parties, of course.

Now, they come into the—they come to me and ask if they may present positions of their candidates and their party platforms to the patients and I have always allowed them this privilege since I consider it to be my duty to do so.

Senator PERCY. Both parties?

Mr. SLADER. Not only both parties, there are somtimes three, four, or five candidates and I am now referring to the so-called nonpartisan aldermanic elections.

Senator PERCY. Yes.

Mr. SLADER. And there are frequently many candidates and we have many representatives who come in.

Each of them has an invitation from me to come in to see the patients, either individually or en masse, as it were, because most of our people are fully ambulatory and I would say 98 percent of them are and they do this and they hold meetings, election meetings.

They pass out literature and so on. The voting is done by absentee ballot. There may be a few people——

Senator PERCY. In other words, none of them leave to go vote?

Mr. SLADER. No, sir.

Senator PERCY. How far away is the polling place?

Mr. SLADER. Basically, it is by ballot, but not always.

Senator PERCY. I said, how far away is the polling place?

Mr. SLADER. I don't think it is more than a few blocks, Senator.

Senator PERCY. I see.

Mr. SLADER. I have never been there.

Senator PERCY. But for the most part it is absentee ballots?

Mr. SLADER. Yes, sir. Now the candidates, the candidate's representative are present in the nursing home during the time the ballots, the balloting is done.

The last time it was done, it was done openly in the foyer. A table was provided by me for representatives who were present. They spent most of the day there.

They had notary publics present who certified as to the voting. I did not at all participate other than to provide meals and equipment, furniture.

We, the staff, as names were called, the staff attempted to locate the patients, bring them in the area and then step out.

There was no participation, to my knowledge, in the voting process other than what I have just described; contrary to some of the stories I read in the papers.

Senator PERCY. Yes, but you are familiar that there is an investigation being made?

Mr. SLADER. Oh, yes, yes.

Senator PERCY. All right.

Mr. SLADER. I am quite familiar with that, Senator, and that is how the voting was done.

I am speaking of what particular reference—or with particular reference to the last one.

Now, there were, I think, four or five people present around this table while the voting was being done in the open, in the foyer, and I had nothing to do with it.

Responsibility for Training of Staff Personnel

Senator Percy. Can you tell us something—well, maybe I can simplify it by simply saying you take full responsibility for the training of your people and to be certain that you have trained, competent people working in Melbourne Home?

Mr. Slader. I take full responsibility for the assignment to my department heads, Senator.

Senator Percy. Yes.

Mr. Slader. And I generally supervise the training program, the manner in which it is carried out, the manner in which it is recorded and the followup procedures necessary to see to it that a proper training program is carried out. Yes, sir, I would say generally, yes sir.

Senator Percy. And you are aware that the State appointed a task force, a high-level task force to study nursing homes and it included among it a number of the chiefs of the Bureau of Personnel and Community Health and the director of the Department of Public Aid, Dr. Albert Snoke, director of the Comprehensive Planning Agency; the Development and Health Agencies, Chief of the Division of Health Facilities Department, Department of Public Health and a number of others?

Are you familiar with the summary of the State findings as of March 7, 1971, as it relates to Melbourne Home?

Mr. Slader. No, sir, I am not.

Senator Percy. Possibly you and Mr. Sullivan would be interested in this summary.

Mr. Slader. I have never seen it.

Senator Percy. Because it does relate then to a current appraisal by an absolutely top-level group of competent professionals.

This facility does not satisfactorily meet licensing standards for even an intermediate care facility.

It was found that the nursing leadership was too recent in their appointments to be fully knowledgeable of the requirements and the careful needs of the patients.

This analysis indicates lack of staff to cover intermediate level nursing care including restorative nursing care, training programs, administration of medication, supervision for the type of patents in the facility; primarily patients discharged from mental hospitals with many behavioral problems.

There is no knowledge evidenced with respect to the proper development of patient care in the facility.

Their housekeeping, cleanliness and maintenance was unsatisfactory as were the supplies of furnishings and equipment.

Enumerable specific examples of such are contained in the detailed survey reports.

Many additional visits after June, 1970 licensing indicates that there are in existence evidence that there is a lack of written medical reports and a lack of written policy.

You might also be interested in the specific action that this task force has directed:

Public Health send a notice that they do not qualify for skilled payment.

Public Aid to notify the owner that they are not going to pay the last bill or any future bills sent to Public Health.

Public Health to send letter to Dr. Brown in re: Melbourne deficiencies.

At Monday meeting with Dr. Brown he is to be advised that we are going to proceed with revocation hearing.

AGAIN—WAS PROFIT THE PRIMARY MOTIVATION?

Now, once again I ask, after going into a business from one that was not successful and into one that you hoped would be successful, has the profit incentive been the primary motivation? At no time, though I gave you repeated opportunities when I asked what the motivation was, did I ever hear that there was even a partial mixture of a desire, as Mr. Benjamin Cohen professed yesterday, to help his fellow man who is in an aged condition and needs assistance. I give you the opportunity now to indicate whether that is a motivation or whether the motivation has been entirely as a business and, therefore, that is the controlling motivation. This might then lead me to the conclusion, unless it is corrected by you, and I urge you to correct it if I am wrong, that the profit motive has caused you, then, to simply not repair, not correct these violations and continue to persist in carrying on activities which, since 1965—6 years, now, and that is a long segment out of the lives of people who have been living there—that there have been these repeated violations which again were reported in the Chicago Tribune on March 1, in an article which has been stated to be a gross exaggeration——

Mr. SLADER. Senator Percy, I did not respond fully to your previous question and for that I am sorry.

I had intended to.

Senator PERCY. Well, that is why I want to give you this opportunity, because the record should be complete as it exists as far as that question is concerned because it is a crucial question.

Mr. SLADER. There were several questions involved and I believe I replied to one and then didn't fully respond to the other. That was the only reason I didn't respond.

Now, with respect to motivation, and I believe this is the central core of what you stated, Senator, if I analyze your statement correctly.

The profit motive, as you call it, or the return on investment and so on, was one of the motivations but was not the only motivation.

I was interested, and I still am, and I hope I will continue to be, in what you have called the care of man.

My wife and I are both involved in this and I think, we have been told this by investigators and by people whom I referred to earlier are in the home 80 percent of the time and by their supervisors and we do provide an excellent level of care. I think our patient care is of the best.

Mr. SULLIVAN. Senator, may I interject a question?

May we have available to us a copy of the report from which you read a part?

Senator PERCY. Most certainly.

I think you already have a copy of the report because I have read it into the record.

Mr. SULLIVAN. Is that the whole report regarding Melbourne that you read?

I take it that there are other portions.

Senator PERCY. I only omitted one sentence which didn't seem pertinent but I will put in in the record now.

These are summaries, by the way, but they are all backed up by a great deal more detail and you are certainly entitled to the summary; and the portion I omitted was simply this:

The Director of Nurses was appointed one month ago and the assistant, three weeks ago.

At the time of the visit a two-week schedule was requested, one for floor coverage. This was omitted or did not correspond with the coverage in the master schedules in the Director of Nurses' office for 317, 312, 24-hour coverage.

To save you time you can have a copy of the total summary.

City and State Reports Seemingly Conflict

Mr. Sullivan. Well, there seems to be a very different basis upon which this report is based and some difference of opinion as between the State and the city as to what is a satisfactory level of operation.

I take it from listening to the testimony that the conflict may run a lot deeper than that between the State and the city and that may account for the fact that many of the reports that Melbourne has are based on the department or rather the Board of Health of the city of Chicago and they do not indicate any intention to take drastic action while the State people do recommend it.

Senator Percy. Well, this is the action that has been indicated to us in the records that we have available to us.

A large part of the findings of these hearings have been a failure to follow up and enforce regulations that do exist.

I think it is the intention and the purpose of the State and the city, as they have testified before us, to vigorously follow these up.

I have no hesitancy whatsoever in saying that these task forces have made these findings and that this, then, is the action that can be expected.

Now, as I understand your statement, you have every intention to provide the best of care and it is your feeling that you have provided the best of care for the patients that you have.

Would that include, then, food?

Mr. Slader. Yes, sir.

Senator Percy. Meals?

Mr. Slader. Yes, sir.

Food Costs Per Patient Per Day—58 Cents in 1969

Senator Percy. Now, according to the best information, Mr. Slader, that I could put together through our government auditors, and you realize they have only had a few days since I requested that they be assigned to this work, but the best figures that they have been able to put together are; that for the fiscal year ended October 31, 1967, based on a computation that has been made on actual food costs for 1967, average patient days and patient days, that was not available for 1967 but interpolating 1966 and 1968, the estimated cost of food expense per patient per day is 52 cents for the fiscal year ending October 31, 1967; 53 cents for the fiscal year ending October 31, 1968; and 58 cents for the year ending October 31, 1969.

Now, just from listening from thousands of housewives and, hundreds at least, I suppose thousands when you take into account the number of shopping centers I have gone into in the last year or so and in talking to housewives about the problems in inflation, it seems that you somehow avoided inflation and are able to buy food, not only a great deal less expensively than we can buy it for the State institutions, for penal feeding, but also certainly for the average housewife.

What are the total number or average number of patients that you have, Mr. Slader?

Mr. SLADER. I would estimate them to be in the area of 180.

Senator PERCY. So that you are buying for 180 and you do not have the benefit of a State institution where they buy for tens of thousands sometimes, on a mass basis. You are better than a housewife in your purchasing and you can get wholesale prices but you are not certainly up to the huge volume area.

Would you care to comment on whether you feel that this is a proper proportionate amount, 52 cents a day, multiplied by 365 days by 180 patients, that it averages out to $400,000 which you receive from the Public Aid alone for the care and maintenance of your patients.

Is that, in your judgment, an adequate amount to invest in the feeding, proper feeding of those patients?

FOOD GOOD . . . PLENTIFUL . . . ALL EAT SAME FOOD

Mr. SLADER. Sir, in the years in question and for which we have provided detailed daily patient census reports to your investigators, we have provided that.

I don't understand this matter of interpolation at all because we provided complete detailed information. The average daily food prices are in the range you have covered.

Now, we had a hearing at the Board of Health and one of the matters that came up was the matter of food and we were told that the food was good and they didn't want to hear about the food, that it was ample and it was all right, so that was not a matter for discussion at that point.

Our food service has been frequently investigated and to the best of my knowledge, and I have seen the reports, the reports are excellent.

There is no limitation on the amount of food served. The food is the same food that I eat, my wife eats, and the staff eats. There are no special meals for administrators or staff. It is good food.

It ran about that price at that time. It is much more now because food prices have escalated as has everything else or almost everything else.

However at that time, at that point in history, Senator, I believe the figures you stated, which were furnished by us to your investigators, are substantially correct.

Senator PERCY. All right. Those are, then, substantially correct?

Mr. SLATER. I believe so.

Mr. SULLIVAN. These were the figures on the sheets that we gave your investigators.

Senator PERCY. So that you do substantiate those figures.

Mr. SULLIVAN. Except for the 1970 figure where, I take it, you referred to the interpolation.

Senator PERCY. No, I didn't give any 1970 figures.

Mr. SULLIVAN. I am sorry.

Senator PERCY. Because these were apparently not available yet. When will those figures be available?

Mr. SULLIVAN. Mr. Metz has to answer that.

Mr. METZ. The figures for 1970 will be available, I would say, in another month or so. Right now they are at the computer and are being processed. To make them available immediately would be a real inconvenience but eventually they will be made available.

Senator PERCY. I see.

Mr. SULLIVAN. If you would like we can supply the figures in a month when they become available.*

Senator PERCY. All right, fine. I would like to ask what the rent is that is paid from the corporation to the partnership.

RENT, FROM CORPORATION TO PARTNERSHIP, $5,000 MONTHLY

Mr. SLADER. Yes, sir; as best I can recall I believe the figure is substantially accurate, about $5,000 a month over the period, during the entire period of the operation of this nursing home and that dates back to November 1, 1961.

Senator PERCY. So it is about $60,000 a year?

Mr. SLADER. Yes, sir; on an average basis, yes, sir.

Senator PERCY. Yes: now, as I understand, then, you had taxable income in 1969 of $51,747.

You had compensation to officers, and do I infer that the officers include yourself, your wife, your partner, and his wife?

Mr. SLADER. Yes.

Senator PERCY. Does she receive compensation?

Mr. SLADER. By she, you mean Mrs. Wolski?

Senator PERCY. Yes.

Mr. SLADER. She receives no compensation.

Senator PERCY. Okay. So that the compensation is for—so that the compensation for officers is limited to three of you?

Mr. SLADER. Yes.

Senator PERCY. Each of you who perform duties?

Mr. SLADER. Yes.

Senator PERCY. Describe your wife's duties.

Mr. SLADER. She is assistant administrator.

Senator PERCY. And I again want to make it a matter of record that there is absolutely nothing wrong with paying an administrator-owner a salary quite separate from the profit that would be made because you perform services that would have to be performed by someone else anyway, but the level of compensation is of interest.

*See appendix 1, item 3, exhibit B, p. 1345.

The three officers were paid, in 1969; $73,500 which is the same amount as paid in the preceding year.

Rent was then paid of $60,000 which in effect goes in and flows directly to the same, in this case, four people, two husbands and two wives, so that the gross income, as I see, it for the combined taxable income compensation to officers and rent, is $185,248 for the year 1969, is that correct?

Mr. SLADER. I don't have the figures in front of me, Senator, but I would like to say this, if I may.

Senator PERCY. Yes.

Mr. SLADER. I think you stated that the figure paid to the officers was the same as the prior year.

Senator PERCY. The figures provided to us are $73,500.

Mr. SLADER. I don't believe that is correct, Senator. In prior years we had received no compensation; in the years prior to 1968.

Mr. SULLIVAN. Just a minute. I just wanted to check one thing, Senator, because I think there is a simple explanation.

Senator PERCY. This is the year 1969, fiscal year ending October 31—rather 1967, fiscal year ending October 31; no compensation paid.

In the year 1968, $73,500 was paid; and in the year 1969, $73,500 was paid.

Can you answer or tell the committee whether compensation was paid to the officers in fiscal year 1970 which ended October 31?

Mr. SLADER. Yes, I can answer that.

Senator PERCY. Was it the same amount?

Mr. SLADER. No, sir.

Senator PERCY. Or more or less?

Mr. SLADER. Less, sir.

Mr. SULLIVAN. I don't think the amounts you read are accurate either. I think what happened is that they accrued certain salaries in the year prior to 1969, but didn't pay them and they were never paid.

This recap which Mr. Metz tells me, has been given to the committee, shows the actual dollars paid and averages it out over the 9 years of operation shown and I think, Senator, that is really the more helpful document.

Senator PERCY. We will receive this then for the record*

Mr. SULLIVAN. Can I get that back and Xerox it.

Senator PERCY. As I go back to 1967 when no compensation was paid, the taxable income was $67,420 so that $20,000 a year more was earned that particular year even though no compensation was paid to officers. I want to take into account then that you had the perfect right to charge a salary of a reasonable amount for the services being performed and you could have transferred whatever or how much you wanted up to $60,000 or $70,000 down there. It is the same difference as it is going to essentially the same three people in one

*See appendix 1, item 3, exhibit I, p. 1351.

group, four in another, but this is an accurate figure then as best I can determine.

BUILDING DEPRECIATION AND AMORTIZATION

Now can you also give the committee for the year 1968 or 1969—I presume they would be fairly close—what the depreciation and the amortization was on the building.

Mr. SLADER. I don't know.

Mr. SULLIVAN. Those are the partnership records and apparently Mr. Metz can figure it out.

Senator PERCY. Would you provide that to our auditors?*

Mr. SULLIVAN. For what years?

Senator PERCY. The same years you provided the other data; 1961 through 1970.

You are pulling them off the same accounts anyway.

Mr. SULLIVAN. Fine.

Senator PERCY. Is it your understanding that we can clarify the accounting of this, that though it is listed as an expense it is not an expense in the sense that it is for tax purposes but it is not for the purpose of cash flow; that whatever that dollar amount is, is cash that flows and is available for the operating expenses or for the working capital or for payment of dividends or whatever it may be.

I presume you have the policy of not paying any dividends?

Mr. SLADER. There were no dividends.

Senator PERCY. It all comes then to a total gross statement of increasing the value on investment that has been derived by the partnership and by the partners in the partnership?

Mr. SULLIVAN. I think you have to take into consideration the mortgage cost which would not show on these.

Senator PERCY. Yes, but of course that mortgage cost is an increasing value. It is taking cash and paying off the mortgage and building up equity in the property.

Mr. SULLIVAN. Except for the interest paid on the mortgage, that is true.

Senator PERCY. That is right, the cost, the carrying cost of that.

Mr. SULLIVAN. Right.

Senator PERCY. And we would like to have then the payments on principal as well as the interest.**

Senator STEVENSON. I think it might be helpful also if we could find out how much Dr. Wolski makes on fees in the treatment of the patients.†

Senator PERCY. Yes, that has already been requested.

Mr. SULLIVAN. I think I would like to get that back too, that is my only copy of that and I would like to supply a copy to the committee. They already have a copy but we will give you another one of that if you would like.

Senator PERCY. I will sign this as received by the committee.

Mr. SULLIVAN. I will keep it as a souvenir then.

Senator PERCY. Strike a copy off and furnish us with a copy.

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*See appendix 1, item 3, exhibit C, p. 1346.
**See appendix 1, item 3, exhibit D, p. 1347.
† See appendix 1, item 3, exhibit A, p. 1345.

THIS UNREASONABLE PROFIT . . . COMING FROM WHERE?

Now Mr. Slader, I would like to ask you the question then:

With the history of violations over the period of years, with court suits where fines have been paid, where the city and State have been involved in this—and this costs a lot of money for the city and State to get deeply involved in this—I wonder if you would care to comment on the reasonableness of the figures that I have given: $185,248 plus whatever has been realized in cash flow, as result of the depreciation and amortization; as against the $10,000 investment that you made. Somehow straighten it out later to give you 50-percent equity against the $40,000 that total cash payment that has been made in the property.

That seems to be a lot more profitable than I presume the apartment hotel business and a good deal more profitable than any business I have seen in a long long time.

I can understand why the New York Stock Exchange is promoting nursing home stock, if this is true, but I think it is a matter of business for the Senate of the United States to determine whether this is an unreasonable profit and whether this profit is coming out of the hides of the old people.

Whether this is coming out of their food plate.

Whether this is coming out of their enjoyment of life.

Whether this is coming out of just simply not painting the walls and taking care of the stench and so forth and this is really the heart of the whole inquiry that we are trying to make.

Mr. SLADER. Senator——

Mr. SULLIVAN. Before he answers, may I ask that we be permitted to explain certain expenses that he did not get into with respect when the building was converted to a nursing home but no questions were asked of Mr. Slader about those costs which I think are significant and I think he should be permitted to explain them.

Senator PERCY. Of course you can, certainly.

Mr. SULLIVAN. Would you do so?

Senator PERCY. You can certainly discuss those but I presume that any repairs or maintenance costs were expensed off. They are not capitalized. Have some of these been capitalized?

Mr. SULLIVAN. I don't know but he might be able to tell us. There was an initial substantial expenditure of funds, as I am told, way back in the year when the conversion was made and I would like him to explain that.

Senator PERCY. I would be very happy to hear his response to that question, and to my initial inquiry.

In his case, when a deed in trust was established, was the rent then that is paid an arms length transaction? Could we have a legal comment on Internal Revenue Bureau's position on the control of the fairness of the rent established under a deed in trust arrangement when we have the same principal establishing the rate of rent, $60,000 a year, which is then put in the cost structure but paid to the same people that are taking it on expense.

Mr. SULLIVAN. I would respond to that this way:

I don't think it is an arms length transaction, if the fixing of this rent, because it is the same people who are blessed on both sides of the transaction.

It is my understanding that Mr. Metz tells me that IRS has audited both entities, the corporation and the partnership through 1968.

Senator PERCY. I'm sorry, I didn't get that?

Mr. SULLIVAN. They have been audited by IRS through 1968.

Senator PERCY. I see, and they are familiar, are they, with this arrangement, with the legal aspects of it?

Mr. SULLIVAN. I assume so.

STAFF DIRECTED TO TURN OVER PROCEEDINGS TO IRS

Senator PERCY. I am simply, for the record, requesting and directing the staff of the Committee to turn over to the Internal Revenue Service and the Treasury Department, this portion of our proceedings so that they may follow through on it.

I would like to also ask, because so many nursing homes seem to have this dual arrangement which Mr. Slader, you have indicated you don't really understand or know why it is set up this way, but a lot of them seem to have it and you are obviously a man of intelligence.

Is it possible that the Association has coached and advised owners as to how they should establish these fiscal arrangements.

To your knowledge as an officer, and treasurer of the Association, is there counseling in this aspect of the nursing home management and ownership just as there is in courses offered in many other things?

Mr. SLADER. I have never heard of it Senator and I have never participated in any such discussions if they were ever held.

Mr. SULLIVAN. Hoffman, Sol Hoffman is one of the most astute lawyers in the city of Chicago.

Senator PERCY. Who is?

Mr. SULLIVAN. Sol Hoffman who was Mr. Slader's attorney or a lawyer that set this up.

I don't know whether you are familiar with him.

Senator PERCY. I am not.

Do you happen to know if he has advised a number of other nursing homes; in other words established a pattern and reason for doing this?

Mr. SULLIVAN. I don't know. Maybe Mr. Slader does.

Mr. SLADER. I don't know either but I believe that most certainly many of the nursing homes are setup in this manner.

Senator PERCY. Yes, I just am not familiar with why it would be done or what the purpose is.

I would like to—I would like to keep a life simple. And not complicate it unnecessarily and this business of taking it out of one pocket and putting it in the other pocket with the books that are involved and the reports that have to be filed is just something that I don't really understand. I would like to have some explanation and we will request him to give us advice as to why this advice has been given to you.

Mr. SULLIVAN. Senator, I may say that I am not a tax lawyer or even a business lawyer but I am familiar with practices in say the building area where they set up separate corporations to build each different subdivision and maybe to take over certain functions in the subdivision for tax reasons, to split the income down and I think you will find that is one of the basic reasons, the tax reason. I can't actually answer your question.

ANNUAL RENT OF $60,000 ON $100,000 BUILDING

Senator PERCY. I think it makes it all the more pertinent, your own question, which I consider a valid question, and would have an opportunity to have Mr. Slader explain what he has put back in this building. We would like to have as much detail on that as possible because as I see it, when you put $10,000 of your money and $30,000 of the partners in and they total including mortgage of $100,000 into a building and you pay $60,000 rent on that building, there has got to have been a whale of a lot of rehabilitation and investment back into that facility to make it worth $60,000 a year, arms length or otherwise.

Go ahead Mr. Slader.

Mr. SLADER. In the first place it is not $60,000 a year for the years 1962 through 1968. In those years it was zero dollars per year and if you average it out you won't find it therefore to be $60,000 a year. I think that is important.

Senator PERCY. Did the home operate at a loss during those years?

Mr. SLADER. It operated at a loss of approaching $100,000 the first year and a loss approaching approximately $150,000 the second year and when you net these losses against the net profit and net income you arrive at a different figure than the one which is indicated by the most recent figure.

Senator PERCY. Were you profitable by the third year?

Mr. SLADER. Yes, sir. By the third year I believe we had entered into the black.

Mr. SULLIVAN. We have given a summary of the operation per year from 1962 through 1969 with the averages in the first column but I think Mr. Slader made a mistake in his testimony and I would like to ask or to consult with him for a minute.

Senator PERCY. Fine.

Mr. SULLIVAN. So that we don't get into any question on it.

Senator PERCY. Surely.

(Discussion off the record.)

Mr. SLADER. Mr. Sullivan points out that I may have erred.

I don't recall that I did but if he remembers it correct, that is good enough for me but I didn't mean to say that the salaries hadn't been paid.

Mr. SULLIVAN. I though he said rent.

Mr. SLADER. I meant to say that salaries hadn't been paid.

Mr. SULLIVAN. Yes, as I say, I thought he said rent.

Mr. SLADER. He recalls that I said the rent wasn't paid.

Senator PERCY. You did say rent.

Mr. SLADER. Then I am sorry. I misunderstood the committee.

Mr. SULLIVAN. The amount shown on our spread sheets are the amounts that the accountants tell me, the amounts that were paid for each year for rent and it shows rents paid every year.

Senator PERCY. How much was the beginning rent for the first year?

Mr. SULLIVAN. In 1962, $72,000.

Senator PERCY. In 1962, $72,000?

Mr. SULLIVAN. Do you want me to read each year?

Mr. SLADER. It averages about $5,000 a month.

FIRST-YEAR RENT—$72,000, BEFORE REHABILITATION

Senator PERCY. In other words the rent was $72,000 the year the purchase had been made for $100,000 before any repairs and any rehabilitation was done?

Mr. SULLIVAN. Well, I think Senator, until you get this explanation about the rehabilitation, that there is a distortion and I would like to proceed with that.

Senator PERCY. I would also like to put in the record that the home at that time was licensed for only 41 beds in the first year.

Mr. SULLIVAN. All right. Go ahead.

Mr. SLADER. The home was licensed as a nursing home on November 1, 1961.

As it was previously stated it could not have been licensed until it had been converted structurally, physically from a hotel into a nursing home.

This took many hundreds of thousands of dollars to do.

In order to complete the conversion from a hotel type of environment into a physical structure capable of licensure, it was necessary to undergo a great deal of physical rehabilitation, meaning the removal of walls, plumbing, electrical, ventilation, heating, new roof, et cetera.

Now in order to do this the owners had to invest additional sums of money and to the best of my present recollection it was over a half million dollars.

The sums invested are not limited therefore to the $10,000 or the $40,000 which was previously discussed. That was the initial purchase of the hotel but not the nursing home.

It became a nursing home later after a vast sum or relatively larger sums of money were spent.

Senator PERCY. And again I will ask the question. Were those sums capitalized and subject to depreciation?

Mr. SLADER. Yes.

Senator PERCY. So that the depreciation should reflect that answer?

Mr. SLADER. Yes, sir.

Senator PERCY. They were not expensed?

Mr. SLADER. No sir.

Senator PERCY. And do not appear at any time in the operating statement?

Mr. SLADER. Not at any time.

Mr. SULLIVAN. But you see those partnership records I believe which were not produced because they were not asked for and furthermore these records wouldn't be produced anyhow because the subpoena started with 1966 and didn't cover this period.

Senator PERCY. Well then we will certainly be interested in your continuing cooperation to make certain that we have all of the financial records required to make this analysis.

I would like to ask the question again. Do you feel that this profit, which is salaries, profit, rent, et cetera, and depreciation and amortization, is a reasonable profit or would you, as a businessman, consider this a low profit or a relative high profit and rate of return on investment?

NET INCOME BELOW "INDUSTRY" EXPECTATIONS

Mr. SLADER. I believe the figures are inaccurate, Senator, to start with.

I believe the net income, the real net income from this property is below what is expected in this industry. The figures haven't yet come out in the testimony.

Senator PERCY. What does the industry reasonably expect then and by what standards is it judged?

Is it a per patient profit or is it a return on investment or is it a return on gross and I ask the question because a fairly responsible source indicated that you were quoted as saying that you, as a practice, take 25 percent off the top?

Did you ever make such a statement?

Mr. SLADER. I don't recall ever making such a statement.

Senator PERCY. Then what are the standards that you established, and the industry, first speaking as an industry spokesman, what are the standards that the industry establishes as to what they ought to shoot for in profit, which you have not yet achieved, but I presume are shooting for?

Mr. SLADER. In the first place Senator I say this respectfully, I am not an industry spokesman, have never held myself out to be one.

Senator PERCY. But you are an officer of the association.

Mr. SLADER. Yes sir, I am.

Senator PERCY. So that I am asking you as an officer of the association to just explain this statement that you have made, that you have not yet achieved the standard that the industry has established as a reasonable profit?

Mr. SLADER. I want to make this clear. I don't believe that the industry has established a standard but there are people who invest in nursing homes who have stated what they believe to be a reasonable return on investment, and I am merely quoting these unnamed persons, so to speak.

The impression I have is that the average investor in nursing homes expects a return of something like 15 percent to 20 percent per year on his investment in this type of enterprise.

What Is Considered Equity?

Senator Percy. And when you call—what is his investment; is it his equity?

Mr. Slader. His investment is his equity.

Senator Percy. Or his cash that was put in or includes all the debt incurred such as mortgages?

Mr. Slader. No, sir, I am referring to, and this is my own opinion now, I am referring to net—to the net return on net equity owned only.

Senator Percy. Net equity?

Mr. Slader. That is my impression that that was what was meant.

Senator Percy. You indicated that your beginning equity was $10.000.

Mr. Slader. Mine personal, yes.

Senator Percy. And since then it has increased?

Mr. Slader. Yes.

Senator Percy. How much more cash can you produce records to the committee for having invested in the enterprise of your own cash, other than cash generated by the operation itself?

Mr. Slader. Are you referring to the equity of all the owners, Senator, or mine personally?

Senator Percy. Just your personal 50 percent.

Mr. Slader. Mine personal?

Senator Percy. That is, you and your wife.

Area of $250,000 Equity

Mr. Slader. I think it is in the area of $250,000.

Senator Percy. And you can produce the records for the committee?

Mr. Slader. Oh, yes, without question.

Senator Percy. So that then, you would then expect that your profits should be on that, around $50,000 a year, 20 percent is it?

Mr. Slader. Well, if we maximize it at 20 percent, yes, sir.

Senator Percy. All right. And that is what you are shooting for and you feel that you have not yet achieved that?

Mr. Slader. Oh, I haven't, no sir. I don't—I didn't believe it was possible to do it in the first 10 years, and we haven't—we are just approaching 10 years now.

Senator Percy. Mr. Cohen yesterday said, that one of his brothers felt that it was improper to operate these homes for profit, and that the government should really operate them.

I am not sure I agree with his other brother. I certainly have not come to that conclusion, but would you feel that you would want to make a statement as to how you feel for the advice and counsel of the committee?

Is it best for us to try to aim, in the future, for operating these homes for profit; is the benefit of a profit incentive system adequate and consistent with the establishment of, and meeting of the standards that we have established to perform on behalf of society, to function and service, that these homes should perform with respect to the care that we should be taking of the elderly——

Mr. SLADER. I believe that a nursing home which is properly operated, and I believe ours is, which is backed up by the placement agencies, which is run or operated by people with motivation such as the kind of motivation I referred to earlier, that is, of care for other people, that is a prime consideration.

A secondary consideration, and it should not be excluded from consideration, is the so-called profit motive, but it should never be the primary consideration, and this is what I believe in, Senator.

Senator PERCY. Yes.

Mr. SLADER. I believe there are many other people in the field who are trying to do a good job and feel the same way.

Senator PERCY. Then I would like to conclude my questioning by going back to where we really started when Mr. Sullivan pointed out the article that appeared in, or on March 1st written by Pamela Zekman.

Pamela Zekman, in this article, and I would like to ask this question then first:

She said:

> My presence on the staff was testimony to the poor administration of the nursing home which receives thousands of dollars every month in welfare payments.
>
> After I answered a newspaper ad for a nurse's aide, my phony references and job history were accepted without question, apparently because I eagerly accepted a starting salary of $1.70 per hour. I soon learned why they needed new employees.

STATEMENTS IN ARTICLE—TRUE?

Is it true that she did start at $1.70 an hour; that her references were phony, and her job history was phony and they were not checked before she was hired?

Mr. SLADER. In response to your question, Senator, I made an intensive investigation of the facts surrounding this entire matter.

This is personal investigation and I am not trying to be—I am trying to be responsive, Senator.

Senator PERCY. Well, I think a yes or no answer is all that we really require.

Mr. SLADER. I don't think I can give you a yes or no, with all due respect, and I would like to expound on this if I may.

Senator PERCY. You certainly may if you want to expound, expound.

Mr. SLADER. This investigation was buttressed by the investigation which Mr. Sullivan alluded to earlier.

My personal investigation disclosed that my directive to my head nurse was disregarded in this instance; that a proper investigation of the application was not made; that the head nurse at that time was a Miss Likens, a registered nurse, who did employ this individual along with others.

Senator PERCY. But she is the head nurse?

Mr. SLADER. No, she is not.

Senator PERCY. She had been?

Mr. SLADER. Yes, she had been. It is our policy, Senator, to delegate the responsibility for reviewing applicants for any position

other than department heads or assistant department heads, to the person in charge of the particular department; namely, maintenance, dietary——

Senator PERCY. And how many departments are we talking about?

Mr. SLADER. Basically four.

Senator PERCY. And how many people?

Mr. SLADER. How many people employed?

Senator PERCY. Employed, yes.

Mr. SLADER. It varies between 70 and 80, Senator, depending on the situation; rarely less than 70.

Senator PERCY. Now, how about department heads?

Mr. SLADER. Now, the four major department heads—of course, there are auxiliary departments such as occupational therapy activity programs and so on, which are not major departments.

The four major department heads do at the present time and always have during my tenure in this position, did their own interviewing, their own application checking, all their own investigating, their own training, et cetera.

I never met Pamela Zekman, to the best of my knowledge. I don't believe I know what she looks like. I have never seen her.

Senator PERCY. But you were compensated as the full-time administrator?

Mr. SLADER. But as such——, yes sir.

Senator PERCY. And how long was she reported to have worked for your establishment?

Mr. SLADER. Three afternoons, a total of three afternoons, yes.

Senator PERCY. Three?

Mr. SLADER. Yes, yes.

Senator PERCY. Were you on the night shift or—I mean she worked an 8-hour day?

Mr. SLADER. I believe so.

Senator PERCY. How did it happen with only seven or eight employees there and you being the administrator and director of the nursing home and she worked there, unless you were on vacation—I give you the opportunity to say why you didn't happen to meet 12½ percent of your total population or employees and a very exotic one, as I understand it, certainly in age level she would stand out a little bit from the patients?

Mr. SLADER. It is 70 or 80 employees, not 7 or 8.

Senator PERCY. Seventy to 80, excuse me. That is an entirely different story then. You had, at that time, 70 to 80 employees?

Mr. SLADER. Yes, sir.

Senator PERCY. On the payroll?

Mr. SLADER. Yes, sir.

Senator PERCY. All right. Well, it is possible, then it is possible that you didn't see her?

Mr. SLADER. I generally meet all my employees, but not always in the first 3 days of their employment, Senator, not always.

Senator PERCY. All right.

Mr. SLADER. In this case I don't believe I ever met this young lady.

I understand her to be a young lady because I did see a photograph of here in the newspaper, and she appeared to me to be a young lady.

Senator PERCY. But she was hired at $1.70, no references were checked, and your position now is that the head nurse who hired her was not carrying out the policy that you had, and you are saying that it was her responsibility?

Mr. SLADER. It is a dual responsibility. It is also my responsibility but it was delegated responsibility.

Senator PERCY. Right.

Mr. SLADER. I don't deny responsibility, sir.

Senator PERCY. But ultimately you are responsible?

Mr. SLADER. Yes.

Senator PERCY. For implementation of the policy?

Mr. SLADER. Yes, and for supervision. I don't deny this.

Senator PERCY. Then she started her article by saying:

> The man and woman had been herded into the bathroom of the northside nursing home, and now they stood naked, facing each other in helpless humiliation.
>
> Shivering and self-conscious, the two patients had responded almost mechanically to the orders to undress barked by a nurses aide. "God damn it, hurry up. I have no time for you." The aide snapped when they hesitated for a moment.
>
> The woman stood silent, staring at the floor. Then in a final desperate effort to salvage some dignity from the incident, she clutched a thin sweater to her breasts and protested: "But he's not my boyfriend."

I must say that this is not a—this is a rather dramatic story.

HAS PUBLIC BEEN MISLED BY INCIDENT STORY?

Do you have any evidence that this is not true or that the public has been misled by this, or could such an incident have occurred?

Mr. SULLIVAN. I have checked this out, Senator. Do you want me to respond?

Senator PERCY. I would be happy to have you respond.

Mr. SULLIVAN. Mr. Metz and I determined that the statements made in this article must have been made about one of three persons employed by Melbourne.

I am somewhat reluctant to put their names in public because of what will follow.

We interviewed them and I have——

Senator PERCY. Then you are talking about the patient not the nurse's aide?

Mr. SULLIVAN. Right, I am talking about the nurse's aide.

Now, the patients—that is, I am talking about the nurse's aides, not the patients.

We were able to identify the nurse's aide that Pamela Zekman must have been talking about, because we found out who worked with her during these 3 days.

Mr. Metz interviewed them and I talked to this lady, the particular one involved in this incident, or who must have been involved in this incident, and she just flatly flat-up denies the accuracy of that statement.

Senator PERCY. Is she still an employee of the home?

Mr. SULLIVAN. Yes.

Mr. SLADER. Yes.

Senator PERCY. And she would be willing to testify under oath to that?

Mr. SULLIVAN. I assume she would. She told me. I talked to her at great length in my office about it. Mr. Metz took a statement from her out at the home.

She appeared with us before Mr. Frey at the Board of Health of the City of Chicago where she denied the statements.

She is an impressive young lady. She has training in nurse's aide. She works at other hospitals today in Chicago.

She is employed in a hospital in addition to her employment at Melbourne, and she flatly denies the truth of almost everything that Pamela Zekman states, except she said there was an incident, but it is totally out of context and exaggerated in the article, and this particular incident she denies.

Senator PERCY. Of course, Pamela Zekman could only write about the incident that occurred in the 3 days that she worked there.

Did she admit that there was an incident?

Mr. SULLIVAN. Like this?

Senator PERCY. Of this type.

Mr. SULLIVAN. No.

AIDE DENIED CONFRONTATION INCIDENT AND PRACTICE

Senator PERCY. In other words, she denies that there ever was a naked man and woman confronted, and it was the practice to have them come in and bathe this way.

Mr. SULLIVAN. That is correct.

Senator PERCY. At the end of the article, and here is a physical question that I presume could be verified.

She says:

> On my last day at work I arrived and found the lobby flooded with water. The sewage pipes from all five floors had clogged and a water pipe had burst, I was told. A warning went out on all the floors not to drink or turn on the water because it was unsanitary. The ban lasted 3 hours.
>
> "This is always going to happen in a place like this," a workman confided. "What they ought to do is tear down the building and start all over again."

Now, his statement came only a day after the nurse's aide made this grim observation:

> I don't know how this place gets past the health department. They don't put any money in here. They just take it out. All I know is I wouldn't put my dog in this dump.

Mr. Sullivan, did you attempt to verify that statement or to obtain certified or affidavits from the aide that presumably was mentioned, because I presume that the notations of Pamela Zekman that she made immediately after these incidents occurred, and the record that she kept would clearly point out the name of the individual.

Mr. SULLIVAN. I don't know what workman is referred to, and I had no way of determining who that person is.

This other statement attributed to a nurse's aide, I will have to ask Mr. Metz something off the record.

(Discussion off the record.)

Mr. SULLIVAN. All three, Mr. Metz tells me, all three of the nurse's aides who we interviewed—one nurse an two nurse's aides, denied making this statement.

I might say that one of these women is a registered nurse.

Mr. METZ. Right.

Mr. SULLIVAN. And the woman has many years' experience.

Now, with regard to the flooding of the water, Mr. Slader has personal knowledge of that and this is a good example.

Senator PERCY. Yes.

Mr. SULLIVAN. This incident is a good example of the kind of exaggeration that this article has in it, and I would like to have him testify.

Senator PERCY. Mr. Slader?

Mr. SLADER. All I can say, and I don't like to say it in public, but I suppose I have to—my toilet overflowed.

Senator PERCY. Your what?

Mr. SLADER. The toilet in my office overflowed and the water got into the hallway, which is not the lobby.

I doubt if we had more than few gallons of water on the floor, and it was immediately mopped up.

There was no stopping of the drinking water, and the drinking water system was not affected at all.

There was no cessation of water supplies. It didn't last 3 hours. It didn't last 3 minutes. It didn't occur at all, and I have knowledge of these facts because I was on the premises at the time it occurred.

AIDE VERIFIED MR. SLADER'S VERSION OF INCIDENT

Mr. SULLIVAN. I might say, Senator, that, as I understand it, there was no burst pipe as the story erroneously reports.

Almost everything she says about it is untrue, if what Mr. Slater says is true, and one of the ladies that we interviewed verified Mr. Slader's version of this incident.

Senator PERCY. Another section of the report states:

> **The stench from urine, dirt and decay is overwhelming. It permeates the building, becoming stronger as you move from the downstairs lobby to the second through fifth floors, where patients are housed. In some cases they sleep six to a room.**

At the time this was written was the standard 75-foot square feet per patient per bed?

Mr. SLADER. No, sir, it was 60.

Senator PERCY. 60?

Mr. SLADER. Yes.

Senator PERCY. Is it true that as many as six patients slept in a room, and that means then that there was 360 square feet in the room and that you met the standards?

Mr. SLADER. Yes, sir.

Senator PERCY. Another section of the article reads:

The home is so overrun with vermin that at night employees have conceded large sections of the building to the rats. On the third floor, I was told, they barricade themselves in a small area while rats roam around the patients' living area.

But on this night the rats, cockroaches, and stench of excrement were momentarily ignored as we frantically tried to bathe the patients in a short a time as possible.

Do you have problems with vermin, rats, and roaches?

Mr. SLADER. We have no problems, Senator, that I have ever known about with respect to rats per se.

We did have, and from time to time we do have problems with respect to other insects, et cetera.

I personally don't know of any building of this type or this size, or hotel for that matter, which doesn't have these problems. It is a matter of degree.

If you find one insect you are infested to that extent.

We have an on-going extermination program. We have outside exterminators. We have our own people who exterminate, but in spite all efforts and in spite of all of our efforts, I must honestly admit that there are times when these things happen.

I suppose it will always be so.

CLAIMS "RAT INCIDENT" FALSEHOOD

Mr. SULLIVAN. I might say, Senator, that with regard to some of the other matters in this article, such as this statement that—I can't find it right now—but something to the effect that at night the nurse's aides concede large portions of the third floor to the rats and barricade themselves—the nurse's aides that we talked to deny the accuracy and they say it is a total falsehood, just a total falsehood.

Now, what more can you say unless this woman comes here, and I don't know that she even claims to have personal knowledge of this.

This, I can't find it right now in the article, but this may be one of these hearsay things that she attributes to somebody else.

Senator PERCY. She said, "I am told."

Mr. SULLIVAN. If she was here, she would say, "Well, I don't know, but somebody told me."

Now, we asked the people, these ladies, "Did you ever hear or see Pamela Zekman complain about the stench, or run from a room gagging with nausea?" and they denied seeing her do these things.

Now, other than having inspections, an inspection team go into the third floor at night, I don't know how we are going to get at the truth of this.

Senator PERCY. Yes. Mr. Sullivan, I want you to know that we have not raised any cases just from newspaper articles.

I have been in politics long enough to know that not everything that appears in the newspapers is always accurate.

Mr. SULLIVAN. Yes.

Senator PERCY. Therefore, we did not raise any case against Melbourne, or any other case where we did not have not only a newspaper task force report but also BGA firsthand knowledge, as well as either a Senator, or a member of our staff having been in the home, so that we have sufficient verifications.

In addition we have not raised any case that was not substantiated by corroborative evidence from the city as well as State officials.

I would simply ask the question of you in the most general way, have you been in the home?

Mr. SULLIVAN. I have not. Mr. Metz has been there. He has been up on the third floor in the evening and I asked him, you know, "Did you see people barricaded?"

Senator PERCY. I would ask both of you: Would you want any relative of yours, from what you know of the home, anyone that you know, assigned there for the rest of their lives.

"THIS DOESN'T HAPPEN TO BE A HOME FOR THE AGED"

Mr. SULLIVAN. I would say, Senator Percy, I have been in a great many homes for the aged.

This doesn't happen to be a home for the aged.

Because of my personal involvement with these things, and there are but very few of the homes for the aged that I have seen that I would want to put someone near and dear to me in.

I haven't seen this home, but, from what I have heard, it sounds like it would fall in my category of 95 percent, so, I don't distinguish this home from most of the others I have seen, but I do suggest to you Senator Percy, that when you ask about this bursting pipe, you must—well, I don't know, maybe you had some other verification about this story.

Senator PERCY. One of our valued staff members has himself personally been in the home.

Mr. SULLIVAN. Yes; but on this incident of the burst pipe, that is an incident in the past and it can no longer be verified except by talking to the people who were present at the time Pamela Zekman claims she was there.

I would like her to come in and testify under oath about that.

With regard to this matter of the third floor, I don't remember if Mr. Halamandaris was there at night, but if he was, I would like to hear his version of whether people were barricaded against the rats on the third floor.

Senator PERCY. Would you care to take the stand, Val?

Mr. HALAMANDARIS. I wasn't there at night but I will be glad to take the stand.

Senator PERCY. Mr. Halamandaris is the staff member who developed this hearing.

Would you care to be sworn in?

(Mr. Halamandaris was then given the following oath by Senator Percy.)

Senator PERCY. Do you certify that the evidence that you are about to give to this committee is the truth, the whole truth, and nothing but the truth, so help you God?

Mr. HALAMANDARIS. I do.

Senator PERCY. Would you proceed to describe the conditions which you found on your own personal inspection?

SWORN STATEMENT OF VAL HALAMANDARIS, PROFESSIONAL STAFF, SENATE SPECIAL COMMITTEE ON AGING

Mr. HALAMANDARIS. Well, we arrived at the Melbourne Nursing Home, and I am speaking of myself and Mr. William Recktenwald, of the Better Government Association. We were greeted at the door.

Senator STEVENSON. When was this?

Senator PERCY. Yes.

Mr. HALAMANDARIS. This was last week, on March 25.

Senator PERCY. So that it has been well after all of this has been made public, and all of the State reports have been made?

Mr. HALAMANDARIS. Yes.

We arrived at the nursing home where we were greeted by an armed, uniformed guard—ostensibly hired from a private detective agency. I could describe him as being large in stature and intense.

There were written orders on the inside of the door to the effect: Do not allow anyone in this nursing home. Do not allow anyone whether he is a delivery boy, a nurse, or even the police, without written orders or without permission from Mr. Slader. The notice was signed "Daniel A. Slader, Administrator."

I questioned Mr. Slader about that particular notice that he had on the inside of the door.

Mr. Slader said, "Well, I don't interpret it that way. I don't mean to indicate that nobody can come in here like it says."

I don't know how he wants us to interpret that sign which he still has on the inside of his door. Maybe he will tell you, but to me it simply indicated "No one gets in here unless I say so, not even the U.S. Senate."

BARRED FROM ENTRY

As a matter of fact, the second time when I went to the Melbourne Nursing Home, which was the 31st, to deliver a subpena, the gentleman on my left [indicating Mr. Slader] barred me from entering the Melbourne Nursing Home.

He refused to let me enter and at this time I asked him, "Why?" He said, "Well, we have extended every courtesy that we feel we should to you. You have seen the nursing home. There is no value in your going through it again."

This was his statement.

Going back to the chronology now:

We entered the foyer of the nursing home. The first thing that was apparent to us was the scurrying back and forth of people who could be described as mental patients, and by that I mean, that in their gestures, their arm and head movements, they indicated some difficulty, something which would be very noticeable to you if you walked into the nursing home. It would be an evaluation that you could pick up quickly. Anyone walking into a nursing home would obviously note that these patients were different from nursing home patients who are, by and large, physically ill and disabled.

The smell of new paint was the next thing I noticed. It was very apparent that the painters were busy fixing up the facility.

Mr. Slader indicated to me and had one of his patients tell us that this painting had been going on since January 21.

Now, if he can document that for us, beautiful.

Kept Waiting 35 Minutes Before Touring Facilities

Shortly thereafter, we sat in Mr. Slader's office, and Mr. Slader called his attorney and we noted the time that we were kept waiting, approximately 35 minutes, before we were allowed to see the facilities—at which time Mr. Slader led us on a tour of the facility.

It was obvious that this nursing home, having been inspected by the city, two or three times a day for the last week—that is an exaggeration, but Murray Brown of the city can provide the exact number of inspections—there was an effort being made to keep the nursing home clean and presentable.

The basic point that I would make and that is the conclusions that I formulated—going into a nursing home after it has been inspected day-in and day-out by the city and by the State—are bound to be different than what Pamela Zekman would see, as an employee working in the nursing home, before there has been any attention or controversy raised in the public press or other media about the Melbourne Home.

In the nursing home, obviously from what we saw, was not what Pamela Zekman saw, because there has been a very strong effort on the part of Mr. Slader to improve conditions and to remove the pressure that has been created by the Tribune series.

It is my general opinion the conditions in the nursing home were improving, that Mr. Slader was making an effort to patch up the physical plant.

Efforts To Rehabilitate Only Due to Investigations

He will tell you this is something he does as a matter of routine. It is my conclusion that he did it only after the strong stimulation of the investigation by the BGA and Tribune.

One thing that I noted was a little confusion about the number of employees he had at the nursing home. Perhaps Mr. Slader can tell us how many he has, or how many he had in the past, and how many of these are part time.

I noted, during my visit, that there were 100 cards numbered at the time machine and I started pulling them out and—much to my surprise—there were about 30 of them, that were blank. I didn't know the precise number that were blank until I asked Mr. Slader, and Mr. Slader told me, "Well, we have 60-some employees and 30 blank cards."

"Why the 30 blank cards?"

My assumption is that again this is a——well, just to make things look a little better.

We examined the kitchen facilities of the nursing home and found the things to be generally clean; the food being prepared adequately.

I opened the door to the back alley and there was a pile of old—shall we say—tables, eating tables, old mattresses, discarded wheel

chairs, old Clorox bottles, everything that you can think of that is used in a nursing home as paraphernalia.

This was stacked up blocking the alley—reaching a height of 6 feet and some 10 feet in dimension the other way. When questioned about that Mr. Slader said:

"Well, we are cleaning out the top floor. The top has never been occupied by patients." I would like some clarification on this point.

Was Fifth Floor Ever Used for Patients?

Mr. Slader indicated to me that the fifth floor was not—or has not ever been occupied by patients—and my reading of the city health records indicates that the fifth floor has been occupied by patients in the past. Perhaps he can clarify that for us.

He indicated that the discarded material out in the alley had not been used recently by patients, that he was merely cleaning house and that this was found in the attic, and that one has to do this from time to time.

"One has to throw out certain equipment which has sort of outlived its usefulness," and this was his explanation for the pile of tables, discarded wheelchairs and old mattresses that we saw in the alley.

Now, one could make certain generalizations as to whether this was removed again to give a better appearance, but I am not in a position to say.

I will answer any questions the senators would like to direct toward me.

Senator Percy. Did you have any knowledge at all of the flooding?

Mr. Halamandaris. No.

Senator Percy. Did you check on that at all?

Mr. Halamandaris. No, sir, I had no knowledge of that.

Senator Percy. Or the staff?

Mr. Halamandaris. No, sir.

Miss Zekman's Exact Note of Incident

Senator Percy. I would like to put into the record the exact note made by—not from the newspaper story, but made by Miss Zekman the evening of the incident.

She said:

> Later we were informed that the sewage pipes from the fifth floor on down clogged and had backed up. The water pipe had also apparently burst.
>
> It took 12 men working many hours, to the tune of a total cost of $1,100, we were told, before the mess was straightened out.
>
> Three hours after I got to work we were told that the water was safe. In the meantime, many patients had asked for water, and it took a great deal of effort to prevent them from drinking.
>
> One man insisted that he was dying of thirst, and he had no dime for the coke machine.
>
> I worked on this shift this time with a Gloria Johnson, who had been an aide at the home for 2 years, has 6 months to go to become—has 6 months to go in school to become an LPN.
>
> She said: "Daniel Slader must be splitting a gut over the accident."

She said, "He always gets mad when he has to spend money. He gets upset about anything that costs him money."

Now, that will complete the so-called overflow of the toilet, and if there is conflict of testimony, this is not, of course, testimony, but it is my reading of it into the record, the more complete notations that were made.

If it would serve any purpose we will try to pursue this, but I tend to think that corroborative evidence, though the task force that went to work on this undoubtedly became emotionally involved.

I hope that they were factual, and I have no reason to believe that they were not factual in what they were trying to portray, and though they became emotionally involved as a result of their revulsion at the practices that they found, that same revulsion has been experienced by me and others. This is not true of better than 50 to 60 nursing homes that I have been in across the State of Illinois.

I have found, for the most part, the ones that I have gone in, have been pretty good. They do not compare at all with some of the conditions that have been reported, and some of the conditions that I have seen myself recently.

Mr. HALAMANDARIS. I have one more comment, just to finish up what I started earlier, and that is in regard to my appearance at the nursing home the second time which would have been last Wednesday I believe, the 31st of March, to serve the subpoena.

Mr. Slader barred me at the door and indicated that since I had been through the facility once, there was no need of my coming in or even as far as his office.

He made us, shall I say—he indicated strongly that since it was a nice day he would like the subpoena served outside.

It was a windy day and one half of the subpoena was caught in the wind, and Bill Recktenwald had to chase it three or four blocks. I thought this was a discourtesy, not to even let us in the nursing home as far as his office.

One of the reasons he wouldn't let us in the nursing home was that there was major painting and construction going on in the foyer. At least that is the way it appeared from outside the nursing home.

Now, I don't know who you would allow into the nursing home. Perhaps the privacy of the patients could sometimes be breached. I don't know who you would allow to come and go, but I think you should include among those who should be admitted, the policemen, the fire department, the employees of the United States Senate, and maybe a few others, but then again, maybe Mr. Slader has a different opinion.

Senator PERCY. Would you care to comment on this testimony, Mr. Slader?

STATEMENT OF DANIEL A. SLADER—Continued

Mr. SLADER. Yes, sir, I would very much like to, if I may.

First of all, with respect to the statement made by the preceding witness as to his most recent visit:

I had, I believe, two groups of investigators on the premise at that time.

I had someone in my office whom I had been discussing a problem with, and I, at no time, ever received from Mr. Halamandaris, if I am pronouncing that correctly, any verification of the fact that he was a staff member of this committee.

He showed me a card the first time indicating he was an employee of the United States Senate.

He had no letter from Senator Moss or yourself, sir.

Mr. HALAMANDARIS. I had a subpoena.

Mr. SLADER. I am talking about the second visit, and I believe this card is what he showed me the first time when I extended to him every possible courtesy the first time after having once obtained clearance from Mr. Sullivan.

I recall asking him, and I hope he will confirm this, just what it was that he wanted to see.

He did tell me, and I did show him through the nursing home.

At the conclusion of his visit, and I am referring to the first visit, I asked him, and I would like him to confirm or deny this too; that if there was anything else he cared to see and he indicated there was nothing else he cared to see, and that was the conclusion of that visit.

I believe I was polite to him. I believe I extended him every courtesy both as a person and as a staff member of this committee, and I intended to show him, and I did show him, everything the gentleman wanted to see.

I responded to his questions. I don't believe I was unreasonable.

THREE MEETINGS GOING ON AT TIME

With respect to the second visit, there was no appointment, as there was in the first. I had three meetings going on at one time, and I thought it would be extremely difficult at that moment in time, Senator, to escort Mr. Halamandaris through the building a second time.

I would be glad to do it at any time. I would have been glad to do it later in the day, but at that particular moment in time I didn't feel that I could do justice to my other visitors.

Mr. HALAMANDARIS. I didn't ask to be escorted through the nursing home the second time.

Mr. SLADER. I assumed that is what you wanted.

Mr. HALAMANDARIS. All I said was, "May I see you a moment. I want to give you something." And you said, "Let's do it out here."

Mr. SLADER. Well, it was a nice day, Senator. It was a lovely day.

Mr. SULLIVAN. I might say that the first visit, the delay was caused by my not being in the office when Mr. Slader's call came in.

I told him after the Zekman incident, unless it was people that he knew, he was to check with me before he let people go around through the home, because it was a problem of newspaper reporters getting in there.

Then I did call back and I spoke with Mr. Halamandaris and he told me who he was and I had no doubt about the accuracy of his identification, and I told Mr. Slader, "Show him anything he wants to look at."

Now, he and Mr. Recktenwald were admitted on the grounds that they are legitimate, and that they were properly there for this committee.

Mr. Slader was asked by Mr. Halamandaris about the occupancy of the fifth floor, and I think that needs to be cleared up too.

Do you want to clear it up?

Fifth Floor Occupied as Nursing Home

Mr. Slader. Yes.

The floor to which, I believe, Mr. Halamandaris is referring, although I can't speak for him, is the sixth floor, Senator, and not the fifth floor.

The fifth floor has been occupied as a nursing home.

This is a six-story building that we are talking about. There are no patients and never have been any patients housed on either the first floor or the sixth floor.

The patients are housed on the second, third, fourth, and fifth floors only.

The sixth floor is used as a storage center or storage area, Senator.

The junk referred to by the previous witness is furniture that had not been used in this nursing home since, I believe, 1963.

The sixth floor is being cleared up gradually of an accumulation of furniture which is no longer usable, and is therefore being discarded and stored, not in the alley, because there is no alley, Senator, but rather on nursing home property.

Senator Percy. You do not deny though, that there was a large accumulation?

Mr. Slader. Of course, not.

Senator Percy. That was thrown, cleared out?

Mr. Slader. A very large accumulation.

Mr. Halamandaris. That is a peculiar way to store things.

Your comment was that you were storing them.

Mr. Slader. They were stored items and had not been used since 1963.

Senator Percy. Wouldn't it have been in the interest of safety standards to have not had an accumulation of that type hanging around the building?

Mr. Slader. Senator, the accumulation, I believe, lasted for 2 days.

Senator Percy. I mean, when it was originally stored in there in that condition and then discarded under the pressure of the glare of public notice.

Mr. Slader. No, sir; that was not the reason.

Senator Percy. Was this a normal procedure for you to clean house every once in a while?

Plan Sixth Floor Usage for Patients

Mr. Slader. No, sir; it was neither normal, it was neither normal nor were we proceeding under any order, directions, or suggestions. It was neither. It was a third thing.

The sixth floor is in the process of being made habitable, in other words, for use by patients, and in order to do that we need to remove the contents of the rooms which were intended to be for use as recreational areas and as bedrooms, and for that purpose, and that purpose only, Senator, was this move in progress, was this movement made.

It was made prior to Mr. Halamandaris's visit. It was made during his visit. He did not go on to the sixth floor, and didn't see the work being done, nor was it made—it was made subsequent to his visit also, and it is still going on. This was an ongoing thing.

He happened to be there at the time that this excess equipment was stored prior to removal from the premises, but that is all it was. It was nothing but that.

And, I suspect if he were to pay another visit today, he will find a further accumulation.

Mr. SULLIVAN. I might say, Senator, that with regard to the inference or claim that the painting had started since the newspaper publicity, there is an inspection report of the board of health dated January 8, 1971, which states: "Plastering and painting being done. Workmen in building."

Which now—it doesn't describe it any further, so we don't know what was being done, but they do use the plural workmen in building and it is signed by the registered nurse that made that.

Mr. Metz shows me one from February 2, 1971, "Plastering and painting in process."

Senator PERCY. Do you employ Handy Andy workmen?

Mr. SLADER. Oh, yes.

Senator PERCY. So that we could ascertain from their records the nature of this flooding which you have described as the overflow of your own toilet.

Mr. SLADER. Yes, sir.

Senator PERCY. And which is described here as something a little more serious than that?

Mr. SLADER. Yes, sir.

Senator PERCY. Could we have then those records?* I presume the bills have been paid?

Mr. SLADER. Yes, sir.

Senator PERCY. Fine.

I would now like to turn the questioning over to Senator Stevenson, who, I understand, has one additional question.

Senator STEVENSON. I will be very brief.

Senator PERCY. And Senator Stevenson, I would also like to turn the chair over to you unless you also have a deadline.

Senator STEVENSON. I have a deadline approaching.

Senator PERCY. Approaching?

Well, I would just like to say to you, Mr. Slader and Mr. Sullivan, for your help and your colleagues, Mr. Metz, that we have thought a great deal before asking you to come here, and it is a painful process for you and it is for us too, but it was very painful for the sisters, mothers of patients who had died or who had been

*See appendix 1, item 3, exhibits E, F, and G. pp. 1348–50.

somehow abused and mistreated, to also start these hearings and they came, as you could obviously see if you were here, deeply disturbed at the necessity of revealing the inner thoughts and feelings they had, but they felt it was in the public interest to do so.

We had to decide that it was in the public interest to take a few homes. I wish we had time for homes like Balmoral, whose owner could testify to what he really does and how he feels about this; show his financial return on investment, but how he is able to care for people because it is absolutely marvelous what he and many others, that I have seen, have done. I think it is a discredit possibly to the owners and the managers to have only had some poor experiences represented here. Time only permitted two such illustrations, and we never anticipated that we would take this much time.

Industry Must Police Established Standards

But I do say to you, as an officer of the association, I hope you will use every possible influence with every other owner, to see that they don't have to go through this. That the industry itself polices the standards that have now been established, and correct once and for all this condition that affects so many thousands of citizens that we place a high regard on; but, by the way they are treated, do not seem to be practices consistent with what is being carried out.

It is in that spirit that I thank you for being here and I am sorry you have had to go through it, but I think you have contributed to our better understanding of the problem.

Senator Stevenson. Mr. Sullivan, I think you made a suggestion earlier that there was some difference of opinion between the State and the city authorities about conditions, the actual conditions of the Melbourne Nursing Home.

Inspection Report Cites Numerous Violations

I have a copy of an inspection report of the City Board of Health dated November 18, 1970.

This is a spot check of the facilities, and I won't read all of the violations, but among other things it says:

On the fifth floor room 501 in need of paint.
503: wall covering peeling.
505: mattress stained.
507: ceiling plaster broken.
Fifth floor: janitor's closet broken wall.
509: wall dirty, broken wall, broken plaster. Wall covering off of the wall and more broken plaster.
Sixth floor: not painted. Bedding sunken, mattress stained.
515: walls dirty, plaster needs painting.

And it continues on the fourth floor:

416: mattress in soiled condition and so on.
Third floor: —not quite as many violations.
Second floor: landing ceiling paint peeling and hanging paint.
Shower and tub room ceiling has peeling paint. No curtain or separator between shower and tub.
Second hallway: replastered areas need paint.

And it continues:

Adequate storage not provided. Linen carts stored in Room 311.
Household cleaning supplies stored in closet of Room 412.
Medical Record Room has inadequate storage boxes. Letters covered floor. Unable to move about in room to reach records.
Employee records checked. Tena Moore, has outdated venereal test, chest x-ray, urinalysis—all of the outdated, and the same for other employees.

And then it concludes:

That conditions in this home have improved. The floors are cleaner and the bathrooms do not smell. However, various maintenance problems do exist and prevent this inspector from approving it for licensing.

It is my previous understanding that there was some improvement following that inspection and that a fine was imposed and that a license was issued.

Now, this particular report does not go into the food, but it is also my understanding from the records that the Melbourne Home spends about 58 cents per patient per day for food.

Average Food Cost Per Patient Per Day—$1.50–$2

The average cost, according to the Department of HEW, in the country for food in nursing homes on a per patient per day basis is between $1.50 and $2.

I might add that the per day per patient food cost in the Chicago jails in 63 cents as compared to your 58 cents, and not withstanding that some sick, mental patients included, need at least special diets.

Now, I am of the further understanding that the city is a process of taking action against the Melbourne Home, that a proceeding is pending in court now against this home and others, and also, I would like you to verify this, if you would, that the Chicago Board of Health is having a hearing on the revocation of the city license for this home on Wednesday, April 7, is that correct?

Mr. Slader. Yes.

Senator Stevenson. I wanted to get those observations and facts into the record.

Mr. Slader. With respect to the citation case, Senator——

Senator Stevenson. You may respond if you would like.

Spotlight Is Now on This Home

Mr. Slader. It is my impression, and based upon information which I believe to be correct, that there is hardly any nursing home in the city of Chicago or the State of Illinois, that doesn't have these reports or something like that from time to time, and those reports are available to you for your examination.

The spotlight is now on this home along with a few others, but I think it ought to be focused on all nursing homes with respect to this sort of thing.

Now, I am not, I am neither affirming or denying the accuracy of the statement except in one instance, if I may.

A home can be perfectly free of violations at any point in time, and the next instant have committed a violation.

To be precise, I am referring to the stained mattress, which I

think is a good example of what sometimes happens, and which should immediately corrected if it occurs.

There are occasions when an incontinent patient, and we have a rather large number of them, will void and stain a mattress.

Now, the inspector may have gone through just a few minutes later, and I don't know in this particular instance, but just a few moments after this occurred, in which case it is a violation and should be cited, and it is cited in this case, if that is what happened, but this happens frequently, not only in our home but in many homes.

How much cognizance of this situation is taken by the Board of Health, and when the correction is made and there are no other repeat violations for the same room and the same bed, then it is considered cleared up and abated, and this is a proper abatement action.

Now, this occurs with respect to many other things. We have this problem of the torn wallpaper.

Well, we have patients who are senile, and, in a few cases they present some behavioral problems, who do pull the wallpaper off of the wall. This is why they are in nursing homes in the first place.

If we don't take corrective action with respect to that particular piece of wallpaper within a fairly short order, I would say we are negligent and we ought not to be able to remain in the field. If we take corrective action and it is so proven, by subsequent reports, then I say sir, we have done what we were supposed to do.

We cannot keep it 100 percent all of the time. It can't be done by anybody.

I submit sir, that you will find this situation in all, or almost all nursing homes in the country.

Senator STEVENSON. Are you suggesting then, as an administrator of this Melbourne Home, and as treasurer of the Metropolitan Nursing Home Association, that this home and the conditions reflected in this report are typical?

VIOLATIONS TYPICAL OF HOMES WITH 188 BEDS

Mr. SLADER. I am trying to be fair to everyone and to be responsive, and to be respectful at the same time.

I don't know if they are typical. I say that violations of this nature do occur from time to time, and in all nursing homes.

I don't know if it is to this extent, because a small home wouldn't have this extent. A home with 25 beds will not have as many violations as a home with 188 beds, which is what we have.

So, to that extent it is not typical. I assert, sir, that it is typical of homes with 188 beds or that approximate number, yes, I believe that to be true.

Senator STEVENSON. Well, God help the elderly in nursing homes if this one is typical.

That is all I have.

Senator PERCY. Thank you, Mr. Slader and Mr. Sullivan and Mr. Metz.

Mr. SLADER. Thank you.

Senator PERCY. The committee will call at this time, and I will ask that both Dr. Albert Glass, director of the Illinois Department

of Mental Health, and his special assistant, Mr. Robert Lanier, and Dr. Jerome Hammerman, assistant professor at the School of Social Services Administration of the University of Chicago, to take these three chairs here.

Gentlemen, I wonder if you could each identify yourself and it will not be necessary to swear you in.

We want to welcome you. I am very apologetic about having you wait so long.

Senator Stevenson and I were quite convinced that we could end the hearings by 1 o'clock, as we have both made unbreakable commitments to leave. Would Dr. Snoke please also come forward.

Dr. Snoke, would you come forward as chairman of the State task force.

Senator Stevenson and I will have to leave now.

I would like to authorize and direct Mr. William Oriol, staff director for this committee, to take the chair now, and I can assure you that not only Senator Stevenson and I will read very carefully everything that you have to say as soon as the record is available to us early next week, but will also communicate with you should we find other areas.

However, I can assure you that the staff will be drawing out for the public good from you, your expertise and knowledge in these fields, and that will be made available to the entire U.S. Senate.

If, before we leave, there is any comment you would like to make, we would be happy to hear from you, but I am deeply sorry that we have come to the time when both of us must leave, but most appreciative of your being here, and we value your judgment and opinions and we will assure you that we will follow through on them.

We took a far greater amount of time with our last witness than we ever anticipated that we would, of course.

Senator STEVENSON. I want to add my apologies at having to leave the hearing.

I have to catch an airplane to go to Rock Island.

I want to back up what Senator Percy said, and I too, will read the testimony and profit from your contributions.

I am very grateful to you and I apologize again for having to leave.

(Senators Percy and Stevenson then left the hearings.)

Mr. ORIOL. Dr. Glass, would you care to proceed?

Dr. GLASS. Yes.

I have a prepared statement which I think we have copies of.

Mr. ORIOL. Yes, we have some right here.

Dr. GLASS. I would like to read the statement, and you may interrupt us with questions.

Mr. ORIOL. If we interrupt you we will assure you that the whole text will be included as given here.

STATEMENT OF DR. ALBERT GLASS, DIRECTOR, ILLINOIS DEPARTMENT OF MENTAL HEALTH

Dr. GLASS. Thank you.

The placement of elderly patients from State mental hospitals into nursing homes has been a common practice in Illinois as else-

where for some years. Available statistical data indicate that the largest decline of elderly patients (65 years and older), in Illinois State mental hospitals over the past 6 years, which included placement in nursing homes, occurred in fiscal 1968–69.

I call your attention to the chart numbered 1 which demonstrates this in the presentation.*

Geriatric Transfer Program

Beginning early in fiscal 1970, the present State administration established screening and selective placement procedures for elderly, geriatric, admissions to state mental hospitals. By statutes commonly known as the Copeland bills, the definition of persons in need of mental treatment was amended in the Mental Health Code as follows:

> This term does not include a person whose mental processes have merely been weakened or impaired by reason of advanced years.

The statutes also provided for a preadmissions screening examination period of 7 days for elderly persons with presumed mental disorders, which could be accomplished at general hospitals or at State mental hospitals to determine the need for mental hospitalization or other appropriate services, including nursing home placement.

We have copies of the two Copeland bills introduced by Senator Copeland.

The objective of the preadmissions screening procedure is to prevent unnecessary admissions to State mental hospitals of aged persons with predominantly physical diseases.

In practice, however, admissions of aged to State mental hospitals declined only slightly because proper alternatives to mental hospitalization were not readily available. Thus in default, most aged persons, 88 percent, after preadmission evaluation, were still admitted to the State mental hospitals. Admissions of this aged group have continued at the rate of 150–200 per month, which produced a need for establishing selective placement in appropriate long-term-care facilities.

Mr. Oriol. May I interrupt Dr. Glass?

Dr. Glass. Yes.

Mr. Oriol. What you just said is that you agreed to the concept of preadmission evaluation, or precommitment agreement.

Dr. Glass. No, preadmission.

Mr. Oriol. Preadmission?

Dr. Glass. Yes.

People Didn't Belong in Mental Institutions?

Mr. Oriol. On the grounds that the people really didn't belong in the mental institution?

Dr. Glass. Yes. They had mainly physical diseases, and this was the thrust of, or the purpose of the Copeland bills.

Mr. Oriol. But because appropriate alternative facilities were not available, they did enter the State institution.

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*See appendix 1, item 4, p. 1352.

Dr. GLASS. 88 percent, yes sir.

Mr. ORIOL. Now, what appropriate alternative facilities were you looking for?

Dr. GLASS. Well, appropriate alternative facilities like home health care or the ability of a family to take care of their elderly member, or general hospitalization or nursing home care. As I say, if these alternatives were not appropriately available it would take much more time than the 7 days.

Mr. ORIOL. Why were nursing homes not available, or why weren't they applicable or appropriate?

Dr. GLASS. The problem of getting, of helping these people obtain placement, and under the proper financial auspices would take more time than the 7 days, and usually it took several days to accomplish and reach a decision.

So there wasn't sufficient time then to accomplish either the placement in a nursing facility, finding one, and so forth, near their home and all of that, or neither was there, in most instances, sufficient family help and support, or their own financial support or home health care, or some other way of solving the problem.

Mr. ORIOL. You see what I am leading up to?

Under the Copeland bill, they accelerate discharge on one hand and tried to prevent overadmissions on the other hand.

Dr. GLASS. I beg to differ with you about the accelerated discharges. I haven't said anything about that.

Mr. ORIOL. No.

Dr. GLASS. You are informed that there were, and I want to go into that, but there was no accelerated discharge.

Mr. ORIOL. Well, let me pursue this for a moment.

Who would prescreen the nursing home to determine whether or not it was appropriate?

Dr. GLASS. It could have been——

Mr. ORIOL. For people who are discharged it is quite often appropriate.

BILL MANDATES FORMAL ADMISSION AFTER 7 DAYS

Dr. GLASS. It could have been appropriate, but what I am saying is that in a 7-day period when an elderly person arrives from a mental home, evaluations must be done, lab tests must be done, and there just isn't enough time.

Mr. ORIOL. Why couldn't you extend the period?

Dr. GLASS. The law says 7 days.

Mr. ORIOL. I see.

Dr. GLASS. And then most of them entered the hospital and that made the fact that they came in—the fact that they came in made necessary a selective placement program thereafter, when you did have enough time in the mental hospital.

You see, the admission procedure under the law was not completed during the 7-day period. Then formal admission took place at the end of 7 days.

The bill only mandated 7 days.

Mr. ORIOL. Roughly what average age were these patients who went through this preadmission?

Dr. GLASS. The average age of the preadmission, of these individuals coming directly to the State mental hospitals, is approximately 72 years.

Mr. ORIOL. Seventy-two?

Dr. GLASS. Yes. Over 65 but they may be 85 or, in some instances, even 90.

So we are talking about a group of elderly people with the prescreening examination which is done at the mental hospital which is under the statute which states a 7-day period.

Now, in some instances when the family could assume care, or the family could have resources, financial resources to pay for care, that could be accomplished, but in most instances, 88 percent, that could not be accomplished.

This then made it mandatory that we establish a placement program thereafter for them, so as to accomplish those matters which could not be accomplished in the 7-day period.

Mr. ORIOL. I am sorry I interrupted you. Do you want to go on now?

Dr. GLASS. Now, I want to point out that a relatively small number, 35 to 40 per month, reach age 65 from the existing patient population of State mental hospitals, which number is more than offset by attrition due to discharge and death.

What I am pointing out, is that it is the number coming in that constitutes the reason for the placement procedure.

To accomplish placement of the appropriate elderly patients from State mental hospitals in licensed facilities, a Geriatric Transfer Program, which you have heard about, was instituted in the fall of 1969, which includes the following procedural phases:

In other words, persons who entered, having physical illnesses, we felt were not proper subjects for placements. Some had physical illnesses, some had had surgery and were being treated.

THE FIRST STEP IN THE PROCEDURE IS SELECTION

It is the responsiblity of the hospital staff to select those elderly patients who no longer require hospitalization for physical or mental disorders but need nursing care or a supervised living arrangement. In effect, selection for placement was confined to those patients with physical disorders such as heart disease, diabetes, anemia, vascular disease, or other systemic illness which were sufficiently controlled and stabilized. Aged patients who have progressive severe physical disease are maintained in the hospital.

SECOND: PREPARATION

Family members are informed by letter that hospitalization is no longer needed and that nursing or supervised care is indicated. A request is made for cooperation and assistance in the placement.

Application is made to the department of public aid for medical assistance to the aged in order to provide payment for placement which is needed in the vast majority of aged patients. That is, the financial part is needed.

The patients are prepared for transfer in special programs at the hospital which involve upgrading of self-help skills and other activities. A recent physical examination with laboratory tests is performed and summarized to include personal care needs, diet and medication, so that all necessary information will be readily available to the placement facility.

Third: Placement

Upon the completion of the second phase, State health department personnel are requested to locate a suitable vacancy in a licensed community facility near or at the site of the patient's origin. When all arrangements have been made, the placement is implemented.

Fourth: Followup

Upon transfer, followup staff are assigned to visit the patient periodically in his new setting and to evaluate his needs and the program within the community placement facility.

Currently 165 personnel are fully engaged in this followup responsibility. More staff are to be added. Staff are continuously being allocated to this followup program from their former assignments as patient-care staff within the mental hospitals.

It should be understood that these personnel are not inspectors. Their role is to help community facilities improve programs designed to help the patient achieve a more gratifying life and a more self-reliant status.

Mr. Oriol. I would just like to understand this: A person who had been in a mental hospital and who had been discharged to a nursing home, let us say——

Dr. Glass. Yes.

Mr. Oriol. How often would the followup staff visit this person, or would they not visit that person in a nursing home?

Dr. Glass. Yes, well, let me explain that since last fall when this program came on, and we have continually allocated more and more people until we have 165 personnel in the mental health section, and according to the code, we were required to visit every 3 months and we promptly lowered it to every month and now, as indicated, we will visit more often.

Mr. Oriol. Well, so these followup personnel do go to the nursing homes?

Dr. Glass. Oh, yes.

Mr. Oriol. And when they do go to nursing homes what do they determine? What do they look for?

Followup Personnel's Interest Is Program

Dr. Glass. Their interest is program.

The program provided for the patients of the nursing home, that is their role.

We are talking about other things, but their program has to do with the homes program and activities.

Mr. ORIOL. Such as medication?

Dr. GLASS. Medication usually is looked at if there are questions asked but ordinarily, local physicians prescribe the medication, if further medication is needed, other than what the hospital has summarized in their discharge summary.

Mr. ORIOL. Well, what do you mean when you say they look to program?

You were starting to speak to that.

Dr. GLASS. Yes, programs are prorams of recreation, programs of physical therapy, programs of social movements and social rehabilitation. These are the kinds of programs.

For example, you heard that in one particular place, or in some places, we have someone there every day.

Mr. ORIOL. Yes.

Dr. GLASS. And we are increasing our capability in this regard. These are what we call our subzone staff. They are assigned then to work in the area outside the hospital.

They do a variety of work outside the hospitals, with community organizations and so forth, the subzone staff does, but the equivalent of 165 full-time people are now occupied in visiting community facilities, community licensed facilities.

Mr. ORIOL. Now, what do you mean by the equivalent?

Dr. GLASS. Well, a person may do—he may be working with the community in that area part time, half time, and the other half time visiting the nursing homes, so if we have a certain number of personnel in that particular area, we must have almost close to 1,000 people in our subzone staff; so when I say the full-time equivalent, in some instances they are full time like in our Uptown area, but in other instances they have been assigned part time to placement facilities, so that they can include this in their subzone community work which includes a variety of community activities for discharged patients or entering patients.

You heard Dr. Weinberg talk about prescreening in the community. Well, they do some of that, too.

Mr. ORIOL. Now, you say very firmly here that they are not inspectors.

"THEIR ROLE IS NOT THAT OF INSPECTORS"

Dr. GLASS. Right. Their role is not that of inspectors.

Mr. ORIOL. But if they were visiting a nursing home and saw clear violations which seemed to detract from the care available, what would they do?

Dr. GLASS. Their job is to work with the nursing home administrator and with the State department of public health people with whom we are closely associated and the department of public aid.

Now, if they see something that isn't immediately done or is persistently neglected when they visit there, they draw the individual's attention to it.

Mr. ORIOL. If they saw a bedsore what would they do?

Dr. GLASS. A bedsore, well a bedsore, certainly they would advise the individual to get the doctor who is assigned to the case to prescribe for it.

Now, these are not all——

Mr. ORIOL. Suppose they came back and the bedsore they saw the last time had worsened?

Dr. GLASS. Well, I can point out to you that all of these people who are on our funds or public aid funds that we visit, have authority to call their physician and have him prescribe.

Mr. ORIOL. The patients themselves?

Dr. GLASS. No, the operator.

Mr. ORIOL. The operator?

Dr. GLASS. Yes; he has authority to call the physician and prescribe for them.

Mr. ORIOL. How is it assured that each such patient will have a physician?

Dr. GLASS. Well, they have physicians, all homes have physicians.

Mr. ORIOL. Oh, so it is a house physician?

Dr. GLASS. Well, they use several. They rarely use one, and in some instances the physician comes periodically; say in the morning and sees whoever has to be seen, or it might be two or three times a week, or they always have somebody on call.

Mr. ORIOL. Do you have any requirements as to the number of times a physician shall see a patient?

Dr. GLASS. No; he can see them any time. He can make as many visits as are needed.

Mr. ORIOL. But you have no requirements?

Dr. GLASS. No, no requirement on the number of visits.

Mr. ORIOL. Yes.

Dr. GLASS. No. Public Aid has none. He can have, or he can make any number of visits that are needed.

Mr. ORIOL. Do you know whether any of these discharged patients were assigned to Kenmore or Melbourne nursing homes?

Dr. GLASS. Yes.

Mr. ORIOL. They were?

Dr. GLASS. Yes.

DID FOLLOWUP WORKERS DETECT ANY CONDITIONS?

Mr. ORIOL. Did your followup workers detect any of the conditions that have been described over the past 2 days?

Dr. GLASS. You are talking about the general conditions of sanitation and so forth?

Mr. ORIOL. And some very specific problems that were mentioned.

Dr. GLASS. Well, I don't know whether they could have detected the problems that you discussed here about some instances that occurred in the evening, or something like that.

Mr. ORIOL. Well, it comes to a total picture as presented by certain witnesses.

Dr. GLASS. But you must understand that the inspectors are in there every month.

Mr. ORIOL. Yes, but if you saw something the inspector had missed, what would you do?

Dr. GLASS. Well, in what way "missed something", what do you mean?

Mr. ORIOL. Apparently some of the conditions described in the last 2 days were not detected by inspectors.

Mr. GLASS. Apparently not. Well, apparently they did detect a lot according to the inspection reports.

Mr. ORIOL. Do you now allow discharged patients at Kenmore or Melbourne?

Dr. GLASS. Allow them?

Mr. ORIOL. Yes.

Dr. GLASS. No.

Mr. ORIOL. Have you stopped, did you deliberately stop discharging patients to them?

Dr. GLASS. Melbourne—Kenmore has been closed and we moved the patients.

Mr. ORIOL. You have?

Dr. GLASS. Yes, sir.

Mr. ORIOL. When did you do that?

Dr. GLASS. When we had a notice from the Board of Health.

Mr. ORIOL. Do you have some questions?

Mr. MILLER. Yes, a couple of questions.

I gather from your statement, when these people are transferred from the mental hospital, they are not subject to substantive mental illness at that point, is that correct?

"MELBOURNE: USING IT IN A SPECIAL WAY"

Dr. GLASS. No. We should get into the Melbourne Home which is a separate kind of a facility.

I though you were talking about the aged, and I thought we ought to get to the aged, the Geriatric Transfer program, as I described it, which is the aged program at Melbourne—the program at Melbourne, as they pointed it out, for many years they have been using it in a special way.

I think we can get into that and we could then keep the continuity and then turn back to Melbourne.

Mr. MILLER. I would like to pursue my question, if I may, and I am willing to confine it to the aged.

Is the understanding correct that the older patients that are transferred, are not substantively subject to the mental illness at the time they are transferred?

Dr. GLASS. The aged, yes.

Mr. MILLER. Now, does your supervision, your followup still apply to them?

Dr. GLASS. Oh, yes.

Mr. MILLER. My question is, and perhaps Dr. Snoke, when he testifies, may want to comment on this:

What is the rationale for such followup in such cases unless there is a comparable followup with other public-aid occupants of these institutions?

Dr. GLASS. Yes, that is a good question, and what we have done in thte recent months is entered into an agreement with Public Aid to follow all of their patients through. We have such a signed agreement since January.

Mr. MILLER. But on this followup, how much is confined to those institutions to which mental hospital transferees are sent?

Dr. GLASS. No, in other words——

Mr. MILLER. All of them?

Dr. GLASS. We have an agreement with Public Aid to have our followup team for the aged patients who have never been in a mental hospital, and this is what we are now doing.

Mr. MILLER. Thank you.

Dr. GLASS. Now, let me discuss the results of the first year's operation of the Geriatric Transfer program which included the new screening procedure, that is, the 7-day procedure and the selective placement program.

It revealed a reduction of geriatric discharges from that of the previous 2 fiscal years.

PROCESS OPERATED TO SLOW DECLINE OF POPULATION

I think if you will look at chart 1 you will see that approximately that there was in effect the selective process has operated to slow the decline of the State mental hospital geriatric population to approximately 100 per month.

(Chart 1 follows:)

CHART 1.—PATIENTS 65 YEARS OF AGE AND OVER, ON BOOKS POPULATION, ADDITIONS, AND TERMINATIONS FOR D. M. H. INPATIENT FACILITIES

[Provisional data]

Fiscal year	On books population beginning of year	Additions			Terminations			Net loss/gain	On books population end of year	On books population (all ages) end of year	Percent of population 65 years of age and over of total on-books population
		Total admissions	Number patients turning 65 during year [1]	Total additions	Total discharges	Total deaths	Total terminations				
1965	12,607	2,693	319	3,012	1,556	2,608	4,164	−1,152	11,455	47,125	24.3
1966	11,455	2,859	1,406	4,265	1,514	2,271	3,785	+ 480	11,935	44,618	26.7
1967	11,935	2,592	892	3,484	1,855	2,306	4,161	− 677	11,258	41,692	27.0
1968	11,258	2,530	771	3,301	3,405	2,149	5,554	−2,253	9,005	35,018	25.7
1969	9,005	2,369	519	2,888	2,849	1,589	4,438	−1,550	7,455	30,472	24.5
1970	7,455	2,249	413	2,662	2,629	1,286	3,915	−1,253	6,202	27,368	22.7

[1] Estimated figures.

Dr. GLASS. The reason I repeated that is that I heard here that someone said that it accelerated the process but in fact it did the reverse, it reverted, it slowed it down because it introduced selective orderly process so that the process that operated slowed the decline of the State mental geriatric population to 100 a month.

During the present fiscal year, the same procedure of selective placement has produced similar results with a decline of approximately 100 per month of geriatric patients in mental hospitals. Approximately 75 percent of geriatric discharges constitute placements in licensed communities facilities. The remainder are returned to their own home or that of family members or the placement responsibility is assumed by the family if they have sufficient resources to do it.

As I pointed out, apparently some confusion has been created by the terminology of geriatric transfer program for many have assumed that an accelerated placement of elderly in nursing homes was taking place. However, the reverse has occurred, did to the more selective placement process of the aged for whom discharge was indicated.

The selectivity of the placement program is demonstrated by the relatively low death rate of the patients who are transferred to appropriate care facilities in contrast to the higher death rate from the more severely ill aged who are maintained in the mental hospitals. Correspondingly, experience thus far indicates that readmissions to mental hospitals from this elderly placement group is less than 7 percent.

Simply stated, these patients who are selected are not those who are seriously ill. The more seriously ill are kept in our medical, surgical units in our infirmaries because the ones that are placed have the prospect for a long-term stay.

Mr. ORIOL. You point out that the death rate is likely to be higher among people who are more severely ill?

Dr. GLASS. Yes, it obviously works out that way.

Now as I said, our experience thus far indicates that readmissions to mental hospital from this elderly placement group is less than 7 percent.

Now by that I mean, over a year following placement, whereas we have a readmission rate for our ordinary patients which is far greater than that, far greater than 7 percent.

I would like to discuss: Who are the elderly admissions to the State mental hospitals?

Admissions of patients 65 years or older to State mental hospitals are indistinguishable from other elderly patients who are admitted directly to general hospitals and/or nursing homes with exception of a lower economic status with either no immediate family or the existing family members unable to provide the supervision and the care that is needed.

It is rare for the more affluent elderly to be admitted to the State mental hospital. Usually these aged persons are admitted to a general hospital, or placed directly, or through hospitalization into nursing homes or care is provided, in homes of the more affluent family members.

Nature of Illness in Elderly Patients

In the main, elderly patients have moderate to severe physical illness which is clearly shown by the high death rate after admission to a State mental hospital of from 30 percent to 35 percent during the first year following admission.

Incidently, these figures of the death rate of elderly admissions to the State mental hospitals is pretty common nationwide.

In New York at Rockland State Hospital they had a death rate of 39 percent.

We know that when elderly patients come into a State mental hospital, many of them are very grievously ill and some in their terminal illness.

The diseases present largely involve the cardiovascular system affecting blood vessels to the heart, brain, and other vital organs, tumor or cancerous disorders, severe arthritis, diabetes, prostatic hypertrophy with complications and other chronic degenerative disorders, commonly found in advanced years of life.

Further, in those elderly patients, 70 years or older, degenerative process often occurs in the cells of the various bodily tissues, particularly brain, skin, muscle, and bone, which is slowly or rapidly progressive. This so-called senile degeneration is in addition to damage produced by vascular and other diseases. Because of the above degenerative processes affecting the central nervous system, a major problem in the elderly patient is a mild to severe impairment of memory. The memory impairment may be caused by vascular disease or senile degeneration of the brain. If severe, the memory defect constitutes an important need for supervisory care, for such an aged person is unable to connect events all the time. There is difficulty in imprinting current events which prevents prompt recall when needed. Thus an elderly person may relate clearly the details of younger years, but may have considerable difficulty in recalling current happenings and circumstances.

With severe memory impairment, the aged person may appear confused and cannot effectively plan or prepare meals, or accomplish other usual tasks of day-to-day living. Thus, nursing or supervisory care may be needed not only for physical disease but to insure that the aged person receives adequate food, shelter, and other necessities of life.

In addition to the above problem, there is a loss of status for the aged in our culture which is worsened for those with marginal economic resources, and may produce varying degrees of depression. Status is even further lowered by admission to a State mental hospital which so often results in a label of mental illness.

Many of our patients who come to us know about this mental hospital. It has been in their area for years and so with this, once admitted, the label of mental illness become almost inevitable.

"Traditional Stigma of Mental Illness Exists"

That the traditional stigma of mental illness exists, is demonstrated by the often heard statement that the "mental" elderly should not be comingled in a nursing home with the somewhat more affluent

persons who come to the nursing home directly or through a general hospital.

Arguments are made that it is the placement of the elderly from mental hospitals who have incontinence and other problems which has produced the current situation in some of the Chicago nursing homes. Yet it is ironic that neither professional personnel or nonprofessional observers can distinguish the origin of nursing home residents without access to the placement records.

Mr. ORIOL. Is it strictly a matter of mingling with the affluent persons or strictly a matter of mingling with persons who do not have mental illness or isn't it simply a matter of younger people mingling with older?

Dr. GLASS. If we can get to the Melbourne Nursing Home I will speak of that.

Mr. ORIOL. I am not now talking about the Melbourne Nursing Home.

Dr. GLASS. Here are the differences between not the severity of the illness. Young people have mental illness as do older people but it is not the degree of loss of memory.

These are the reasons why more affluent patients are placed in nursing homes, as well as less affluent, because they can't take care of them.

I want to point out, as I said, that it is ironic that neither professional personnel or nonprofessional observers can distinguish the origin of nursing home residents without access to the placement records.

If you go to a nursing home and you see elderly people with physical diseases and mental impairment and so forth, you cannot distinguish how the route of their placement came about; whether they came via the State mental hospital after admission for several months or whether they came directly to the nursing home.

Mr. ORIOL. Well the whole purpose of the program is to put people in the nursing home who shouldn't be in a nursing home.

Dr. GLASS. Right.

Mr. ORIOL. So that there shouldn't be any problem there.

Dr. GLASS. There shouldn't be, but once they come out of the mental hospitals, then they have the stigma of having been in a mental hospital, and it is very hard for us to get rid of this problem.

Mr. ORIOL. I still go back——

Mr. MILLER. You mean they become mental in the minds of their fellow patients? Not other patients?

Dr. GLASS. Not other patients, it is also not so much mental in the mind of the person placed as it is of other people in regarding the traditional fear of mental conditions.

Mr. ORIOL. You mean the personnel at the nursing home?

Dr. GLASS. No; the personnel can't tell. No; they can't tell the difference. They work with them but it is the concern of people in the general public that somehow or other, if they come from a State mental hospital and they are elderly, they are mental and therefore their behavior and the behavior wandering and being confused is identical.

Mr. ORIOL. Do you send discharged patients to homes that are primarily where the patient load is mostly people on public assistance?

Dr. GLASS. We have some but it varies.

In some homes they take maybe 10 or 15 of ours and others are funded through private sources.

In others they may take half of ours. It varies.

PATIENTS GO TO "PUBLIC ASSISTANCE" HOMES?

Mr. ORIOL. Oh, what I am saying is that—what I am asking is that in the homes to which you discharge patients, a large number of other people are probably on public assistance, isn't that right?

Dr. GLASS. Yes, and haven't come through the Mental Health.

Mr. ORIOL. That is what I question with reference to the more affluent persons?

Dr. GLASS. Yes, but there are homes where there are more affluent people and we have some of our discharged patients.

Mr. ORIOL. Do you have a ceiling above which you will not pay more then?

Dr. GLASS. We pay at the rate of Public Aid.

Mr. ORIOL. You pay the rate of Public Aid?

Dr. GLASS. Yes, the same rate on the same system, the point system.

Mr. MILLER. You have indicated that you prefer to discuss institutions like the Melbourne Home separately.

Dr. GLASS. Right.

Mr. MILLER. But related to the mental patients because it is pertinent to your comment on the allegation that this transfer program has created severe problems in the Chicago nursing homes.

Dr. GLASS. Yes.

Mr. MILLER. Can you indicate how many, or what percentage of the Chicago nursing homes are receiving nonelderly patients?

Dr. GLASS. Yes. The one that you spoke about is, Melbourne.

Mr. MILLER. Yes.

Dr. GLASS. That is a special home and I will describe that but, for example, in the Chicago area we are placing in about 60 homes in the Chicago city proper, in 60 of their some 100 homes, our discharged patients go into them.

Mr. MILLER. Are these confined to the elderly?

Dr. GLASS. Elderly. Here I am talking about the elderly.

Mr. MILLER. Yes, sir.

Dr. GLASS. And we have approximately, oh, 422 patients of the 1,300 total number of beds in the Chicago area.

Mr. MILLER. Then when you comment about the difficulty in distinguishing between the mental hospital transferee and the nonmental hospital transferee in these homes, you are challenging the validity of the claim that this transfer program has increased the problems, created the problems?

Dr. GLASS. Right, both by numbers and by difference—in other words, the numbers that have gone in there represent, oh, something like one out of every seven or eight that are occupants.

Mr. MILLER. And in your opinion——

Dr. GLASS. And by also, not only numbers, but by a difference between the kind of presenting problems that these individuals have.

Mr. MILLER. And in your opinion the maximum impact or validity of such a claim would be restricted to a very few homes in the Chicago area?

Dr. GLASS. We are talking about the Melbourne, and that is a special case as far as I can see.

Mr. MILLER. Are there others?

MELBOURNE HAS BEEN USED IN A SPECIAL WAY

Dr. GLASS. No, Melbourne happens to be, apparently as you heard for a long time, has been used in a special way, not for elderly.

Mr. MILLER. But for mental health patients?

Dr. GLASS. For certain patients that came out of mental hospitals, and I will describe it.

What I am saying, I am talking about the geriatric program, placement program, which started in the fall of 1969.

Geriatrics is our word for the elderly only, and this is the program that I am discussing.

Mr. MILLER. Right, and the young transferees, if any are assignees, as the case may be——

Dr. GLASS. That is a different program.

Mr. MILLER. That does not apply?

Dr. GLASS. It doesn't apply to the geriatric placement transfer program. All of the figures that——

Dr. SNOKE. Dr. Glass, why don't you zero in at this time on that 7,000 figure that was supposed to be discharged immediately, and this is the one that is supposed to have inundated the nursing homes.

Now, how many were there?

Dr. GLASS. Now, it seems to me that many people have the idea that this 7,000 have actually happened. We can tell you exactly in this chart No. 1, how many have been discharged, 75 percent of which have been placed. So we know precisely what has happened, and it obviously hasn't accelerated. This is the point that I think Dr. Snoke is trying to make, or I am trying to make; however, Dr. Snoke has made it.

I would like to go on with this:

Another thesis commonly heard in the present controversy, a need for scapegoating, is that the elderly from mental hospitals are overloading available nursing homes.

In actuality, patients placed through the Geriatric Transfer program, certainly in the past 2 years, represent a small portion of the nursing home occupancy, not exceeding 5 or 6 percent.

The need for nursing home beds is caused by the increasing number of elderly in the general population.

Currently, individuals 65 years and older, represent approximately 10 percent of the total population and this proportion continues to rise. In Illinois there are over 1 million persons 65 years or older. The vast majority of these senior citizens have little difficulty in independent living or working arrangements. Most of these elderly who have temporary physical disorders obtain hospitalization and/or convalescent and supervisory care in the homes of family members. For more persistent physical disabilities, direct nursing

home placment is utilized, however, there are 5 percent to 10 percent of the aged whose financial resources and family help are marginal or nonexistent. It is this group which has produced an increasing need for nursing or supervised care facilities.

For example, currently 37 percent of some 77,000 aged recipients of public aid are placed in group care living facilities.

Now, when I mentioned that patients placed through the Geriatric Transfer program represent a small proportion of the nursing home occupancy, not exceeding 5 or 6 percent statewide; in other words, there are 57,000 occupants which are in nursing homes and shelter-care homes, but 45,000 nursing home beds is what they have, of which we have placed a total of—what is our total—65 and older, which we have placed a total number of elderly of 3,132.

Couldn't Possibly Have Overloaded Existing Facilities

So that is why I say it is somewhere about 6 or 7 percent, and we couldn't possibly have overloaded the available facilities by this geriatric transfer program, but curiously enough, it is a slower program than that previously used, because if you look at the previous years there were many more discharges than 1970 and currently.

Now, I think I would like to point out that the need for nursing home beds is not caused by the geriatric program. It is caused by an increasing need, an increasing number of elderly in the general population.

We know that 27,000 of the 57,000 placed in Illinois pay their own way, so a large number is involved.

However, as I said, there are 5 percent to 10 percent, and I think that is as close as I can come to it, of the aged whose financial resources and family help are marginal or nonexistent.

There are some 22,000 now in group care facilities, licensed group care facilities; I am pointing out that this group needs the beds, is pushing; and I think it is most important to understand that the crux of the problem is not the affluent but the poor aged, and they are the ones that come into this.

So then they are placed under Public Aid, and they of course join this group and make up this 35 percent.

A proper question is, Why have so many elderly persons never before mentally ill, with phsyical disease and declining functions been admitted to State mental hospitals?

The answer lies in the historical development of care for the aged. aged were placed in county homes. Also, homes for the aged were established by various church-supported organizations.

For many years and still existing, the relatively few poor and

With time and increasing longevity of the population, the number of aged who needed long-term group care facilities steadily increased. State mental hospitals were established beginning in the latter half of the last century.

For example, Jacksonville State Hospital, the first in Illinois, opened its doors in 1851. Soon a custom developed of placing the poor elderly in mental hospitals. At the turn of the century, such admissions became a common practice facilitated by a need for in-

voluntary commitment, for many elderly refused to leave thier homes.

Mr. ORIOL. Dr. Glass, the next page and a half appear to be sort of a historical background.

Dr. GLASS. Yes.

Mr. ORIOL. Which I think we are fairly familiar with and perhaps we can just talk about the situation in Illinois.

Dr. GLASS. All right.

I would like to point out what I think are some of the solutions to this problem.

HISTORICAL REVIEW OF MENTAL HOSPITALS

What I particularly wanted to get to in this historical review was why they came to mental hospitals.

Now, as I said, mental hospitals opened about the latter half of the last century, and in fact, Jacksonville State Hospital in Illinois opened its doors, as I said, in 1851.

At the turn of the century it was common practice and it was facilitated by a need for some kind of commitment, because many elderly just refused to go.

The nursing home industry started somewhat before World War II in these family residences, that is what they started in.

In the post-World War II years, construction of nursing homes and other group care homes began, and a new industry was born. In time, there came inspections, first concerned with sanitation, fire prevention, and safety protection, and later standards for programs.

The substandard older homes are in the process of gradual elimination. Skilled nursing homes are of more recent origin to render services to patients convalescing from serious disease and injury. The length of hospital stay has been decreased and limited to acute medical and surgical treatment.

As the mental hospitals moved from custodial care to active treatment, particularly after World War II, it became evident that elderly admissions were mainly physically ill or required nursing or supervisory care, rather than treatment in a mental hospital.

WHAT IS THE SOLUTION?

I say this: The problem as we are seeing it is the problem of the poor. I say it is clearly evident that the problems of the aged and the poor have not been resolved in.

Now, some States, notably California, have enacted legislation which makes preadmission examination mandatory for elderly patients presented for mental hospitalization, and does not permit placement in State mental hospitals merely because of convenience.

As a result, in California, elderly persons are admitted to general hospitals, maintained at home with home health care, or placed in a nursing home as appropriate.

A well-known study in California reported on the results of the preadmission examinations accomplished prior to any type of hospitalization. More appropriate and realistic arrangements, including

nursing home placement, were found for 97 percent of elderly persons presented for admission to State mental hospitals.

For the above reasons, California has half as many aged persons in their State mental hospital population as Illinois, although it has almost twice the population.

A recent study in New York City indicated that almost two-thirds of elderly admissions to a State mental hospital could be prevented by proper screening and placement.

The present administration's program of preadmission examination and selective placement from the State mental is a marked improvement over past programs.

However, preadmission screening can be accomplished in general hospitals, and, if necessary, placement made in appropriate long-term facilities without the mental hospitalization stigma which should not exist, but does.

Mr. ORIOL. Since the Copeland bills were passed——

Dr. GLASS. Yes.

Mr. ORIOL. Let us put it this way. Since they took effect——

Dr. GLASS. Yes.

Mr. ORIOL. How many persons 65 years and over have been discharged under this accelerated program?

TOTAL DISCHARGES WERE 2,629

Dr. GLASS. I think if you look at the data, and we have good data for fiscal 1970, as you see if you take fiscal 1970, you notice there were 2,249 admissions of elderly.

There were 413 who turned 65 within the hospital population giving a total addition of 2,622. Total discharges were 2,629.

Now we tell you we know that 75 percent approximately go into placement. The others are able to go home or go to their own home.

Mr. ORIOL. Fiscal year 1970 was the first year?

Dr. GLASS. The first full year.

Mr. ORIOL. And part of 1969 when the accelerated discharge program was in effect?

Dr. GLASS. Well, in fiscal 1968 and fiscal 1969 I don't know whether I would call it accelerated or not, but whatever was going on then. As you see, the peak was in April 1968, and then it began to slow down.

Mr. ORIOL. Well, is it safe to say that since the bill went into effect you have had about 3,000 or so?

Dr. GLASS. I would say the rate that was going in 1971 is about the same, about the same rate as we were going in fiscal 1970.

Mr. ORIOL. I am trying to determine how many people, since this program went into effect, have been discharged?

Dr. GLASS. Oh, we would have to calculate it for you.

Mr. ORIOL. Now, you say the rate of increase or the rate of discharge——

Dr. GLASS. Of decline.

Mr. ORIOL. Well, I guess when you compare 1968——

Dr. GLASS. And 1969.

Mr. ORIOL. But going back to 1965, it was 1,556?

Dr. GLASS. Yes.
Mr. ORIOL. 1966 there was 1,514?
Dr. GLASS. Yes.
Mr. ORIOL. 1967 it was 1,855, and 1968 it was 3,405?
Dr. GLASS. Right.

HIGH YEAR IN 1968 FOR DISCHARGES

Mr. ORIOL. It seems like a very high year?
Dr. GLASS. Yes.
Mr. ORIOL. So that when you compare what has happened since only to 1968, it does look as if it slowed, but if you compare it to 1965 to 1967 it appears to almost, well, I won't say triple, but at least double.
Dr. GLASS. From 1965 to 1967, now, I wasn't here so I don't know, but there was apparently an increased discharge of elderly but you must understand that their admission rate was higher then, too.
Mr. ORIOL. Dr. Hammerman, do you happen to know what made 1968 such a big year in terms of discharges of these mental patients?
Dr. HAMMERMAN. Of the elderly?
Mr. ORIOL. Of the elderly. Do you happen to know that from your own experience?
Dr. HAMMERMAN. No; I don't, other than I would suggest that there is some relationship to the funding, the backing which the Federal Government makes to the States in terms of the location of the patients, and I don't recall the exact year this came about, but I think it was about that time that it became possible for the State to place out at a lower cost than to keep in.
Dr. GLASS. Do you mind if I——
Mr. ORIOL. May I conclude and then you certainly may answer.
Dr. GLASS. All right.
Mr. ORIOL. Now, was this the advent of Medicaid or Medicare? Is that what you meant by the sudden availability of Federal funds?
Dr. GLASS. First, Medicare doesn't pay for placement in a nursing home. It pays up to a certain amount only.
Mr. ORIOL. So then it is Medicaid?
Dr. GLASS. Now, Medicaid then matches, but it is no guarantee to the State because the State gets paid for its elderly patients in mental hospitals. So there is no gain in money.
Now, we get paid, the State gets paid for all of its elderly under Medicaid which is under title 19 of the so-called Long amendment.
So there isn't any gain.
I heard this from people before, that the State gains money but that is not so.
Every time they placed one out, they lose their funds.
Mr. ORIOL. Are you saying that Illinois, because of the Long amendment, all the funds authorized under that amendment are used solely for mental health purposes?
Dr. GLASS. It is used for elderly.
Mr. ORIOL. For the elderly?

Dr. GLASS. The 65-and-older under the specific Long amendment.

Mr. ORIOL. Yes.

Dr. GLASS. So that if your program in the State mental hospital moves to upgrade and pays, or spends more than it does the previous year, then under the Long amendment, you bill and this has been done regularly in most States and it is done here.

So it is an error to think that if you place the patient out then you get the Federal people to pick up half and the State half—this just isn't true.

If you place people out, the State loses that payment as that patient leaves that State mental hospital.

Mr. ORIOL. Well, we will want to look very carefully into that Long amendment situation and really analyze that because that is a very critical question.

Another question I would like to raise now is the question of where this great fear or this common belief arose——

Dr. GLASS. Where it arose?

Mr. ORIOL. May I finish, please.

Dr. GLASS. Yes.

Mr. ORIOL. About the discharge of the 7,000 to 10,000 elderly patients by mid-1971.

Now, in Mr. Ahrens' testimony this morning, he said that this was an estimate provided by the Department of Mental Health soon after the legislation was passed.

Now, it would seem that that would cause alarm—Dr. Weinberg in this morning's testimony attested to his concern about the very same number.

So it does seem that there is a widespread impression.

Dr. GLASS. Yes. I particularly want to point that out because I have heard that question.

Mr. ORIOL. Yes?

NO SUBSTANCE TO PLACING NUMBERS OF PATIENTS

Dr. GLASS. I have heard that quite often since I have been here and yet I find that there is no substance to it.

Mr. ORIOL. To what?

Dr. GLASS. To the placing out of a large number of people by extrusion.

Mr. ORIOL. There is no substance to the fact that the estimates were made by the department?

Dr. GLASS. Well, the estimate may have been made on the total number.

Mr. ORIOL. Yes?

Dr. GLASS. Talking about the admissions because you have to add annual admissions to the total number.

Mr. ORIOL. The clear-cut 7,000 to 10,000 elderly patients would be returned to the community by mid-1971 under the new legislation?

Dr. GLASS. Well, I have no firsthand knowledge of the statement, but I can only tell you that I never heard anything about it.

Mr. ORIOL. Well, you weren't here.

Dr. GLASS. I know it.

Mr. ORIOL. Was there anyone else here?
Dr. GLASS. I never heard anything about it before I came here.
Mr. ORIOL. Did you read this report?
Dr. GLASS. Yes.
Mr. ORIOL. This report?
Dr. GLASS. Yes.
Mr. ORIOL. Well, this report clearly mentioned that, so that if you read it you will have heard about it.
Dr. GLASS. I have heard about it, but before that report came out.

PROFESSIONALS IN COMMUNITY EXPRESSED ALARM

Dr. HAMMERMAN. I must say many professionals in the community at the time who were not drawn into the discussions did express a great deal of alarm and made that alarm very well known.
Now, to what extent that may have been influenced or it may have influenced a new look at plan and the prospective placement that would be made is difficult to judge, but the professional community did react strongly.
Mr. ORIOL. Yes, we get that clear impression.
I have a letter dated March 30, 1971, from William J. O'Brien who is chairman of the Community Mental Health Board of Chicago, someone I assume you work with, Dr. Glass, rather closely?
Dr. GLASS. I know Mr. O'Brien.
Mr. ORIOL. And unless there is objection, I would like to have it entered into the record.
I will read you two paragraphs from it.

We have never advocated keeping persons in mental hospitals and have agreed to the philosophy of community based mental health service, and we have opposed the accelerated movement out of state institutions when adequate facilities and services were not available in the community.

Now, this letter is dated March 30, 1971?
Mr. GLASS. Yes.
Mr. ORIOL (reading).

Our personal investigation and interviews with concerned relatives confirmed that persons transferred to private facilities were not receiving follow-up care and treatment by the Illinois Department of Mental Health. On numerous occasions we called this to the attention of those responsible.

Would you comment on that?

". . . WE HAVE NOT COMPLETED THE TASK"

Dr. GLASS. Yes; I am well acquainted with Mr. O'Brien. I talked to him many times and I pointed out to him that beginning in last fall about November, we began moving our aftercare teams in and adding to them.
Now, what I think he is saying is that we haven't achieved yet, and there is no question about it, we haven't achieved our full capability in mobilizing all of the people we want in aftercare, and we are doing it now.
So I would agree that we have not completed the task. Of course, we are moving in this direction and have ever since.

Mr. ORIOL. I will go on to the next paragraph.

Dr. GLASS. Yes.

Mr. ORIOL (reading).

While there has been a gradual reduction in the daily residential population in the Illinois State Hospital over a period of the past five years, this gradual reduction was accelerated beginning in January, 1969. The rate of discharge and transfer to private facilities has more than doubled in the period from January 1, 1969, through December 31, 1970; that during this period the residential population was reduced by 6,000 or 22 percent of the total over the 2 years.

Dr. GLASS. Yes, he is talking about all age groups.

Mr. ORIOL (reading).

In addition to those already discharged, there is a program, the geriatric placement program which is designed to discharge and place at least 4,000 geriatric persons by the end of 1971.

So here is another expression of concern.

Dr. GLASS. He says 4,000.

Mr. ORIOL. You see what I mean, there is a whole lot of reports about that.

85 percent of those discharged, transferred to private facilities are maintained by the Illinois Department of Public Aid.

He seems to disagree completely with your statement that things are slowing down.

Dr. GLASS. First, I talked about the geriatric decline, as you know, but the same decline is present all over.

Mr. ORIOL. Yes?

Dr. GLASS. Look at the bar graph check which goes through the years, and it breaks it down to—it breaks it down into three categories, in this bar graph.

One, those who have been in the hospital less than a year.

Those who have been in 1 to 4 years.

Those in 5 years or more, but it has totals and you can see very clearly that the big drop, the biggest drop started in 1967 or 1966—in 1966, from 28,000 to 24,000 total.

We are talking about mental disorders and this chart does not include the retarded.

Mr. ORIOL. We have another chart there.

Dr. GLASS. We have a total decrease in population.

In this bar graph you see that which is projected in the graph, you see that from the decriments, as you notice here we are talking about the decade of 1960, for the first 3 years, 1, 2, 3—1960–64, the first 4 years, the drop—there was a drop, but it was gradual. As a matter of fact, all over the country, State mental hospitals began to plateau off in 1955 and begin a slow decline. This was a nationwide thing.

Then the zone centers were built. The zone centers were conceived in 1960 by Dr. Gerty and they were actually built in 1963, 1964, and 1965, and came to completion.

Now, when they came into operation with more rapid treatment programs, then the discharge rose. The zone centers were located in the populated areas and we are talking about a phenomenon that occurred in Illinois.

Then the more active intensive programs began and with that there was a greater discharge of patients.

Now, it really didn't begin in January 1969, you see, it begins here in 1966, 1967, 1968, and 1969, and now it is kind of slowing in 1970 and 1971.

Mr. ORIOL. I have one——

CHANGE IN MENTAL HEALTH PROGRAM

Dr. GLASS. And the reasons for it are that there has been a whole change in the mental health program here in Illinois.

Now we are getting away from geriatrics to some degree.

We are changing the whole program, but it is not just in Illinois. It is in most States.

Here is a national curve. Can we have the national curve? And we are talking about mental illness, not just geriatrics* or did it include geriatrics. I want the single curve as compared with the national.*

Mr. ORIOL. You are welcome to submit that for the record.

Dr. GLASS. It is a common curve. It shows Illinois which was behind the national curve joins with it in its decline of resident national population.

Now, I think Mr. O'Brien is in error if he says it started in January 1969, because it is very clear that it started when the zone centers got built and came into operation.

Mr. ORIOL. On this other question of where this impression arose of the 7,000 people, elderly people to be discharged?

Dr. GLASS. By 1971, was it?

Mr. ORIOL. Right, well, this is another one. On page 37 of the report I showed you before which was submitted for the record this morning by Mr. Ahrens——

Dr. GLASS. Yes, I read that.

Mr. ORIOL. Which is a report on the impact of the community—the impact on the community on the accelerated discharge program of elderly patients from Illinois State mental hospitals.

This was prepared by what was then the Division of Senior Citizens for the City of Chicago and it is dated January 1970.

On page 37 it says:

> In his statement of September 12, 1969, in connection with the signing of legislation to permit the reduction of numbers of elderly patients at State hospitals, Governor Ogilvie affirmed the administration's goal of moving 7,000 hospitalized senior citizens into nursing homes and shelter care facilities by September, 1970.

Now, this is an excerpt from a letter?

Dr. GLASS. By September 1970?

Mr. ORIOL. Yes.

Dr. GLASS. Is that a quote from Governor Ogilvie?

SOURCE—ILLINOIS MENTAL HEALTH PLANNING BOARD

Mr. ORIOL. Oh, no, no, this is—I am trying to give you the source of it—this apparently is a report from the Illinois Mental Health

*See appendix 1, item 4, p. 1353.

Planning Board which was included as an exhibit in the report.

So if this is inaccurate, I would like to have you state so.

Dr. GLASS. I don't know if it is inaccurate or not. It was at a time when I was not here, but all I can tell you is I have heard nothing about this.

Mr. ORIOL. Has there been since then a statement of goal by number?

Dr. GLASS. No.

Mr. ORIOL. No?

Dr. GLASS. No, there hasn't been at all.

Mr. ORIOL. So that your present rule is discharge as many as is feasible.

Dr. GLASS. Yes, a selective orderly process which has been going on apparently since the program started.

Dr. SNOKE. I think we ought to emphasize here that the problems that we are facing are in the various nursing homes and whether they are inundated or not should be a problem of what actually is in the home, not by what somebody estimated was going to be there.

That is, if we have a problem of overcrowding, it isn't a problem of overcrowding because the Governor estimated 7,000. It is a problem of overcrowding because somebody put these people in there.

Mr. ORIOL. I don't think crowding is really the central issue.

Dr. SNOKE. Well, placement then.

Mr. ORIOL. There are vacancies to which people could be sent. I guess the problem exists just with certain homes.

Dr. SNOKE. Placement.

Mr. ORIOL. Placement?

Dr. SNOKE. Yes.

PROBLEM IS NATIONWIDE THING

Dr. GLASS. The problem exists in the transition and this is a nationwide thing.

I am sure you are aware of it. The issue is that people are wanting to know what to do about the aged, particularly the poor aged who constitute the group having the greatest need for help when they reach the years of their declining capabilities.

Now we are in a transition period. I think we are in a transition period where we are dealing with a lot of homes that were started and are marginal in that respect.

Many States, some States have gone through this transition.

Now I think we have to. The problem is, looking at what is needed now for the elderly citizen, what kind of program, what kind of inspection will be made?

How can we insure by legislation that we can achieve the goal of meeting the needs of the aged; it is a problem like pollution. We have known it was going to come. It is predictable and yet we wait until it gets here.

Mr. HALAMANDARIS. I appreciate your appearance here today but you have been successful in wearing me down sufficiently so that I have decided to interject.

I now have no idea how many patients have been discharged from mental institutions.

I have no idea of when it started or why. At this point I am almost totally confused.

I have a letter in front of me—let's put it this way, and let me have your reaction to it and maybe we can nail down some few things and then have lunch.

The letter again is from Mr. William J. O'Brien dated March 4, 1971, and you should have a copy of this, Dr. Glass, because it is written to you.

The third paragraph begins:

In a review of the results of the investigation by the Tribune it is noted that they examined some 25 nursing homes and since there was a significant problem in that there were a number of mentally retarded people, et cetera, from the state institutions in these nursing homes.

Now they get to what is their information:

Our information is that there is 102 nursing homes that are presently accommodating 7,334 persons.

In addition to this there are 25 homes for the aged with a population of 1,379; 10 shelter care facilities with a population of 3,349 [that is] 349; 14 licensed residential care facilities with a population of 13,338 and five nonlicensed facilities with a population of 542.

Now, that is statewide?

Dr. GLASS. Statewide figures.

Mr. HALAMANDARIS. Is that accurate or not?

Dr. GLASS. I can give you our figures as we have collected them.

Mr. HALAMANDARIS. Let's do that for the record.

Dr. GLASS. All right.

Mr. HALAMANDARIS. And, I would say, if they are unlicensed facilities in the city or in the State of Illinois, let's do what we can to license those facilities.

That is about the only comment I have.

What are the exact numbers, please?

Dr. GLASS. The numbers of nursing homes that we have are 1,192.

The total number of licensed beds then are 67,256. The number of beds occupied in those facilities which are shelter care and nursing homes is 57,778.

Now, the number of vacancies is different.

TOTAL NUMBER OF PATIENTS PLACED, 7,618

The total number of patients that we have placed, whether they are paid by our funds or public-aid funds, is 7,618 by our computer breakdown.

Now, of those a certain number are being paid for by the patients' own funds. We are not sure how many of this number are paid for by Public Aid, our funds, their own funds; because we often act as the patient's agent and we carry him financially on this.

Mr. ORIOL. May we have a copy of that for the record.

Dr. GLASS. This is incomplete.

Mr. ORIOL. May we have a complete copy of it?

Dr. GLASS. When we get our completed form we would like to send it and have it admitted into the record.*

*See appendix 1, item 4, p. 1351.

Now, in the city of Chicago there are some 450 living on room and board arrangements.

Mr. ORIOL. This is shelter care?

Dr. GLASS. No, these are room and board arrangements. These individuals are capable of independent living and are living on room and board arrangements which are funded by Public Aid.

Now, we do not regard them as unlicensed facilities because they are room and board arrangements.

Some are only two in a rooming house and so forth.

So this is, I know for the Chicago area, I don't know the room and board arrangements downstate.

Mr. MILLER. I have three or four questions which I would like to place quickly and get answered quickly.

Dr. GLASS. All right.

Mr. MILLER. I still persist on this matter of the Chicago nursing home situation.

According to Dr. Brown, approximately 105 or 106 homes is the number that they have licensed.

Dr. GLASS. Yes.

HOW MANY HOMES RECEIVE TRANSFEREES?

Mr. MILLER. I would like to know precisely how many of those homes are recipients of young transferees or other patients who are still subject to mental illness.

Dr. GLASS. All right.

Mr. MILLER. The number of homes, that is all I am interested in.

Dr. GLASS. Yes. There was 60 nursing homes. Now, we have a program——

Mr. MILLER. I am not talking about the number that you have transferred older persons to who are not subject to mental illness. I am talking about mental health patients.

How many of those institutions have such patients?

Dr. GLASS. We have approximately 3,000 mostly in shelter care homes with the one exception of the Melbourne Home which has been used by our specialized facilities for many, many years, and we have taken a good look at that but then I have to describe another program which is Medicaid.

Mr. MILLER. Now, I have a very simple question. There are 105 or 106 homes?

Dr. GLASS. Yes. These are all nursing homes.

Mr. MILLER. These are the ones reported by Dr. Brown as licensed nursing homes in the city of Chicago?

Dr. GLASS. He didn't report them as shelter care homes.

Mr. MILLER. No. I would like to know how many of those homes are recipients of persons who are still subject to mental illness?

Dr. GLASS. Well, the majority of them who are under 65 are in Melbourne.

Mr. MILLER. How many other institutions receive them?

Dr. GLASS. There may be one or two but I don't know.

Three or Four Out of 105 or 106 Homes

Mr. Miller. No more than three or four out of the 105 or 106 homes?

Dr. Glass. Yes, very few.

Mr. Miller. That suffices.

Dr. Glass. But Melbourne is the one program that has been going on for a long time.

Mr. Miller. And now——

Dr. Glass. Now, there is another program in health care homes——

Mr. Miller. Now, I am trying to relate this to Dr. Brown's statement that this transfer from mental hospitals has created a serious problems in these 106 homes.

That is the reason that I asked the question and I wanted to nail that point down.

Dr. Glass. If they couldn't have——

What Is Average Public Aid Rate . . .?

Mr. Miller. What is the average Public Aid rates paid for a nursing home or to a nursing home for a discharged mental hospital patient?

Dr. Glass. They pay on the point system as you know, depending upon physicial disability.

Mr. Miller. The average?

Dr. Glass. What is the average?

Mr. Miller. Is it $260?

Dr. Glass. The payment is based on a point system depending upon the amount of disability and it may go up to $450.

Mr. Miller. What is the average payment, that is what I am interested in.

Dr. Glass. I don't know. I think our Public Aid or the Public Aid people there, I see some of them there, and they might know the average.

It is similar to the average on Public Aid. Mr. Swank, do you know the average?

Mr. Swank. About $300 a month.

Dr. Glass. About $300 a month in a nursing home?

Mr. Swank. Yes.

Dr. Glass. Or shelter care home?

Mr. Swank. Nursing home.

Dr. Glass. OK.

What Is Rate in Mental Hospitals?

Mr. Miller. What is the rate of pay for the patients in the mental hospitals, the rate of pay or the cost?

Dr. Glass. Oh, the cost is, you see, it is running about $500 or $550, somewhere between that but above $500.

Mr. Miller. There is a substantial savings, then, as a result of the transfer of patients who are not mentally ill.

Have any of them been denied any beds because of this transfer program, in your judgment?

Dr GLASS. Sometimes in certain areas of the State they have been unavailable, the beds have been unavailable for a time, for the geriatric patients.

Mr. MILLER. Would you say that is a serious problem?

Dr. GLASS. No, not serious.

Mr. MILLER. Now, I would like to ask about, and perhaps Dr. Snoke would care to comment on this and also Dr. Glass, about it.

I understand that you have cut—removed your patients from Melbourne, is it?

Dr. GLASS. Whatever homes have been closed, yes.

DO YOU HAVE ANY STANDARDS?

Mr. MILLER. What about substandard homes? Do you have any policy with regard to admitting?

Do you have any standards other than the simple fact that they have a license?

Dr. GLASS. Well, they must be in licensure.

Mr. MILLER. I understand that, but do you have any standards beyond that?

Dr. GLASS. There are other standards used by our after-care teams and they have the option of where the individual will be placed.

Dr. SNOKE. The answer is "Yes." You wouldn't put some of your mental health patients in some homes that may be licensed but in your judgment the atmosphere is wrong.

Dr. GLASS. Yes. It differs around the State.

In the zone, the director feels that this home doesn't have a program, if he feels that the program isn't satisfactory, as far as he is concerned, he has the option of not placing the patient there.

WHY MELBOURNE HOME SELECTED FOR DISTINCT TREATMENT?

Dr. HAMMERMAN. I am serious—listening to all of this—in knowing what were the distinct programs or the distinct program virtue of the Melbourne Home that warranted this massive infusion of patients and resources?

I just haven't heard it yet.

Dr. GLASS. Well, you can't hear it from me because you heard the gentleman, it started in 1961.

Dr. HAMMERMAN. Well it is still there today and it is, in fact, in operation.

Dr. GLASS. It started in 1961 and back when it started, at that time there was an effort at rehabilitation of patients who had achieved the highest level they could achieve in the hospital and the idea was to move them to the community with a more active program to see if we could achieve more improvement.

Mr. ORIOL. You mean as a result of the transfer their program was improved by going to Melbourne?

Dr. GLASS. As these individuals had reached a plateau, yes.

Now, I am speculating, frankly, because this occurred in 1961 and has been going on.

The concept then or now is that the individual has been in a men-

tal hospital for—lo, these number of years—whatever period of time is involved. Then he has reached a plateau and if he could be moved to the community with an active program perhaps he could achieve further improvement.

I think this is the concept they used. I would suspect so.

Mr. MILLER. Your question about the particular home in question, however, I think is a question that the members of this committee have been giving their attention to throughout the whole hearing.

Dr. GLASS. What I am saying is that this is the overall idea of doing something, but whether it works in Melbourne or whether it didn't, and whether it has worked in its early years or it did not, I don't know.

Now, we are, of course—we don't feel that a nursing home is the place to do this.

Mr. ORIOL. Oh, what do you find lacking? What are you now looking for?

Dr. GLASS. I think that nursing homes, by and large, should be programs for the elderly or the physically disabled.

Mr. ORIOL. Are you through with your questions?

Mr. MILLER. Yes.

How Elderly Patients Are Selected for Transfer

Mr. ORIOL. To go back again to this matter of selection of what elderly patients shall be moved from the hospital under the geriatric transfer program——

Dr. GLASS. Yes?

Mr. ORIOL. On page 2 of your statement, you say it is the responsibility of the hospital staff?

Dr. GLASS. Right.

Mr. ORIOL. To select those elderly patients who no longer require hospitalization for physical or mental disorders?

Dr. GLASS. Right.

Mr. ORIOL. What sort of a team do you have? What is the procedure for determining that? Is a physician involved?

Dr. GLASS. Oh, yes, on the geriatrics service we have physicians, nurses, social workers, psychologists and this team makes the judgment.

Mr. ORIOL. Would you take us through—I mean, when does it start and when does it end and who is involved?

Dr. GLASS. Well, the chief of the geriatrics service is involved as the chief of the team.

Mr. ORIOL. You have one in each State hospital?

Dr. GLASS. Oh, no. We have several teams, depending upon the size of the geriatric population.

For example, at the Chicago Reid, they receive 30, 40, or 50 a month admissions. It is an active service and this is the team, and they don't have but one physician.

Mr. ORIOL. I would like to do this on a per patient basis. What starts the process going to discharge one person?

Dr. GLASS. They make regular rounds on each patient, and as they see the patient has reached an improvement state, a stabilization——

Mr. ORIOL. Who is they?

Dr. GLASS. That is the people who operate the geriatrics service, the staff people.

Mr. ORIOL. That is what I am driving at. Who are the staff people?

Dr. GLASS. The staff people are the physician who is in charge, nurses, social workers.

Mr. ORIOL. You are talking about plurals?

Dr. GLASS. The chief of the team is a physician.

Mr. ORIOL. Yes?

Dr. GLASS. The chief of the service at Chicago Reid.

Mr. ORIOL. Well, how does it get started? I mean, are they just walking about——

Dr. GLASS. They screen their patients constantly.

Mr. ORIOL. Is this at the end of the month, in end of the month reports?

Dr. GLASS. No, I think as far as I know it is a daily thing. They screen their patients constantly and have cases conference, and someone is brought up at a case conference as a likely person for placement.

Then if all agree, after reviewing the case, that the patient has stabilized and is able to get around with support; the question comes up as to whether or not he is a candidate for placement. Then it is acted upon.

The team screens all the time in their daily rounds.

WHO MEETS TO MAKE THE DECISION . . .?

Mr. ORIOL. When they have a likely candidate for discharge, who meets to make the decision on whether he is eligible for discharge?

Dr. GLASS. This is done by the team.

Mr. ORIOL. And what documents do they have in front of them?

Dr. GLASS. When he is eligible for discharge?

Mr. ORIOL. When they are making the decision on whether he is eligible for discharge?

Dr. GLASS. They have his clinical chart.

Mr. ORIOL. Who is they?

Dr. GLASS. The geriatric team.

Mr. ORIOL. Who must assign the document that makes that happen?

Dr. GLASS. The chief of the geriatric service.

Mr. ORIOL. For the whole State?

Dr. GLASS. Oh, no, each hospital has its own.

Mr. ORIOL. I am very confused, then. If you have anything that will describe this procedure in more detail, we would like that for the record.*

Dr. Glass. Now, each hospital does its own. Each hospital receives admissions. Each hospital has its geriatrics service and geriatrics team.

Mr. ORIOL. Is a course of physical examination more intensive than usual given?

*See appendix 1, item 4, chart 3, p. 1354.

Dr. GLASS. In all admissions physicals——

Mr. ORIOL. I am talking about discharges.

Dr. GLASS. Yes, well, in all admissions the physical phase of it is the most important because the individual usually comes in with a good deal of physical problems.

Mr. ORIOL. Does the physician who signs the document actually examine the person?

Dr. GLASS. Oh, yes.

Mr. ORIOL. He does?

Dr. GLASS. Oh, yes. We have physical examinations performed on these patients during the preadmission washup and then you have progress notes and laboratory work and so forth like in a regular hospital chart.

Mr. ORIOL. Do you have anything else, Val?

Mr. HALAMANDARIS. No.

Mr. ORIOL. As I see it, if there is any additional information on this point, I would be glad to have it for the record.*

Dr. GLASS. We had something put out on this, didn't we, sometime ago?

Mr. ORIOL. Dr. Hammerman, we haven't given you too much time to prepare your statement and now we have kept you waiting for a long time.

Would you gentlemen care to stay up here while Dr. Hammerman testifies and perhaps we will have some discussion later.

Dr. GLASS. All right.

Dr. HAMMERMAN. Mr. Oriol, I tossed coins with Dr. Snoke and beauty won out over age.

If you would like to ask Dr. Snoke for his testimony, I would be happy to defer to him.

Mr. ORIOL. I am sorry, I didn't know Dr. Snoke was expected to testify.

Dr. SNOKE. I just want to make a few comments if I might.

Mr. ORIOL. All right.

STATEMENT OF DR. ALBERT SNOKE, COORDINATOR OF HEALTH SERVICES AND DIRECTOR OF COMPREHENSIVE STATE HEALTH PLANNING PROGRAM, STATE OF ILLINOIS

Dr. SNOKE. I should identify myself.

I am Dr. Albert Snoke. I am the Coordinator of Health Services of the State of Illinois and since last December I have also been the director of the Comprehensive State Health Planning Program for the State of Illinois.

My only claim to fame, I think as far as you are concerned, is that I was executive director of the Yale-New Haven Hospital for some 22 years and during that time was professor of public health and hospital administration at Yale University.

I haven't brought any prepared statements, sir. I have been sitting in on the last day and a half of these hearings listening because I frankly wanted to be educated and also to be able to react to what I have been hearing here.

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*See appendix 1, item 4, p. 1351.

Part of my responsibility is to assist the Governor and his departmental directors associated with health to react constructively to this immediate situation, as well as to develop long-range solutions.

The Governor and I are not concerned with attaching blame nor in trying to pass the buck to anyone. His questions to me have been:

What are my responsibilities?

What authority do I have or need?

Do we have the necessary staff, budget or program to do our job properly?

How do we go about doing what is necessary to assure proper care to patients in nursing homes?

I propose to give him suggestions and recommendations on these points.

Three Comments on the Overall Problem

There are three comments I would like to make on the overall problem.

The first is that we have a broad responsibility. We have come here to talk about nursing homes but actually it is part of the whole matter of the proper care of the chronically ill and the aged. We must consider the whole situation.

The second is that, after listening these 2 days, I must say that I am on the side of the individuals criticizing the nursing home that I heard speaking yesterday morning; in contrast to those that I have been hearing so much since then. It is true that there may be an emotional overlay, and statistically a 2-hour working job or a 2-day working job does not give you accurate or total information. However, my own information and my own experience supports their concern.

Finally, I feel that the BGA and the Chicago Tribune have made a very substantial contribution.

I would like to discuss some of the issues for the record.

Standard Goods . . . Enforcement Necessary

Standards—I think we have good standards. Our problem is that we are doing a poor job in inspecting institutions and in enforcing the standards, However, we should remember that it is relatively easy to develop and enforce standards for institutional care, but it is far more difficult to develop and have standards for 'people' care. This second aspect is intangible but important.

As far as the inspection of the nursing homes and the enforcement of the standards is concerned, I think that the State Department of Health and the City Department of Health could have done a better job. We don't need to argue very much about this—the fact remains that, since the publicity came out and the spotlight was put on the problem, there has been a great flurry of inspections with the closing down of institutions.

I think the criticism was deserved. We could have done a better job. I think we will be doing a better job in the future, and this is one reason why I think this exposé has been of help.

I am disturbed over the problem of the Cook County Department of Health. It may be typical of other areas. We have a responsibil-

ity to see that we work more closely together with them in the future.

There are a number of other agencies that have not faced up to their responsibility. These have not been touched upon in this meeting.

One is the responsibility of the general hospitals. I believe that they are too concerned with acute, episodic care. They have a responsibility regarding what happens to their patients after they are discharged. One of the things that I think we should be exploring, in our planning and programing, is emphasis upon developing a "continuum" of care. If hospitals are talking about being community health centers, they must be concerned with the community overall health care in the community—and not just the acute episode. Some kind of working relationship must exist between general hospitals and nursing homes, so that we can get feedback to the State licensing authorities.

Responsibility Also Rests on Physicians

I put the same responsibility on physicians. Physicians are caring for aged people. Physicians are either going to the nursing homes and knowing what is happening—or they aren't going in and they don't know what is happening. If they are going in, I think that they should be passing on information to the licensing authorities.

Frankly, I would like to see physicians and others stop referring to "crocks." This is a derogatory and continual comment one hears in respect to these aged individuals. It is most inappropriate.

Nursing homes obviously have a collective responsibility through their own organizations. They may have difficulty in disciplining their own members, but I believe they should assume more control and let the State help them with the muscle.

There has been considerable criticism of the Department of Mental Health, and the 7,000 mental patients that were supposed to have flooded the nursing homes.

Doctor Murray Brown referred to the fact that, in 1962, there was a scandal about nursing homes—and that thing then got better up to 1968. He stated that then the situation became worse and that this was because of the outpouring of mental health geriatric patients.

I have been in Illinois since October 1969. One of my first acts was to sit in on the first planning meeting for the pilot program of the geriatric placement program at the psychiatric hospital. This programing was the result of the enactment of the Chicago State Copeland bill, which was signed in September 1969.

They didn't start doing much until November 1969, and didn't really get going until the 1st of January 1970. This is the start of the time when "tremendous numbers" were supposed to have been discharged.

. . . What We Are Talking About

I suggest that it is important to pin down just what we are talking about when Dr. Brown and Dr. Weinberg refer to 7,000 patients, and Dr. Glass tells of 2,600 or 2,800. What figures are we talking about, over what period, and where did they go?

There should be no conjecture here. The facts are available and the committee staff can very easily get from the departments of Mental Health and Public Health the facts that will indicate that the 7,000 patients "dumped" in the nursing homes are pure fantasy.

There were questions raised about the profit versus the nonprofit nursing homes by Senator Percy.

I have a bias, because my whole career has been in the voluntary hospital system. I haven't thought too much of proprietary hospitals as contrasted to the voluntary institutions. I don't have the same bias as far as the proprietary nursing homes go. This may be because I ran a voluntary hospital and I was fearful of assuming responsibility for chronic care patients because I thought I would go broke. I don't know whether I was right or not, but I do know that the problem of financing is serious. I suggest that we cannot, baldly or blandly, say that nursing homes should be nonprofit; nor that we should be against the profitmaking institutions. This is a very complicated situation, for there are even some nonprofit institutions that go into it for a tax dodge. I don't know the answers.

I should also point out that the Federal Government isn't so pure in all of this, either. There is the whole problem of financing. You and your Federal colleagues certainly have mixed us up, gentlemen.

Mr. ORIOL. We are mixed up, too.

MEDICARE/MEDICAID RETROACTIVE DECISIONS HINDER

Dr. SNOKE. Yes. We are mixed up on what are the policies for payment as far as Medicaid, Medicare are concerned. I also have a very uncomfortable feeling that long-term care facilities are unwilling to care for Medicare or Medicaid patients, because of delayed or retroactive decisions on acceptance or inadequacy of payment.

I recognize your concern about the practice of "gang visiting," where the doctor comes in for 30 visits in a half hour. On the other hand, I am told that the doctor will get paid each day, when he sees the patient in an acute general hospital; but, that, when he sends his patient out to the long-term care facility, he can be paid only for visits once a week, or once a month, or something like that. I don't know the facts. I am just raising this question for we should not be putting a premium upon keeping a patient in an expensive general hospital unnecessarily.

Finally, I would like to submit to you a copy of the special message on health that Governor Ogilvie submitted to the legislature April 1, 1971.* In the message are six specific items relative to a program for nursing homes. This is just a beginning, as far as we are concerned, toward the problems of nursing homes and chronic care.

There is one short paragraph in the message that reads:

> While taking immediate action on the problems of surveillance and enforcement as necessary [and here the Governor is referring to nursing homes] We recognize broader issues in caring for the aged and that comprehensive analysis is needed and will be done.

Actually Dr. Hammerman has already started doing this and I have received his preliminary report on this subject. It so happens

*Retained in committee files.

that this is parallel to my concern for comprehensive health planning on the problems of the aged and on rehabilitation of the chronically ill. We expect to put high priority on this subject during the coming year.

I appreciate very much your coming. I hope that you will let Dr. Hammerman say something to you. If you want to throw any questions at me, use your own judgement.

Mr. ORIOL. Dr. Snoke, I will ask one quick question.

One thing we will be interested in getting is the text of the Governor's program that was described in the press, the Chicago Tribune, yesterday. Reference was made to nursing homes but no details were given.

Dr. SNOKE. Yes?

Mr. ORIOL. Do you have——

Dr. SNOKE. I will send you a copy of the total message.*

Mr. ORIOL. Do you have any, at this point, any priority, any one item that you are focusing on as far as nursing homes are concerned; in addition to increasing the number of inspectors?

WILL ACT ON INSPECTORS' REPORTS

Dr. SNOKE. Inspectors, in themselves, don't mean very much. We plan to see that when the inspectors submit reports, judgments, and recommendations, that we will not ignore them, but will act on them.

I think that is, probably, one of the main things that we are going to be doing.

Second, we will be working more closely with various communities such as the city of Chicago. We have worked out—and you have a memorandum on that—arrangements by which we will be working together. Dr. Murray Brown and Dr. Yoder know that we will be trusting each other—up to a point. However, we are also going to check on each other. So that we will be following through to see that Murray does a good job; and Murray will be needling us to do our part.

Now, beyond that, I have a task force that is going to be working with me to develop a long-term program. A representative of the Better Government Association has been invited to review unofficially what we are trying to do.

Mr. ORIOL. Has that task force been named yet?

Dr. SNOKE. It consists of the brain trust of the department heads related to health.

Mr. ORIOL. Oh?

Dr. SNOKE. It is comprised of individuals in the departments.

Mr. ORIOL. It is a standing committee?

Dr. SNOKE. Well, no, it is not a standing committee. It happens to be myself, Mr. Lanier, Mr. Wessel, Dr. Flushner, Mr. Elbow, and others.

Mr. ORIOL. You are not going to have private citizens?

Dr. SNOKE. At this stage of the game, it is an in-house task force.

*Retained in committee files.

Mr. ORIOL. Do you plan a later stage?

Dr. SNOKE. Absolutely.

Mr. ORIOL. Do you have a target for beginning this broad approach.

Dr. SNOKE. I guess I should say the target for the first stage is next Monday morning at 10 a.m. That is when the gentlemen are meeting with me.

I am mildly impatient over getting things done and it is only going to be a matter of time, effort and how many hours in the day as to the rest.

Mr. ORIOL. Will their evaluation include a very close look at the point system as to whether that is functioning properly?

Dr. SNOKE. Yes, sir. There is reference to this in the Governor's health message relative to an Office of Health Economics. We will be taking a very careful look not only at hospital reimbursement and professional reimbursement for the whole health scene, but specifically, at this point system.

There are arguments pro and con and I have been hearing many of the arguments against it and I also have been hearing those for it and what the solution will be I don't know.

However, we certainly are going to look at that.

Mr. ORIOL. Thank you very much.

Dr. Hammerman, it is not so late——[Laughter.]

Dr. HAMMERMAN. The sun is still shining, Bill.

If I have survived this far, maybe you can bear with me for 5 or 10 minutes, and I will try to quickly summarize a few reactions.

Mr. ORIOL. You are listed as assistant professor, School of Social Service Administration of the University of Chicago but before taking on that assignment, you were director of the Drexel Home and was that your title?

STATEMENT OF DR. JEROME HAMMERMAN, ASSISTANT PROFESSOR, SCHOOL OF SOCIAL SERVICE ADMINISTRATION, UNIVERSITY OF CHICAGO

Dr. HAMMERMAN. Yes, before coming to the university, I was director of Drexel Home which is a multifunctional institutional program for the elderly, accommodating about 250 older adults, primarily a very chronically ill and disabled population.

The comments I heard this morning may have some bearing as to where part of the problem lies.

The nursing home operator that spoke this morning indicated that he was serving approximately 188 people and he had approximately 70 to 80 employees.

We didn't identify how many of these were full time or part time.

ONE EMPLOYEE PER ONE CLIENT AT DREXEL HOUSE

The Drexel Home operated at a roughly one-to-one ratio, one employee per one elderly client.

I believe that in the acute general hospital, the ratio may be closer to three or four employees to one patient.

Inspectors in and of themselves are meaningless unless we begin to specify very clearly what standards of output we are concerned about and look to at least some indicators, such as staff-patient ratio, at least with respect to certain types of patient mixes that would guarantee a little better return for our public dollar.

Refutes Profitmaking System for Care of Elderly

I don't have Dr. Snoke's qualms. I think it is a terrible tragedy that we have turned over our sick and disabled older adults to a profitmaking system that must survive essentially at the expense of the individuals that presumably it is serving.

I have no qualms about the carriage trade seeking out the kind of care that they may need and are ready to pay for.

I balk at my tax dollars being squandered in a way which is neither subject to adequate review, subject to control, related to any kind of standard setting which I think is pertinent for the human needs of older adults today.

However, maybe we ought to come back to Drexel Home.

The important element here was that the home was able, and is still able, to bring together a tremendous variety of health and social welfare personnel; physicians, nurses, occupational therapists, physical therapy, et cetera, the whole list of professional skills.

Well, now, when the home must negotiate with the public aid department for a reimbursement for the people it is caring for, what we find is that essentially the difference in cost is made up by two elements; profit, which is not there, but the tremendous additional outlay for staff, which is there.

And so, the government must then say:

> Does a budget, which reflects 70 percent to 75 percent of the cost in staff salaries, represent a reasonable outlay or does, as was indicated earlier, perhaps a 40 percent to 45 percent outlay in staff represent a reasonable outlay.

Our problem with State government today is that it is simply buying the cheapest care it can and not looking any further.

Cheapest Care . . . Giving the People Its Value

Now, I am not suggesting that the outlay that is represented by an enriched program such as that of Drexel Home must necessarily constitute the base that the State relates itself to, but it cannot simply buy the cheapest care on the market and assume that it is giving the people its value.

I think it must negotiate somewhere between what might be called Cadillac services—although I still think of it as a Ford—and the pushcart, which we have traditionally accepted as the model for our chronic long-term care facilities.

Nor am I sanguine about the idea that—about the idea of inspections or harassment for what amounts to a cottage industry that the nursing home represents, that this, in and of itself, will bring any kind of incentive into the system.

Proprietary homes must maintain full occupancy or they will lose money.

Even the nonprofit home must maintain full occupancy or its deficits will climb.

These facilities need to be brought into a coalition of a variety of social health services that move all the way from the most chronic, long term inpatient skilled nursing facility to the most ephemeral, preventive outpatient recreational or social program, so that we combine the broad risks of a population and spread the costs between them. We must get in as early as we can with preventive programs and provide some incentives for moving them back into the community, whenever this is possible—not to simply pile them into institutions.

New Design Merits Active Interest

I think at the present time the Jewish Federation of Metropolitan Chicago is initiating such a design.

I think it merits very careful and very active interest of this committee and of government generally.

I think it is an excellent opportunity to test out what a truly coordinated and comprehensive care program for the chronically ill is capable of accomplishing. It can address itself to very serious questions for which we don't know the answers.

What are the proper mixes of personnel in any facility?

What should be the level of services expected?

What incentives can be created so that people tend to want to remain in the community?

How do you mobilize community resources so that you do help them in their initial decisions?

Mr. Oriol. May I just ask one question?

Dr. Hammerman. Yes.

Mr. Oriol. What you just spoke about, the avenue you just spoke about is strictly through private resources?

Dr. Hammerman. Right.

Mr. Oriol. And do you think that perhaps in specifics——

Dr. Hammerman. When you say private resources it is private sponsorship but a good deal of the resources coming in will be third party payments, in any event for services.

Mr. Oriol. Oh, yes, sure; but I mean in setting it up——

Mr. Hammerman. The auspices is a sectarian group.

Mr. Oriol. We don't have time now, but if you could give some thought to ways that Federal incentives could be given to private organizations for this type of a comprehensive approach, perhaps by providing relatively soon to the Federal assistance, that could encourage this comprehensive approach.

Suggestions About Objectives of Coordinated System

Dr. Hammerman. Well, in the paper which I will submit and which I will not read because it is obviously much too late, I do have some suggestions about the objectives and elements of a coordinated system and the need to focus on these incentives.

Without them we are just moving from crisis to crisis and we are not really developing the leadership which I hope is emanating from Dr. Snoke and his chief and other leaders here in the State.

However, I think they have an excellent partner in the voluntary groups that do see a purpose and an opportunity now to test out, at least on a pilot population, some of these very critical issues that we have to confront before we will ever be able to resolve these problems.

Every generation has buried the institution and every generation comes back to the fact that the institution remains. It is there and we simply have not come to grips about using it intelligently.

(The prepared statement of Dr. Hammerman follows:)

PREPARED STATEMENT OF DR. JEROME HAMMERMAN

My name is Jerome Hammerman. I am a faculty member of the School of Social Service Administration of the University of Chicago. Prior to my appointment at the University, I served as Executive Director of the Drexel Home for the Aged, here in Chicago. This is a multifunctional institutional facility, a member of the Jewish Federation of Metropolitan Chicago.

Nursing home exposés, as helpful as they may be in spotlighting fraudulent or dangerous practices, are merely symptomatic of the failure of our present health care system to adequately organize the technology and resources of medical care for service to the individual and the community. For the chronically ill and aged the situation is much worse since the services they require are poorly conceived of and poorly provided for within the structure of our traditional acute health care model. Medicare and Medicaid, as they are presently being administered, place every conceivable obstacle in the way of the older adult receiving preventive, supportive, or rehabilitative health services. They promote utilization of the most costly and often inappropriate modes of care, fragment an already critically disjointed health delivery system, and increase the older person's insecurity, as well as that of the provider of care, by arbitrarily defining covered benefits and ignoring pressing health care needs that refuse to conform to neat definitions of insurance programs.

Despite increased public support for health services there is mounting evidence that the chronically ill and aged are falling behind in their ability to garner vital and necessary social-health services. We have affirmed the right of the elderly to resources of science and society through a series of legislative acts and public pronouncements, but our ability to deliver on this pledge has been pitifully inadequate. We have created a credibility gap that desperately needs bridging. New forms and not merely reforms are required if we are to bring out health care technology close to its scientific and humane potential.

Expanding health care purchasing power without insuring a resonsible coordinated and comprehensive health care system has compounded the health problems of many Americans, and no where more clearly than with the aged. Services generally associated with long-term care are in short supply, low in quality, or non-existent. The result is, more often than not, the wrong care, in the wrong place, at the wrong time. The long-term care field faces an almost perpetual crisis marked by manpower shortages, escalating costs, tenuous relationships to the mainstream of acute health care, and poorly defined standards for judging quality care. Needless to say, this chaotic 'non-system' is reflected in the therapeutic and ethical climate of our long-term care facilities which, all too often, are not conducive to maintaining more than a semblance of human dignity and hope. The Governor of the State of Illinois recently referred to our assortment of health programs as a "complicated mess, poorly delivered and poorly financed." If one were to examine only the long-term care sector of our health system, these judgements would need to be even more harsh. Ill conceived legislation, poorly enforced standards, and negative incentives are keeping too many elderly in hospitals while forcing others into "intermediate" care facilities of dubious quality.

The deficits the chronically ill elderly face are not merely those connected with a disease process. They are also defined by a person's social situation, the adequacy of his financial resources and the quality and availability of community supports. There is a growing awareness that long-term care for the chronically ill and disabled adult requires the additional perspective of the so-

cial components of care and that these transcend traditional medical services. Because the chronically ill person is, typically, forced to live within limitations which affect many or all of his activities, long-term care becomes, perforce, care of the whole person. The degree and duration of chronic disabilities force attention to the living arrangements and psycho-social consequences of illness in ways which the problems of acute illness often do not.

The entry and distribution of consumer populations in health institutions and in particular long-term care facilities has been the subject of increasing interest and scrutiny by health professionals. The recognition that laissez faire doctrine has to a large extent governed the development of the nursing home industry has led to the acknowledgement by officials and practitioners of the need for a more orderly process than has heretofore existed.

The long-term facility phenomenon, its special characteristics and pattern of use, has given impetus to a search for measuring instruments, standards of performance and other professionally directed formulations which are congruent and meaningful to this field. The ideological borrowings from what was regarded as the parent field, the hospital system, have been increasingly scrutinized as to their applicability. There has been mounting evidence that the pragmatic use of the hospital fields doctrines has distorted and diverted the planning goals and process for the long-term care facility field. It would therefore seem appropriate to focus attention on the planning formulations which will promote definition and identity of the long-term field, provide models for a facility network which is consistent with the needs of its users and whose growth can be plotted over a period of time with reasonable accuracy.

As our knowledge of long-term care facility use has grown, new insights have begun to emerge which have added to our conviction that the determinants for estimating the location, size, and utilization of such facilities could be identified and ultimately expressed in statistical terms. These understandings can be summarized as follows:

1. Long-term care facilities are social-health institutions which are the resources for a segment of the population affected by serious social dislocations resulting from long-term illness or disability.

2. The consumers of long-term care facilities are increasingly older, female, widowed, economically dependent and affected by multiple physical and psychological disorders.

3. Intellectually impaired persons of advanced years constitute a growing proportion of the institutionalized population.

4. For the main part, placement in a long-term facility is contemplated as a terminal living arrangement.

5. Service areas among long-term facilities vary widely depending on such factors as eligibility criteria, special characteristics such as cultural or ethnic orientation, availability of specialized servces, reputation and cost of care.

6. Entry into the long-term care system is usually not governed by professional decision making. Selection is generally a negotiated arrangement in which the needs of the patient are considered almost entirely in economic terms. (The exception to the above is the "extended care" case which, in Illinois, represents as a category less than 7% of the long-term patient population and which requires the act of participation of the patient's physician in the referral process.)

7. Users of long-term care facilities are increasingly indigent or medically indigent persons.

8. There is no systematically developed pre-payment program for the great majority of long-term care users.

9. Length of stay, duration of stay and turnover rate patterns are calculable and subject to statistical analysis. These data can be correlated with actuarial analysis of the mortality experience of analogous populations in community living.

It will be impossible to evaluate, let alone measure, progress of any kind, however, unless we are ready to make explicit a set of objectives, that is, unless we know where we want to go. This implies a reasoned answer to the question of why we want to get there. Only then can we begin to develop and apply more telling gauges to determine whether we are in fact getting near our goals. Our goals have, in the past, been exceedingly simple, essentially cus-

todial. Perhaps modest expectations provide some hedge against immodest expenditures. To a large extent our reluctance to expect more reflects a moral confusion over the feasibility of establishing worthwhile goals for individuals no longer deemed capable of adding to the productive wealth of our nation and our economy.

I would like to suggest some objectives for a program of long-term care. These are not meant to be exhaustive and they surely warrant an extended public dialogue, careful testing and an ordering that would establish working priorities:

1. Access to a coordinated system of comprehensive social-health care of high quality as a right, with safeguards for the financial stability of family groups;

2. A maximum range of services that are uniformly available and acceptable and that do not make unusual demands on the part of the people to be served—mobile services rather than mobile people;

3. A rational and national funding arrangement related to explicit program goals and patient care plans. All too often the source of funding determines the quality and type of care a person will receive;

4. A unified system that covers all citizens. When all social and economic groups are included in a program, consumer demand tends to be more visible and effective;

5. A centralized responsibility for planning, mobilizing, delivering, and monitoring resources, with and in behalf of the users of such care;

6. Minimization of fiscal or physical barriers that cause delay in early diagnosis and treatment. Such hurdles are self-defeating, since more intensive care, at greater cost, will be required over longer periods of time. The financing scheme must support, not hinder, the potential use of services, if quality of care and cost controls are to be maximized;

7. Safeguards for the quality of life or "life style" of the elderly through cooperative decision-making and personal involvement in a plan of care—the blending of need, a professional determination, and demand, the older persons definition for desired care;

8. The development of specific goals and procedures that operationally define: who is to be served? under what conditions? in what locations? with what resources? and ultimately to what end? That is, to bring into being a system with respect to long term care that moves from broad social values to operational objectives, to criteria and standards for judging movement or change. To move from pronouncements to tested applications of controlled services and appropriate short range objectives;

9. A continuum of health services with effective linkages between prevention, acute care, rehabilitation and maintenance services; between institutional programs, hospital, home health, specialized housing, and social services; and finally,

10. The utilization of manpower and facilities in behalf of human need and the return of tested knowledge to this resource pool through programs of education, training and research.

We have in the past expected all this to happen automatically. The fate of 20,000,000 older Americans can no longer be left to chance, the vagaries of benevolence and private charity, or the mysterious hand of the market place.

Some experimentation with designing a comprehensive system of long-term care, centrally coordinated, administered and financed, is already underway. Here, in Chicago, the Jewish Federation has announced its intention, through the establishment of a Gerontological Council, for just such a program.

It projects a comprehensive and flexible program of care for the elderly that will employ existing facilities and agencies, as well as developing new components of service wherever needed. Eight broad program elements are being considered: Diagnostic and Evaluation services; multi-functional out-patient programs; in-patient short term care; long-term custodial care; a community health task force; area transport services; a variety of different housing arrangements; and provisions for research, education and training. I understand that a copy of the proposed plan has been made available to the Committee.

Important values about human beings are being expressed through such a proposal and certain assumptions are being made about the relevancy of specific services to effect an improvement in the quality of life for chronically ill

older adults. Such efforts offer a magnificent opportunity for government and the public to support such demonstrations and research efforts. What is the impact of various program mixes on different client populations? What type of incentives can be developed for both users and providers to maximize projected patterns of utilization? What type of outcomes are being proposed and how fully can they be achieved? At what cost? The questions that need to be posed and answered are directly related to the development of social policies that will guide legislation in this important area of human services. It is imperative that we move from our current position of dealing with the problems of the aged on a crisis by crisis basis to a position of leadership in developing long range programs oriented to providing the best possible care and service to the older citizens of our country.

The provision of a more rational and coherent system of long-term care can best be achieved through the application of appropriate incentives, new patterns of organization, and powerful political and emotional appeals. A shift in our sense of national purpose can produce important shifts in our readiness to allocate resources and upgrade priorities.

The strategy of tying long-term care objectives to cost-benefit measures is one which merits consideration. The large expenditures necessary to provide health care in the long-term care field may be compared for purposes of measurement, to a reduction in dependency, or social stabilization, and these may provide savings of public expenditures in other forms of public outlay. It may be possible to devise, therefore, a formula that transfers savings in one area to providers of medical care. Self-contained comprehensive social-health organizations can, perhaps by a capitation system, derive sufficient return by maximizing services that stress self-care and independent living objectives and reduce utilization of high cost, special institutional, services. Outcome, specified in advance and related to a reasonable functional prognosis and tied to financial incentives, may help break the cycle we are currently in, whereby sickness and disability are rewarded and client improvement is punished.

Nationally we appear to be moving toward a significant revision of our health care system in order to better control the quantity, quality and cost of these services. Group practice arrangements with some form of pre-paid capitation mechanism as a method of financing care, delivery through a corporate or community sponsored health maintenance organization offering access to comprehensive services over which control can be maintained, and expanded opportunities for consumer participation on both matters of quality and cost—all indicate the general direction this planning effort must take. There is much hope generated by these events. To date, however, the unique problems of the chronically ill have been conspicuously absent from these plans. Every proposal for National Health Insurance now pending before Congress assumes that problems of chronic illness and disability have been adequately taken care of by Medicare. These proposals offer an unpromising medium for achieving the type of social health policy suggested here. The tragedy of limiting our view with respect to long-term care is that we can indeed do much better than current practice would indicate. We know enough now to begin to design and support a rational social-health care system for the aged. Our failure to do so will only force unnecessary strains on acute care services by eliciting a redefinition of illness that accommodates itself to funding for covered services.

It would be helpful, rather, to explore the possibility of applying the HMO concept to the long-term care field. Can new methods for organizing and delivering care be structured in such a way as to reward providers for keeping people healthy by fixing financial incentives in favor of prevention and early detection of disease as against costlier forms of episodic care and hospitalization?

Ideally, a social health policy should be predicated on *what* we are trying to achieve and not on *how* to achieve it. In other words, our concern must be with outcomes, performance or output, and how the system of care can be shaped to produce these results. 'How' to achieve these goals, then, can be subjected to an ongoing review and analysis that measures the differential impact of different mixes of services.

If we assume that our primary objective is to maintain or support the individual's capacity for continued self-care and to reduce the rate of physical, mental and social deterioration, within an optimum independent living arrangement, then it would be necessary to establish individual baselines for

judging human potential for change. A cost-effectiveness policy in long-term care will need to put these gains in the context of savings or changes in utilization of a wide variety of social-health services, housing, etc.

As adequate as individual institutions may be, and many can be singled out for commendation, the very nature of their form of service and their inability to control, mobilize and administer a wide range of community based as well as in-patient services, severely limits their capacity to independently establish a comprehensive program in behalf of the chronically ill aged.

It would be naive to think that the health system needs of the chronically ill will provide the motivating 'wag' for changes in our present health system. The traditional acute care model is still the main arena of public debate where the dominant actors are located. Long-term care must, however, become part of the picture of any serious effort to develop a comprehensive health service, and therein lies its hope and claim for inclusion.

Moreover, social health planners should remain custodians of the whole view, the utopian tradition—a restless concern for the intangible attributes of the 'good' life (too easily sidetracked by having to achieve short-term, partial solutions). Visions of betterment can become epidemic in communities, raising civic aspiration and forcing solutions in long-term frameworks that they help establish.

Mr. ORIOL. Do you have anything else?

Mr. HALAMANDARIS. One quick question, for you, Dr. Hammerman.

Are you familiar with the point system as it functions in Connecticut?

Dr. HAMMERMAN. No, I am not.

Mr. HALAMANDARIS. All right.

Dr. HAMMERMAN. I am sorry.

Mr. ORIOL. That is a point system that works very differently from the system here and it makes it interesting.

Dr. SNOKE. It is an evaluation of the nursing home and so on.

Mr. HALAMANDARIS. Right.

Dr. SNOKE. I am from Connecticut and I sent my staff out at times to get them to do this, to evaluate this.

May I suggest that you not just talk to the State Department of Health people who think it is wonderful, but talk with some of the individuals who go into the homes and you will find that it ain't quite as beautiful or as perfect as the advocates say, because like ours isn't as perfect as some of our advocates say.

Mr. ORIOL. Anything further?

Mr. HALAMANDARIS. Would you want to amplify that for me just a little bit?

Dr. SNOKE. I can—well, I can refer you to Mr. Herbert Parrish who is the director of ambulatory services, Yale-New Haven Hospital.

He was the fellow that I used to evaluate nursing homes when I was director of Yale-New Haven and I am not sure if he is the assistant director up there but also contact at Waterbury, James Malloy. They were the two that reviewed this and their point was that you could build up quite a high point system with all kinds of things like teaching arithmetic, dancing, and things of that sort.

Mr. ORIOL. Once again, I would like to thank the witnesses and let the record show that we have about 20 long-term listeners in the audience today who lasted this long and, thank you very much.

(Whereupon, at 3:30 p.m., the subcommittee recessed, to reconvene at the call of the Chair.)

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESS

ITEM 1. IMPACT ON THE COMMUNITY OF THE ACCELERATED DISCHARGE PROGRAM OF ELDERLY PATIENTS FROM ILLINOIS STATE MENTAL HOSPITALS; REPORT—DIVISION FOR SENIOR CITIZENS, ROBERT J. AHRENS, DIRECTOR, DEPARTMENT OF HUMAN RESOURCES, CHICAGO, ILL.

I. INTRODUCTION

For the past two or three years, a number of Chicago neighborhoods, particularly the Uptown community area, have voiced growing concern about the large number of elderly mental patients being discharged to the community from state mental health institutions. For neighborhoods called upon to absorb and plan for massive concentrations of such older persons, this concern relates to a complexity of problems, i.e.

1. Lack of sufficient and/or appropriate institutions to meet both chronic health and mental health needs,
2. Lack of comprehensive supportive and follow-up services,
3. Lack of trained personnel experienced in serving such persons in general community agencies,
4. Lack of sufficient resources to pay for the proper care of retired, dependent or mentally disturbed persons,
5. Lack of adequate comprehensive planning to meet the multiple needs of such persons and, above all,
6. Lack of delineation of responsibility for resolution of various aspects of the problem among the multiple community components involved.

In the face of such built-in problems, new state legislation, (House Bills) 992–995[1]) supported by the Illinois Association for Mental Health, Inc. and signed into law by Governor Ogilvie on September 12, 1969, authorizes the discharge of all elderly patients now in state mental hospitals who have been receiving custodial care exclusively.

Estimates by the Illinois Department of Mental Health indicate that 7,000 to 10,000 elderly patients would be returned to the community by mid-1971 under the new legislation.

Granting the humanity and logic of a state policy which prohibits the use of its mental institutions as "dumping grounds" for older persons for lack of appropriate alternative resources, the fact remains that:

1. The continued lack of such community resources and the complex problems it has created have not been legislated out of existence,

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[1] Synopses of House Bills 992–995.

992. "(Ch. 91½ par. 1–11) Amends Mental Health Code. Revises definition of person in need of mental treatment to exclude a person of advanced years who does not show characteristics of mental illness."

993. "(Ch. 91½, new par. 10–2.01) Adds to Mental Health Code. Requires review of condition of mental patients age 60 or older committed before July 1, 1964, as to his legal competence and as to the possibility of adequate care outside the hospital."

994. "(Ch. 91½, new 3–7) Adds to Mental Health Code. Requires persons age 60 or older to be examined before being admitted to mental hospitals to determine whether they may be given adequate treatment in their home community."

995. "(Ch. 91½, par. 100–15) Amends Act codifying powers and duties of Department of Mental Health. Requires persons placed by Department in outside facilities be visited at least quarterly and that consideration be given social, recreational and other aspects of the person's environment."

2. Under the new state plan formulated in House Bills 992–995, the Illinois Department of Mental Health will effectively relinquish responsibility for 7,000 to 10,000 senile persons or older persons in need of protective services except where limited out patient care is prearranged to communities,

3. The receiving communities will need in the future to serve not only the assorted mental health needs of these 7,000 to 10,000 older persons but must plan for their physical health, housing and other human needs as well.

Whether or not we agree with Governor Ogilvie's statement that the House Bills 992–995 package "ranks among the most humanitarian acts . . ." the predictable resultant demands of the legislation will most assuredly test the humanity and capabilities of the Chicago service systems.

II. RELATED ASPECTS OF MENTAL HEALTH CARE IN ILLINOIS

The last decade has witnessed numerous changes in the provision of mental health care both nationally and in the State of Illinois, especially in relation to rehabilitation and social services, drug therapy, education of brain damaged persons, comprehensive planning of health and social services, and programming through the National Institutes of Mental Health.

State of Illinois priorities for mental health care reflect in part the national emphasis on rehabilitation of institutionalized persons. The Illinois Department of Mental Health as a result provides not only treatment for mentally ill persons but also undertakes to provide supportive services for post-hospitalized mental patients at the community level, thus facilitating their return to or maintenance in such communities.

When this service system was first established in Illinois it was estimated that more than half of the residents of state mental hospitals could be properly and better cared for in nursing homes, half-way houses and other less intensive care settings or could live independently given the necessary supportive services. They key to success in implementing such a plan is accessible, sustained supportive service after release of the patient to the community.[2]

For the past three years, a program has been in effect to remove from state mental hospitals, all persons who were not considered medically in need of protective institutionalization.

Unfortunately, while large numbers of persons have been discharged from hospitals to community agencies and to independent living under this program, the planned state-wide follow-up care program has lagged critically. Limited out-patient services have been developed but are offered selectively only. Released patients between the ages of 16 and 45 appear to be the primary target for this selective follow-up care.

Follow up care typically functions as follows.

Telephone contact is instituted by state mental hospital staff after discharge to ascertain how the released patient fares in a residential hotel, half-way house or similar setting. Even telephone follow-up is rarely done on patients released to professionally staffed institutions such as nursing homes or homes for the aged. No routine follow-up is done on individuals who are refused admission to the institution and referred elsewhere for service.

In practice, mental hospitals have attempted to control intake and at the same time to reduce case loads by referring the physically ill older patients to nursing homes and homes for the aged. Statistics verify the fact that the largest percentage of patients discharged from mental hospitals during the period of 1967–1969 was admitted to nursing homes. The character of the discharged population will change however since by now most physically ill elderly patients in need of nursing care have already been released. In fact, most discharges are now being made to residential hotels, half-way houses, sheltered care homes and a few to independent living. Review of available reports and discussion with state personnel produce the unofficial estimates that about one third of the current elderly discharges are entering nursing homes while about two-thirds (more than 60%) are going to half-way houses, residential hotels

[2] In 1968, the Illinois Association for Mental Health, Inc. adopted its policy statement calling for removal of geriatric (as opposed to mental illness) care from the Illinois Department of Mental Health's jurisdiction. This same policy statement however specified that such action should simultaneously provide for an alternative system of care for aged patients and prevent future "dumping" of the elderly in state hospitals. House Bills 992—995 reflect some aspects of the policy statement of IAMH.

and sheltered care homes. A very small number of patients are released to independent living or to live with their families.

The number of elderly persons leaving state mental hospitals annually in 1967, 1968 and 1969 did not vary substantially. About 250 long-term elderly patients from the Chicago area were discharged each year. About 1,000 additional shorter-term elderly patients were both admitted and discharged within a given 12 months period. Expectations are that both numbers will at least triple during 1970. As the discharge plan progresses through 1970 and 1971 however, expectations are that while the number of discharges for long-term patients will remain about the same (or 750 each year) the number of discharges for short-term patients (initially about 3,000 a year) must gradually diminish over a two year period. Short-term hospital case loads must gradually diminish over the two year period as initial admission is refused to elderly persons who will no longer be eligible for service under the House Bill 992 definition of mental illness which excludes senility. Such persons will be referred elsewhere for care. There are no estimates available on the size of this elderly group.

Finally, certain problems of the elderly mental hospital population have special implications for the planning and operation of alternative community services.

1. A number of long-term patients have literally grown old in the institutions. These individuals confined for years in a highly structured and protective environment face not only the drastic readjustment to new placement but adjustment to aging as well.

2. Since the discharge plan has been effective for some time, it is only logical to assume that those patients for whom appropriate resources existed or whose prognosis promised success in readjustment to the community would be discharged first. It follows that the patients to be discharged in the future must exhibit problems and needs which will be progressively more difficult to meet.

III. EXISTING COMMUNITY RESOURCES AND RELATED PROBLEMS

A. Protective settings

Since "only a very few" elderly patients have been or are being released to independent living, the balance (or about 85–90% of 7,000 to 10,000 persons) continues to be discharged to a variety of settings which offer a modicum of protection and/or health services, i.e. nursing homes, sheltered care homes, etc. It is necessary to inventory and examine the Chicago area resources which will bear the brunt of the Illinois Department of Mental Health's retrenchment from this field of service.

Based on the *Directory of Health Care Facilities and Approved Schools of Nursing* (1968) and the Chicago Board of Health *List of Approved Chicago Facilities* (1969), it is possible to identify the following *licensed* facilities and beds: 219 Nursing Homes with, 14,133 beds; 61 Homes for the Aged with, 8,016 beds; 23 Sheltered Care Homes with, 1,243 beds.

The distribution of these facilities between the city and the suburbs appears in the table below.

	Number of nursing homes	Number of beds	Number of homes for aged	Number of beds	Number of sheltered care homes	Number of beds
City	105	7,122	25	3,421	7	855
Suburbs	114	7,011	36	4,595	16	388
Total[3]	219	14,133	61	8,016	23	1,243

[3] For a listing of the suburbs included in this tally refer to the Board of Health Directory.

All these facilities are known to operate at near capacity. A study conducted by the Hospital Planning Council of Metropolitan Chicago,[4] citing the 1969 edition of the Illinois State Survey and Plan, reports on the number as well as

[4] Utilization and Status of Nursing Homes and Nursing Care Units in Homes for the Aged in the Chicago Metropolitan Area for Calendar Years January 1, 1966—December 31, 1969. Report No. 11, September 1969.

on the utilization and conformance of nursing care facilities. According to this statement there are in the Chicago metropolitan area (which in this instance excludes Lake County, Indiana) the following facilities and beds: 247 nursing homes with 16,289 beds, (105 homes with 6,821 beds in the city and 142 homes with 9,468 beds in the suburbs); a similar count of nursing care units in homes for the aged shows a total of 53 facilities with 2,231 nursing care units, (20 homes in the city with 906 beds and 33 homes with 1,325 beds in the suburbs.)

For information purposes the study notes an additional 2,488 beds at Oak Forest Hospital which cannot for a variety of reasons be included in the study design.

Applying the Hill Burton[5] conformance criteria for 1967 the study reports that in the metropolitan area 57.8% of the beds of all nursing homes cited earlier are rated nonconforming correctable while 22.7% are rated both nonconforming and noncorrectable. For the City of Chicago, 51% of the beds are rated nonconforming correctable and 32% are rated nonconforming and noncorrectable. In the suburban area 62.5% of beds are rated nonconforming correctable and 16% are rated both nonconforming and noncorrectable. Some detailed tables from this study constitute Appendix C attached to this statement.

The number of sheltered care homes licensed in the Chicago area totals 23 with 1,243 beds. This small number represents a severe service gap in the community not only for released mental patients but for many persons with other needs as well. Usually older persons in need of such services are referred either to lessor car facilities (e.g. retirement hotels) or to more intensive care settings neither of which are really apprapriate to the need. Furthermore such placements further reduce the availability of these settings for the elderly who should be making use of them.

B. Supportive services

Even assuming ideal or systematic follow-up care by the Illinois Department of Mental Health, specialized community services not readily available at this time, will be required by a large number of older persons, i.e.

1. the elderly returned to independent living who will need to be reinvolved in the community and its maze of health, recreational, and other services,
2. the elderly refused admission to state mental institutions who will need appropriate alternative services, including counseling in the identification of what such resources might be or assistance in the proper use of these services,
3. the elderly for whom institutionalization is not acceptable under the new legislation but for whom insufficient or inappropriate alternative resources force an inappropriate placement,
4. the elderly released to sheltered settings who nevertheless must function to some extent in the community at large.

By and large, there are very few community services prepared to respond to the demand for service which this group of older persons will occasion.

It is of special interest that placements for discharged mental hospital patients seem to relate primarily to the physical condition of the elderly person. Outposts developed by the Illinois Department of Mental Health have no significant caseload of elderly in their outpatient services. City of Chicago mental health centers are concerned chiefly with providing support to prevent breakdown and serve a negligible number of persons with a history of institutionalization.

There is a scarcity of psychiatric resources in the nursing homes and other long-term care facilities which accept former mental patients in large numbers.

A number of private agencies, principally United Charities, Catholic Charities, Lutheran Welfare Service, Salvation Army and Jewish Family Services, do offer case-work, counseling and other services to the elderly, including some protective services, the unavoidable adjunct of serving this type of client. The Welfare Council of Metropolitan Chicago has recently received a grant from the U.S. Department of Public Health and, in cooperation with the above-men-

[5] 1967 Amendments, Public Law 90-174, "An Act to amend the Public Service Act to extend and expand the authorizations for grants for comprehensive health planning and services, to broaden and improve the authorization for research and demonstrations relating to the delivery of health services, to improve the performance of clinical laboratories, and to authorize cooperative activities between the Public Health Service hospitals and community facilities, and for other purposes."

tioned and other agencies, is developing a research and demonstration Protective Services Project in a limited area of the Uptown community. Agency experience indicates that such caseloads are both extremely time consuming and often hampered by the lack of critical services. It is not known how many additional clients these agencies might serve. Indications are that due to the scarcity of trained personnel generally and low priorities on funding aging programs in both public and private agencies, most of the existing agencies probably already have capacity caseloads.

One or two efforts have been made to coordinate group programs for the well elderly with programs geared to the rehabilitation and return of emotionally disturbed elderly persons to the community. Both Jewish Community Centers and Senior Centers of Metropolitan Chicago, for example, have attempted to provide this service. The well elderly however have resisted association with disturbed or handicapped persons in these settings in spite of careful staff planning and preparation. In both instances the programs had to be abandoned. Whether new approaches to the problem would prove more successful or whether specialized centers need to be established remains to be determined. For all practical purposes, group services are not available at this time to large numbers of disturbed elderly persons.

With respect to the individual and specialized services which may be particularly critical to withdrawn, anxious, or confused elderly patients, the picture is scarcely more promising. There is a great scarcity of home services. Homemaker service is virtually unobtainable. Home delivered meals and congregate eating are available on a minimum scale, i.e. either on a limited demonstration basis or because an agency has accepted responsibility for serving a small group or area. All the assistance services, e.g. escort and transportation, friendly visiting, out-reach and follow-up, are fragmented and more often than not left up to the occasional agency, church or organization which for a variety of reasons may choose to respond to the need. Agency experience with the well elderly demonstrates daily how complex a process is involved before an older person can be located, needs identified and matched to resources, service delivered and a problem resolved. How much less likely therefore that an emotionally debilitated older person should succeed in finding the way through the service maze unassisted'

Finally, the elderly released patients must per force suffer the same deprivations as the well elderly of the community with respect to housing, health services, income, and opportunities for meaningful roles, all of which are known to be inadequate, fragmented and uncoordinated.

IV. RELATED COST AND INCOME FACTORS

A. General problems

Persons able to pay well for private care by and large do not encounter great difficulties in finding safe and adequate placement whether in nursing homes, long-term care facilities, or whatever, although not always in the location or with the services they might like. Most of the elderly to be discharged in 1970 according to the Illinois Department of Mental Health hospitals' projections however will be public assistance recipients. Persons with low income are least likely to secure protective or long-term care beds which meet minimum standards.

Increasingly, developers of nursing homes, retirement villages, homes for the aged, etc. come from the proprietary sector. Cost in these facilities is usually higher than in those operated by non-profit organizations. Unlike non-profit operations which frequently accept a percentage of patients on old age assistance (even if only partial reimbursement for care results) or of non-paying patients, proprietary facilities tend to give priority to the paying over the non-paying customer and to the customer able to meet full cost of care over the public welfare recipient.

B. Public assistance as a source of support

Deterrents to the acceptability of public aid recipients to proprietary and some non-profit facilities alike are various statutory regulations and the payment scale of the Illinois Department of Public Aid.

All public assistance clients placed in nursing homes must be evaluated periodically by a medical team independent of the home to determine if the level

of care and therefore the cost of care in the home is warranted. Any patient whose physical needs do not require the level of care offered may be moved to a lesser care facility, a sheltered care home, a home for the aged or may be returned to independent living. This review process is structured to insure that payment, which is adjusted to the level of care, does not exceed the client's needs. Thus a home for the aged housing a public aid recipient is reimbursed at a lower rate than a nursing home, a nursing home at a lower rate than a hospital, etc.

The fact that public aid recipients occupying nursing home beds must be audited by health teams from outside the facility is itself likely to reduce the availability of beds to public assistance patients unless there is early resolution of the following questions: 1) who has the responsibility of transferring patients from one type of bed to another and 2) does payment decrease when need does or only after the placement change is made? In the implementation of the Illinois Department of Mental Health discharge plan, the Illinois Department of Public Aid will probably be given the responsibility for making such transfers. The problems within the Illinois Department of Public Aid, including under-staffing and inability to handle casework on a timely basis, promise numerous complications for the homes involved.

Generally, administrators of nursing and protective facilities complain that public assistance payments are inadequate to meet their costs and that therefore they must give low priority to such placements or, if they accept them, must operate facilities *below standard.* Both situations are commonplace.[6]

Public assistance payments rarely are the equivalent of full fees. Quality homes on which demands are made by middle and upper income patients give priority to these full paying clients. There is a scarcity of above standard beds within the cost range of public assistance payments.

Mrs. Margaret Kline of the Welfare Council of Metropolitan Chicago's Information Center for the Aging feels that, even in sheltered care situations, a payment of $200 a month would be the minimum payment needed by proprietors to operate the simplest but safe facility. If standards above minimum are desirable, costs must rise proportionately with improvements. It is impossible to provide appropriate nursing, social, recreational, residence and food services at this $200 rate in Chicago.

The range of rates in nursing and other homes is so great that it is not possible to determine from available data what the average cost for certain levels or standards of care would be. Studies of charges in nursing homes, without developing their relationships to variations in services, are misleading and cannot be used as a basis for suggesting realistic payment levels for public aid.

C. Medicare as a source of support

Provisions of the Medicare program designed to pay for extended care have raised unwarranted expectations for the coverage of long-term needs of older people. The average length of extended care stay covered by Medicare has in fact been decreased in the course of the eighteen month period prior to August, 1969. In the State of Illinois, this decrease has been from an average of 90 days plus to less than 35 days.

Of particular importance is the fact that Medicare pays for the maintenance of patients in extended care beds so long as skilled nursing care is required. It will not, however, maintain clients on a custodial basis if the client's needs can be met in another setting, *whether or not the patient is transferred to a lesser care setting.*

As most workers in aging learned shortly after passage of the Medicare legislation, providing coverage for certain services (particularly home delivered services) tends to create or increase demand but does not insure the existence or the mechanism for the development of such services.

Finally, related to Medicare coverage also, is the fact that in the Chicago area, extended care beds certified under Medicare are not spread evenly throughout the community. Some community areas have a larger quantity of such beds than are needed for the number of referrals while other community areas have none or experience serious shortages. Of the 60 homes for the aged in Cook County, only eight are certified for extended care under Medicare with beds totaling 590.

[6] At the time of passage of House Bills 992—995, the state legislature failed to pass a proposed bill to increase public assistance payments above the current scale.

V. CONCLUSION

1. Existing licensed nursing homes, sheltered care and related facilities and services for the elderly are already operating at near capacity or are inadequate to meet current demands.
2. Enforcement of 1970 licensing standards[7] for nursing homes and similar facilities will deplete these resources even further.
3. With the release of additional thousands of elderly persons from state mental institutions, the demand for these community facilities and services will increase drastically.
4. Neither Chicago's communities nor its service systems are prepared to absorb immediate implementation of the Illinois Department of Mental Health release program.
5. Unless there is time to build and correct facilities, to develop services, and to coordinate the release program with these community resources, elderly patients must suffer injury from improper placement, inadequate or nonexistent support, and disruption of the receiving communities and all that such disruption implies.
6. Medicare coverage, critical though it may be, represents partial and temporary insurance only and has raised unwarranted expectations as to the availability of a number of services.
7. The schedule of fees for reimbursement for care in protective facilities authorized by the Illinois Department of Public Aid has seriously hampered the appropriate placement of elderly persons, limited the quality of care they can obtain, and more often than not placed them in competition for such care with more affluent groups.

Numerous questions need to be raised and answered before the problems can be resolved. Some of these have been raised with the Illinois Department of Mental Health by the Division for Senior Citizens.[8] The problems we face were not created solely by the recent legislation, but by compounded social ills which have accumulated over many decades. Whether meaningful answers to the many questions about appropriate care for our senior citizens will be forthcoming remains at serious issue.

Exhibit 1

GUIDELINES FOR USE OF FORM 184

INTRODUCTION

Policy regarding the evaluation of need for care in licensed facilities has been revised to conform with the new minimum standards of the State Department of Public Health. Forms DPA 184 and DPA 484 have been combined into one evaluation form (Form DPA 184) which applies to skilled nursing homes, intermediate care facilities, and sheltered care homes, the three levels of licensure established by the minimum standards.

A *skilled nursing home* is a facility which provides skilled nursing and related care. The facility must have twenty-four hour nursing services directed by a qualified R.N., a charge nurse (R.N. or graduate L.P.N.) for each shift, and as much additional staff as required to meet needs of patients. An assistant director of nursing is required if the facility has 100 or more occupied beds. If a facility has 150 or more occupied beds a nursing supervisor is also required. Patients in these facilities no longer need the type of care and treatment required during the acute phase of illness but do require frequent medical supervision and continuous skilled nursing observations. A skilled nursing home may also qualify for medicare certification as an extended care facility.

An *intermediate care facility,* designated *Intermediate Care Facility I* (ICF-I) by the Department of Public Aid, provides basic nursing services under periodic medical supervision. The facility must have twenty-four hour nursing services with a director of nursing, additional licensed nursing staff according to the number of occupied beds, and as much additional staff as re-

[7] The most recent revision of standards for the Chicago metropolitan area applies to sheltered care homes only. Other revised standards, for nursing homes for example, are yet to be developed.
[8] Appendices A and B, retained in committee files.

quired to meet the needs of patients. Most of the patients have long term illnesses or disabilities which have reached a relatively stable plateau and require only simple nursing care. Other patients whose conditions are stabilized may need medical and nursing services to maintain stability.

An ICF-I under 50 beds is required to have a nursing director who is an R.N. or L.P.N. and, in addition, another R.N. or L.P.N.

An ICF-I between 50 and 75 beds is required to have an R.N. nursing director, and two additional R.N.'s or L.P.N.'s.

An ICF-I between 75 and 100 beds is required to have an R.N. nursing director and three additional R.N.'s or L.P.N.'s.

An ICF-I over 100 beds is required to have an R.N. nursing director, an R.N. assistant nursing director, and an R.N. or L.P.N. on all shifts.

A *sheltered care home* licensed by the Illinois Department of Public Health is designated as an *Intermediate Care Facility II (ICF-II)* by the Department of Public Aid. An ICF-II is a home in which residents are not in need of nursing care, but are in need of assistance, supervision, and/or oversight. An ICF-II is not required to have licensed nursing personnel. It may not provide nursing services (except injections) or oxygen service even though its staff includes licensed nursing personnel, although a resident who is able to administer oxygen to himself may do so.

Non-profit, proprietary and local governmental facilities are all subject to licensing if they provide care to more than two people not related to the licensee. A facility is issued a license designating the level(s) of services authorized and, if the facility has distinct parts, the number of beds authorized for each level.

The *base rate* allowed for each level of care includes those services (bathing, dressing, and personal grooming, and tray service) which are given to or supervised for all recipients as needed. This is based on the average of needs ranging from minimal to complete assistance with these hygienic activities. It is anticipated that, in providing these services, facility personnel will encourage recipients to increase their capacty for activities of daily living.

I. IDENTIFYING INFORMATION

Responsible relative or friend should be someone, preferably designated by the recipient, and readily accessible, who is knowledgeable about his personal affairs and who, because of his legal or personal relationship to the recipient, can make decisions about necessary arrangements concerning the recipient.

The recipient's *usual living arrangements*—such as own home, rented house, rented apartment, son's home, friend's or relative's home, room, long-term care in an institution—should be indicated, together with information concerning care presently available from persons with whom the home was shared.

II. MEDICAL INFORMATION

This section is to be completed on the basis of information provided by a physician, either directly or through his notations in the hospital or facility medical records. It is not to be completed on the basis of information provided by facility personnel.

Complete current diagnosis includes all conditions, chronic or recent, affecting the recipient. This information must be current. The diagnosis on a previous 184 should not be used unless the accuracy and completeness of the diagnosis is verified. Dates of onset are particularly important in relation to the conditions for which current care (nursing, medication, etc.) is needed. Items B thru F are essential for evaluation of the recipient's need for care and his rehabilitation potential, and should be completely answered with information obtained from the physician or his records, or, in the case of E and F, from Mental Health personnel.

III. PLAN FOR CARE

This section is to be completed after evaluation of the recipient's care needs has been made. Whenever feasible, and more conducive to the well-being and happiness of the recipient, it is preferable that care be provided in his usual living arrangements and/or with relatives. Consideration should be given to whether, with necessary community services such as home health services, arrangements of this kind can meet the recipient's care needs. If care can not be provided in a recipient's own home or the home of a relative indicate all areas of need by putting an X in the appropriate box(es).

IV. EVALUATION OF NEED FOR CARE

Points are given, in each area of service listed below, on the basis of the highest level of services required and received by a recipient during the month. If the reason an item of care is needed is not apparent from the diagnosis, the caseworker should make a marginal notation next to the item to indicate why the care is required.

1. Eating

0—No point is allowed when the recipient is able to eat independently.

1—One point is allowed when the recipient requires assistance in cutting food, buttering bread, placing utensils for blind recipient, etc.

2—Two points are allowed when the recipient requires and receives some individual assistance in eating from a staff member. The assistance may vary from complete feeding on some days to partial feeding on others. Also included here is the type of assistance which can be given by a staff member to more than one patient in the same room during the meal.

4—Four points are allowed when the recipient requires and receives complete individual attention by a staff member at all meals. The staff member remains in constant attendance at the patient's side throughout mealtime to hand feed the recipient or to insure adequate intake of food.

#8—Eight points are allowed when the recipient is unable to take food by mouth and tube feeding or gastrostomy feeding are given by licensed nurses on the physician's orders.

2. Mobility

0—No point is allowed when the recipient is independent in movement with or without assistive devices and no assistance is needed to enable him to move from place to place. This includes the recipient who is able to transfer himself to and from a wheelchair.

2—Two points are allowed when the recipient is able to move about but needs a staff member to assist him to get into a wheel chair, to begin walking with the walker, to walk beside him to give assistance, etc.

*3—Three points are allowed when the recipient is unable to move about under his own power. He must be moved by a staff member. This may consist of pushing the wheel chair or lifting the patient. This also includes the recipient who is able to move except that his size or other physical condition requires that more than one nursing staff member be at his side to give assistance in moving about.

3. Behavior or Mental Condition

0—No point is allowed for the recipient who is usually able to act in a manner that takes into account his needs and the needs of others and staff. He can be reasoned with and can adjust his behavior. On the whole, his behavior is consistently cooperative. He is aware of who he is and what is expected of him within the home. He does not require any special supervision.

3—Three points are allowed for the recipient who requires occasional supervision from a staff member. He presents problems such as periods of hyperactivity or confusion, occasional strong reactions to frustrations or disappointments, prolonger periods of silence, excessive pacing or sleeping, or inability or unwillingness to interact. During such "ups and downs" he requires temporary support and vigilance from the staff.

*8—Eight points are allowed for the recipient who requires special and continuous supervision by a licensed nurse. His tolerance is so low and unpredictable that a licensed nurse must be present in the facility at all times.

ALL SERVICES FROM THIS ITEM ON ARE TO BE GIVEN ONLY ON A PHYSICIAN'S WRITTEN ORDERS

4. Current Physical Rehabilitation Needs

Rehabilitation nursing consists of services ordered by a physician, such as range of motion exercises, positioning, transfer activities, gait training, parallel bars, pulleys and training of the aphasic. Bowel and bladder training programs are not included. The acute illnesses and injuries for which 6 or 10 points may be given include fractures of hip, pelvis and extremities; acute brain trauma (to include spinal cord injuries or neurological disorders, but not

to include congenital brain disorders); cerebral vascular accidents with resulting aphasia and/or hemiplegia; amputees requiring pre- and post-prosthetic care and training.

0—No point is allowed for the recipient who has no potential for rehabilitation.

*4—Four points are allowed for the recipient who needs and is receiving rehabilitation nursing services, performed or supervised by a licensed nurse, to maintain current level of function.

*6—Six points are allowed for the recipient who needs and is receiving rehabilitation nursing services performed or supervised by a licensed nurse, following selected acute illnesses or injuries, to improve his level of functioning, for a period from three to six months following discharge from a hospital or rehabilitation facility, *if the facility has an approved rehabilitation nursing program.*

*10—Ten points are allowed for a recipient who needs and is receiving intensive rehabilitation nursing services supervised by a licensed nurse following selected acute illnesses or injuries within a period of three months following discharge from a hospital or rehabilitation facility, *if the facility has an approved rehabilitation nursing program.*

5. Catheterization (including irrigations)

0—No point is allowed when the recipient does not require catheterization or irrigation.

*4—Four points are allowed when the recipient requires an occasional catheterization for a specimen or treatment, or an indwelling catheter for a short term physical condition.

*8—Eight points are allowed when the physician orders a retention catheter to be used continuously. This also includes full care of the catheter and irrigations.

When a retention catheter is used the patient shall not be considered to be requiring or receiving care because of bladder incontinence under item 6, even though in some instances the patient may be on a bowel and bladder training program for a short period while the catheter is used.

6. Incontinence (Bladder and Bowel)

0—No point is allowed when recipient has complete bladder and bowel control.

1—One point is allowed when recipient usually has control except on those infrequent occasions when he has an accident due to nervousness or visitors, or reaction to medications, such as cathartics.

2—Two points are allowed when recipient is neither continent nor incontinent; sometimes he has control; other times he has none.

4—Four points are allowed for a recipient who needs and is receiving servvices to maintain bowel and bladder control following a bowel and bladder training program.

*6—Six points are allowed when the recipient has no bladder and/or bowel control and he requires care for cleanliness or comfort. This includes the patient who dribbles constantly.

*8—Eight points are allowed when the recipient has in the past had no control but is now receiving training thru an active bowel and bladder program. The physician has ordered such a program and the nursing care plan for the patient includes this program (maximum length of time—initial period three months; if successful an additional three months; maximum total six months).

7. Douches, Enemas and/or Colostomy Irrigations

0—No point is allowed when recipient does not require douches, enemas or colostomy irrigations, or requires and receives such service at infrequent intervals for the treatment of a short-term condition.

*4—Four points are allowed when the recipient requires and receives a douche, enema and/or colostomy irrigation *on a regular basis but less than daily.*

*5—Five points are allowed when the recipient requires and receives a douche, enema and/or colostomy irrigation *at least daily.*

When enemas are required and given on a regular basis, the patient is not considered, under item 6, to have bowel incontinence.

8. Diet

0—No point is allowed when the diet ordered by the physician is the menu used for the majority of the patients in the facility, with or without minor modificatons, such as removal of salt or sugar on trays, substitution of salads or deserts, etc. This includes pureed and baby food, or a mechanical (ground) diet.

3—Three points are allowed when the diet ordered by the attending physician is a specific diet which must be prepared separately from the daily menu. This includes salt free, weighed or calculated caloric diets, and diets and tube feedings which require the purchase of special foods.

9. Medications (Oral, Drops, Ointments, Suppositories).

0—No point is allowed when medication is not prescribed, or the recipient's condition is such that the physician gives written permission for the resident to handle the medication himself.

1—One point is allowed for the recipient who requires and receives prescribed medication (oral, drops, ointments, suppositories) administered by staff on a less than daily basis.

3—Three points are allowed for the recipient who requires and receives prescribed medication (oral, drops, ointments, suppositories) administered by staff on a *regular daily basis.*

10. Injections (Hypodermic and Intramuscular)

0—No point is allowed when hypodermics or intramuscular injections have not been prescribed by the physician or when a recipient is permitted to self-administer a drug by hypodermic on the written order of the physician.

*2—Two points are allowed when hypodermics and/or intramuscular injections are administered on a less than daily basis by a licensed nurse.

*4—Four points are allowed when the recipient requires and receives a *daily* injection of medication by a licensed nurse *throughout the month.*

Points are allowed for these services in a sheltered care home when the home has licensed nursing personnel who administer the injections.

11. Intravenous and Subcutaneous Fluids

0—No point is allowed when the recipient does not require intravenous or subcutaneous fluids.

2—Two points are allowed when the recipient requires and receives intravenous and/or subcutaneous medication or fluids administered by the physician. (This allowance compensates the facility for supplies used).

#8—Eight points are allowed when intravenous or subcutaneous fluids are administered by a registered professional nurse upon the physician's order.

12. Suctioning

0—No point is allowed when the recipient does not require suctioning.

*3—Three points are allowed when a recipient has a condition, such as a tracheotomy, to which he has become adjusted to such a degree that he is able to care for it himself with minimum assistance by nursing staff for cleansing purposes.

*5—Five points are allowed when the recipient requires suctioning less than daily.

#8—Eight points are allowed when the recipient requires suctioning *daily throughout the month.*

13. Oxygen (Includes Positive Pressure)

0—No point is allowed when the recipient has no need for oxygen services.

*4—Four points are allowed when the recipient requires oxygen on an emergency basis or intermittently during the month. Also included is the recipient who is able to administer his own oxygen and/or positive pressure treatments with supervision and minimum assistance.

#8—Eight points are allowed when there is a current written order, and the recipient receives oxygen and/or positive pressure treatments on a daily basis, administered by nursing staff.

14. Dressings and Appliances

0—No point is allowed when the recipient requires no dressings or requires only an occasional small temporary dressing for minor cuts or abrasions.

*4—Four points are allowed when the recipient requires *daily* application of Ace bandages, additional care required because of a cast, and/or assistance with the application of appliances such as prostheses, braces and supports.

*6—Six points are allowed when the recipient requires dressings to a moderate sized area and/or moist dressings or soaks, on a *continuing* basis. Such services may be required for, but are not limited to: ducubitii; recurrent leg ulcers; and daily colostomy dressings.

#8—Eight points are allowed when there is a physician's written order for comprehensive dressings required on a regular daily basis, performed by R.N. or graduate L.P.N.

#*15. Put a check in the appropriate column if the recipient *requires nursing care 24 hours a day* for one of the following: stroke; fractured hip; acute brain trauma; quadriplegia; severe coronary; or major surgery (this care may be provided in an ICF-I if the facility is staffed and equipped to provide the necessary care), or if skilled nursing care was recommended as a result of a medical review conducted by the Illinois Department of Public Health.

When the point count has been completed enter the date, total point count, and indicate whether the recipient requires assistance with bathing, dressing or grooming by circling "yes or no". The caseworker should then assess the level of care needed by the recipient, and whether or not the facility under consideration has the kind and amount of personnel required to give the necessary care. For example, if the recipient requires asterisked services, other than injections, he may not receive care in a sheltered care home, since these are nursing services. If he needs nursing services around the clock, he should be placed in a facility which is appropriately staffed.

Skilled Care: If a recipient requires, on a continuing basis, one or more items marked (#) on the evaluation of need for care, the recipient is qualified for skilled nursing care. Items marked (#) and to be considered in determining whether skilled care is required are:

(1) Tube feeding or gastrostomy feeding, under item 1;
(3) Intravenous and subcutaneous fluids given by an R.N., under item 11;
(3) Daily suctioning, under item 12;
(4) Daily oxygen, under item 13;
(5) Comprehensive dressings needed regularly, under item 14;
(6) Twenty four hour nursing care under specified conditions, or skilled care recommended as a result of the medical review program, under item 15.

In addition, a recipient having a total point count of 25 points or more, on a continuing basis, qualifies for skilled care.

A recipient who requires an item of care marked (#) for a limited period of time, or who has a total point count of 25 points or more due to additional care required for a limited period of time, shall not be considered in need of skilled care. However, if it is reasonably anticipated that this level of care will continue to be required, the recipient will be considered to be qualified for skilled care.

Intermediate Care I: A recipient who does not require skilled care but who requires any services which are asterisked is considered to be in need of ICF-I care. The services described in item 15 can be provided in an ICF-I if the facility is staffed to provide these services. In such cases payment will be made at the ICF-I rate.

Intermediate Care II: A recipient who requires only services which are not asterisked is considered to be in need of ICF-II care unless the total point count is zero. If the point count is zero and the recipient requires assistance with bathing, dressing or grooming the recipient is still qualified for ICF-II care. However, if the total point count is zero and the recipient does not require assistance with bathing, dressing, or grooming, the recipient is not qualified for group care. He would qualify for room and board or a restaurant allowance only if box 4 or 5 Item III, A was checked, and then only if no other arrangements could be made to provide adequate meals.

The level of care needed by the recipient should be specified in the appropriate box on page 3: room and board, ICF-II, ICF-I or skilled nursing care. In borderline cases, consultation with the regional medical consultant is recommended.

SPECAL FACTORS SUPPORTING NEED FOR CARE

At the time of the original evaluation of the recipient's need for care the caseworker may note, in the first space on page four, supplementary information, in addition to that noted elsewhere on Form 184, which will support or clarify the need for care.

When complete or partial re-evaluation reveals significant changes in the patient's social situation, condition and abilities, or in the physician's recommendation affecting the need for specific services, this should be described on page four, in the space corresponding to the column in which the point count change is indicated. When a point count is changed, a new column on pages 2–3 must be entirely completed.

VI. RATE DETERMINATION

The monthly rate is determined from the Rate Schedule for Group Care Facilities, taking into account (1) the point count, (2) the level of payment (skilled ICF-I, or ICF-II) (3) shelter factor, (4) activity program (5) rehabilitation nursing and activity program and (6) mental and social rehabilitation program.

Each time an evaluation is completed, there should be a notation made as to the date of the next scheduled re-evaluation. A re-evaluation may be made without determination of eligibility for assistance also being made. For example, if the caseworker knows that certain current services will be needed for only two months, the next re-evaluation date should be based on that knowledge. All recipients requiring skilled care must be re-evaluated *monthly* to determine whether skilled care is still required.

Exhibit 2

ILLINOIS DEPARTMENT OF PUBLIC AID—NOTICE TO PROVIDERS OF GROUP CARE

Rate schedules for group care facilities have been revised, and the new rate schedules are effective for care provided July 1, 1970 and thereafter. County departments are to approve payment at your usual and customary charges to private pay residents up to the maximum allowance for each individual case as indicated on the attached schedules.

EXTENDED CARE FACILITIES

All beds currently certified as ECF beds will be considered to be skilled nursing care beds until a re-evaluation is made by the Illinois Department of Public Health and a license is issued under their revised standards effective June 1, 1970.

There is no change in the billing procedure for Extended Care Facilities.

SKILLED NURSING HOMES/INTERMEDIATE CARE FACILITIES—I

All beds currently licensed as nursing care beds and beds in infirmary sections of homes for the aged (except those certified as Extended Care Facilities) will be considered Intermediate Care Facility—I (ICF-I) beds until a re-evaluation is made by the Illinois Department of Public Health and a license is issued under their revised standards effective June 1, 1970.

All skilled nursing homes and ICF-I's (other than Extended Care Facilities) will bill the Department of Public Aid on the revised DPA 286, Group Care Statement, for services provided Public Aid recipients on or after July 1, 1970. The facility will complete a DPA 286 and will submit it to the County Department of Public Aid (Cook County, to Nursing Home Service) on the first working day of the month following the month of service.

INTERMEDIATE CARE FACILITIES—II (ICF-II)

All beds currently licensed as sheltered care beds in both sheltered care homes and sheltered care sections of homes for the aged will be considered as ICF-II beds by the Department of Public Aid. Under the revised licensing standards, the Illinois Department of Public Health will continue to license these beds as sheltered care beds.

ICF-II's will bill the Department of Public Aid on the revised DPA 286, Group Care Statement, for services provided Public Aid recipients on and after July 1, 1970. The facility will complete a DPA 286, Group Care Statement and will forward it to the County Department of Public Aid (Cook County, to Nursing Home Service) not later than the first working day of the month following the month of service.

The Sheltered Care allowance, at the rate in effect prior to July 1, 1970 will be included in the recipients' grants for July. The amount included in the July grant, for care provided during July, must be included in the credit column of the billing for July care on the DP 286.

The correct total net charge for care provided to Public Aid recipients will be paid directly to each facility beginning with care provided during the month of July, 1970. Payment for care will be made by the end of the month following the month the care was provided unless the submittal of the DPA 286 is delayed or the DPA 286 is submitted incorrectly. No payment for care in a licensed ICF-II will be included in the recipients' grants after July, 1970.

HOMES FOR THE AGED

Effective July 1, 1970, payment in homes for the aged will be authorized at the rate determined by the "point-system", at cost, or at the private pay rate —whichever of these three possibilities is the least.

COUNTY NURSING HOMES

County nursing homes will continue to bill at the rate negotiated with the Department. Rate adjustments are to be considered on the same basis as the foregoing policy governing Homes for the Aged when new rate negotiations are requested.

APPROVED PROGRAMS

The "shelter factor" allowance is increased, effective July 1, 1970, to $40 per patient per month in Intermediate Care Facilities—II and to $50 per patient per month in Intermediate Care Facilities—I and skilled nursing homes. The allowances for rehabilitation nursing and activity programs are unchanged.

An allowance for a mental and social rehabilitation program will be continued for homes which currently have an approved program. The county department (Cook County, Nursing Home Service) will advise approved homes individually of the amount of this allowance prior to the end of July, 1970.

MULTIPLE LEVELS OF CARE

If a facility is licensed and is providing more than one level of care for recipients, a separate DPA 286, Group Care Statement, must be completed for *each* level of care. If a facility licensed for a single level of care is providing care for recipients at a lower level than indicated by the license, a separate DPA 286 must be completed for each level of care being provided, regardless of the rate of payment.

OXYGEN/MEDICAL CAPITATION

Additional charges for recipients receiving oxygen and for recipients in homes for the aged which have an approved "medical capitation" will be included in the "total charge" column of the DPA 286. The amounts and types of these allowances are also to be entered in the "remarks" column.

ASSISTANCE FROM COUNTY DEPARTMENTS (COOK COUNTY, NURSING HOME SERVICE)

County departments will complete a revised DPA 184, Evaluation of Need for Group Care, for all recipients in licensed skilled nursing homes, ICF-I's and ICF-II's during the month of July. Prior to the end of July the county department will advise each facility of the point level, total charge, and credit for each Public Aid recipient in the facility. If other questions arise regarding the completion of the DPA 286, please contact your county department. Any incorrect DPA 286, Group Care Statement, submitted to the county department may delay payment.

INAPPROPRIATE PLACEMENTS

Re-evaluation of recipient's need for group care may indicate that some recipients no longer occupy beds licensed in accordance with their needs.

If a recipient needs a lower level of care than that available in the bed which he occupies and the facility is not willing to accept the lower rate of payment, the higher rate of payment will be approved provided that the facility has notified the recipient, his family, his personal physician, and the county department (Cook County, Nursing Home Service) that the recipient will have to make other arrangements for care (suggested letter attached). This notification must be made within seven days of the date the facility is notified that the recipient requires the lower level of care.

The Department of Public Aid cannot authorize payment for a level of care higher than a facility, or portion thereof, is licensed to provide.

DIRECT SUBMITTAL

Future plans for group care, possibly late this fall, include submittal of individual billing forms for each recipient directly to the Medical Payment Section in Springfield. Group care facilities will be advised of the effective date and billing procedures for direct submittal when procedures have been fully developed.

FORMS

Supplies of form DPA 286 (R-7-70), may be obtained from the local County Department of Public Aid. Use only forms DPA 286 with a revision date of July, 1970 (R-7-70) in billing for care provided during or after July 1, 1970.

EXHIBIT 3.—RATE SCHEDULE FOR SKILLED NURSING CARE PAYMENT; GROUP III

	Not qualified for "shelter factor" allowance			Qualified for "shelter factor" allowance		
Point count	Regular rate	Approved activity program only	Approved RN&A program	Regular rate	Approved activity program only	Approved RN&A program
0-7	$330.00	$336.00	$348.00	$380.00	$386.00	$398.00
8	336.00	342.00	354.00	386.00	392.00	404.00
9	342.00	348.00	360.00	392.00	398.00	410.00
10	348.00	354.00	366.00	398.00	404.00	416.00
11	354.00	360.00	372.00	404.00	410.00	422.00
12	360.00	366.00	378.00	410.00	416.00	428.00
13	366.00	372.00	384.00	416.00	422.00	434.00
14	372.00	378.00	390.00	422.00	428.00	440.00
15	378.00	384.00	396.00	428.00	434.00	446.00
16	384.00	390.00	402.00	434.00	440.00	452.00
17	390.00	396.00	408.00	440.00	446.00	458.00
18	396.00	402.00	414.00	446.00	452.00	464.00
19	402.00	408.00	420.00	452.00	458.00	470.00
20	408.00	414.00	426.00	458.00	464.00	476.00
21	414.00	420.00	432.00	464.00	470.00	482.00
22	420.00	426.00	438.00	470.00	476.00	488.00
23	426.00	432.00	444.00	476.00	482.00	494.00
24	432.00	438.00	450.00	482.00	488.00	500.00
25	438.00	444.00	456.00	488.00	494.00	506.00
26	444.00	450.00	462.00	494.00	500.00	512.00
27	450.00	456.00	468.00	500.00	506.00	518.00
28	456.00	462.00	474.00	506.00	512.00	524.00
29	462.00	468.00	480.00	512.00	518.00	530.00
30	468.00	474.00	486.00	518.00	524.00	536.00
31	474.00	480.00	492.00	524.00	530.00	542.00
32	480.00	486.00	498.00	530.00	536.00	548.00
33	486.00	492.00	504.00	536.00	542.00	554.00
34	492.00	498.00	510.00	542.00	548.00	560.00
35	498.00	504.00	516.00	548.00	554.00	566.00
36	504.00	510.00	522.00	554.00	560.00	572.00
37	510.00	516.00	528.00	560.00	566.00	578.00
38	516.00	522.00	534.00	566.00	572.00	584.00
39	522.00	528.00	540.00	572.00	578.00	590.00
40	528.00	534.00	546.00	578.00	584.00	596.00
41	534.00	540.00	552.00	584.00	590.00	602.00
42	540.00	546.00	558.00	590.00	596.00	608.00
43	546.00	552.00	564.00	596.00	602.00	614.00
44	552.00	558.00	570.00	602.00	608.00	620.00
45	558.00	564.00	576.00	608.00	614.00	626.00
46	564.00	570.00	582.00	614.00	620.00	632.00
47	570.00	576.00	588.00	620.00	626.00	638.00
48	576.00	582.00	594.00	626.00	632.00	644.00
49	582.00	588.00	600.00	632.00	638.00	650.00
50	588.00	594.00	606.00	638.00	644.00	656.00

NOTE: Add $6.00 per point over 50 points.

EXHIBIT 4.—RATE SCHEDULE FOR ICF–I PAYMENT; GROUP III

Point count	Not qualified for "shelter factor" allowance			Qualified for "shelter factor" allowance		
	Regular rate	Approved activity program only	Approved RN&A program	Regular rate	Approved activity program only	Approved RN&A program
0–7	$285.00	$291.00	$303.00	$335.00	$341.00	$353.00
8	291.00	297.00	309.00	341.00	347.00	359.00
9	297.00	303.00	315.00	347.00	353.00	365.00
10	303.00	309.00	321.00	353.00	359.00	371.00
11	309.00	315.00	327.00	359.00	365.00	377.00
12	315.00	321.00	333.00	365.00	371.00	383.00
13	321.00	327.00	339.00	371.00	377.00	389.00
14	327.00	333.00	345.00	377.00	383.00	395.00
15	333.00	339.00	351.00	383.00	389.00	401.00
16	339.00	345.00	357.00	389.00	395.00	407.00
17	345.00	351.00	363.00	395.00	401.00	413.00
18	351.00	357.00	369.00	401.00	407.00	419.00
19	357.00	363.00	375.00	407.00	413.00	425.00
20	363.00	369.00	381.00	413.00	419.00	431.00
21	369.00	375.00	387.00	419.00	425.00	437.00
22	375.00	381.00	393.00	425.00	431.00	443.00
23	381.00	387.00	399.00	431.00	437.00	449.00
24	387.00	393.00	405.00	437.00	443.00	455.00
25	393.00	399.00	411.00	443.00	449.00	461.00
26	399.00	405.00	417.00	449.00	455.00	467.00
27	405.00	411.00	423.00	455.00	461.00	473.00
28	411.00	417.00	429.00	461.00	467.00	479.00
29	417.00	423.00	435.00	467.00	473.00	485.00
30	423.00	429.00	441.00	473.00	479.00	491.00
31	429.00	435.00	447.00	479.00	485.00	497.00
32	435.00	441.00	453.00	485.00	491.00	503.00
33	441.00	447.00	459.00	491.00	497.00	509.00
34	447.00	453.00	465.00	497.00	503.00	515.00
35	453.00	459.00	471.00	503.00	509.00	521.00
36	459.00	465.00	477.00	509.00	515.00	527.00
37	465.00	471.00	483.00	515.00	521.00	533.00
38	471.00	477.00	489.00	521.00	527.00	539.00
39	477.00	483.00	495.00	527.00	533.00	545.00
40	483.00	489.00	501.00	533.00	539.00	551.00
41	489.00	495.00	507.00	539.00	545.00	557.00
42	495.00	501.00	513.00	545.00	551.00	563.00
43	501.00	507.00	519.00	551.00	557.00	569.00
44	507.00	513.00	525.00	557.00	563.00	575.00
45	513.00	519.00	531.00	563.00	569.00	581.00
46	519.00	525.00	537.00	569.00	575.00	587.00
47	525.00	531.00	543.00	575.00	581.00	593.00
48	531.00	537.00	549.00	581.00	587.00	599.00
49	537.00	543.00	555.00	587.00	593.00	605.00
50	543.00	549.00	561.00	593.00	599.00	611.00

NOTE: Add $6.00 per point over 50 points.

EXHIBIT 5.—RATE SCHEDULE FOR ICF–II PAYMENT

Point count	Group III		Point count	Group III	
	Regular rate	Approved activity program rate		Regular rate	Approved activity program rate
0–7	$210.00	$216.00	16	264.00	270.00
8	216.00	222.00	17	270.00	276.00
9	222.00	228.00	18	276.00	282.00
10	228.00	234.00	19	282.00	288.00
11	234.00	240.00	20	288.00	294.00
12	240.00	246.00	21	294.00	300.00
13	246.00	252.00	22	300.00	306.00
14	252.00	258.00	23	306.00	312.00
15	258.00	264.00	24	312.00	318.00

NOTE: Add $40.00 if home is approved for "Shelter factor" allowance.

Exhibit 6

(SUGGESTED LETTER TO PATIENT)

DEAR _____: It has been determined that you no longer require the level of care which we are licensed to provide. Because of the demand for this type of care we must request that you, your relatives, and your physician make other arrangements for your continued care.

The primary responsibility for locating a facility which can provide appropriate care rests with you and your relatives. We will be glad to assist you, as will your Public Aid caseworker, although every effort should first be made by your own family. These arrangements should be made so that your move may be completed within the next seven days.

If you have any questions, do not hesitate to contact me.

Yours truly,

_____

Administrator.

cc: To all known relatives, recipient's physician, County Department of Public Aid (Cook County, Nursing Home Service).

ITEM 2. TECHNIQUES AND FACTORS REVERSING THE TREND OF POPULATION GROWTH IN ILLINOIS STATE HOSPITALS[1]

(By Conrad Sommer, M.D., Springfield, and Jack Weinberg, M.D., Chicago, Ill.)

In January, 1941, a study of the rate of increase of resident population in the nine Illinois state hospitals was made by Dr. Charles F. Read[2] of Elgin, for the purpose of charting a proper policy for the future, to determine what steps were needed and could be taken to stem the tide of the increasing numbers of chronically ill and long-time institutionalized patients. Consideration was given both to the financial costs and to the human values of many thousands of patients spending five, ten or as high as forty years of adult life in state mental hospitals. The question as to whether so much long-time institutionalization was good psychiatric practice was also raised.

As a result of this survey a policy was adopted by the Illinois state mental hospitals that a distinct effort should be made using as many approved procedures of a psychiatric, medical and social work nature as possible to halt the ever-increasing numbers of patients with chronic mental illnesses retained in the hospitals for these long periods of time. In addition to a more liberal policy of release and return to the community it was also felt that the too frequent and too easy recourse to commitment should be prevented by more careful pre-commitment study and greater efforts to adjust the somewhat mentally ill patient in the community. This paper is a report on the policy adopted, the techniques used, the results secured and on other factors contributing to these effects, including the changed social and economic conditions and the larger role now placed by psychiatric treatment in the community by neuropsychiatrists and general practitioners.

POLICY

Convinced by the experiences of other states that a more liberal policy of the release of patients would have important psychiatric, humanitarian and fiscal values, the superintendents of the nine mental hospitals in consultation with the central control authorities adopted a policy that the state's resources should no longer be thrown into the building of additional wards and the provision of new beds but, rather, in the direction of an enlarged extra-mural mental hygiene and supervisory service, a liberal release program, longer and more careful supervision after release, and the establishment of mental hygiene facilities for the community adjustment of patients who would otherwise

[1] Read at the ninety-ninth annual meeting of The American Psychiatric Association, Detroit, Michigan, May 10–13, 1943.

[2] Read, Charles F. A. study of possibilities of fewer institutionalized mental patients during the next 4 years. The Ill. Psychiat. J., II: 1, 7.

be committed. In substance, the content of a resolution on this subject passed by the superintendents of the Illinois state hospitals in May, 1941, on the completion of Dr. Read's survey was as follows:

"Whereas in the past fifty years the population of the State of Illinois has doubled, its mental hospital population has octuplied, rising from 3,850 to 31,500. From 1927 to 1937 the average increase of resident population was 700 and from 1937 to 1941 the average resident population increased 900 patients per year.

Believing that there are at present enough public bed facilities for the mentally ill in Illinois, we propose to freeze the level of resident patient population where it stood at the beginning of this biennium, June 30, 1940, namely at 30,782, and to make unnecessary the future provision of any large number of additional beds by a more active institutional treatment program, and by an enlarged extra-mural program. The future building program should only be of such amount as to be in proportion to the increase in the general population of the state. (This goal was some 700 patients less than the number present in the hospitals at the time of the survey.)"

The present report describes the effort to carry out the mandate of this resolution during the 18 months beginning July 1, 1941.

In embarking on this program it became necessary to keep careful, comparative monthly reports on the progress or lack of progress of the undertaking. The statistical office prepared tables and graphs on the admissions, therapeutic paroles, direct discharges, discharges from parole, returns from parole, deaths, transfers, deportations and other factors influencing the changes in the resident hospital population. A friendly rivalry developed between the staffs of the nine hospitals as such comparative box scores were placed before them each month. The setting of a specific resident population goal seemed to act as a special incentive to carry out this program. However, the moratorium on building since the beginning of the war caused this at first optional program to become an absolutely necessary program. Otherwise intolerable over-crowding would quickly have resulted.

TECHNIQUES

The equivalent time of four additional psychiatrists and eleven psychiatric social workers was added to the staffs of the several hospitals to carry out the new program. In addition other members of the medical and social worker staffs devoted more time and effort in seeking out releasable patients, preparing them for discharge, and assisting with their subsequent supervision. Since the large majority of the patients at the Elgin, Chicago, Kankakee and Manteno State Hospitals were committed from Chicago and Cook County, a new clinic, the Chicago Community Clinic, was established to supervise the patients released from these four hospitals to Cook County. The number of one-day monthly clinics for the supervision of newly released patients throughout the state was increased from 12 to 22. Thus a more careful coverage of the state by the clinics brought the extended extra-mural service closer to many communities and permitted the release of larger numbers of patients requiring careful supervision.

A diagnostic and consultative service to patients about to be committed was established in the full time Chicago Community Clinic and the 22 one-day per month clinics. Judges, physicians, social workers and relatives use this pre-commitment service and are given prescriptions for the vocational, social and home adjustment of patients for whom the pre-commitment study reveals that institutionalization is not required. The members of the clinic gave information to the community as to what the state hospital can and cannot do for the different types of personality maladjustment.

Considerable, perhaps excessive, publicity was given to the fact that the Illinois state hospitals would now become much more liberal in the release of mental patients. The fantastic figure of "7,000 mental patients" was once blazoned in the press as the number of persons immediately to be released. Among the beneficial results of this otherwise dubious publicity was the fact that a number of relatives who had quite forgotten their patients hastened to the hospitals to object to their release. Some who came to object remained to give consideration to the possibility of again caring for their somewhat mentally ill relative at home. Social agencies and local public officials, at first concerned about the possibility of dangerous mental patients being released into

the community, became converted and began to assist in finding more community resources for the mentally convalescent patient. The State Bureau of Vocational Rehabilitation was found willing to include in its program for the physically handicapped those released mental patients for whom our psychiatrists prescribed vocational retraining.

The Old Age Assistance service of the state co-operated by granting financial aid to hundreds of persons beyond the age of 65 suffering from senile and arteriosclerotic psychoses. Although the state hospitals found 2,000 elderly patients in these categories who could safely be released, the difficulties of finding satisfactory places of residency in the community and of appointing conservators to safeguard the interests of the patient and to make possible the payment of Old Age Assistance funds, considerably slowed the transfer of these patients to Old Age Assistance rolls.

There was found buried in the statutes a legal device whereby mental patients could be boarded out in private homes at state expense not to exceed the per capita cost of the patient in the hospital from which he was released. A program of family care for patients too young or otherwise ineligible to receive Old Age Assistance benefits was devised. During this 18 months' period, 340 patients were removed from the state hospitals and placed with families other than their own. The majority of this group became self-supporting or were supported by relatives, a minor fraction was supported by Old Age Assistance and relief grants, while only a negligible number were supported by state hospital funds. In some instances, although the patient did not live with his own family, several of his relatives contributed so that his support outside of the community was possible. Because of the many legal, fiscal and medical procedures about which the social workers needed to have special knowledge, a social service manual on the family care of mental patients was developed.

As the ward physician reviewed his patients one by one to discover those who could properly be released, we were often chagrined at the discovery of patients whose release would have been feasible many years earlier. Several patients were found to have large estates which made possible their release, support and supervision in the community. Forgotten relatives were communicated with, and enlisted in the effort to get suitable patients out into the communities.

More staff meetings were held to discuss the possibility of release of borderline cases, and to prescribe the kind of community care needed. A form was devised and distributed among the physicians entitled, "Physician's Release Recommendations," to be used at the staff meeting deciding whether or not the patient could be released, and subsequently by the physician and social worker supervising the patient after release to the community. The data included the patient's present mental status, his present physical status, the presence of any somatic disease requiring medical attention, the patient's general strength and ability to sustain himself and to work, the patient's public health status excluding the presence of tuberculosis or of enteric disease carrier states; recommendation as to the kind and amount of supervision required; a statement as to the patient's employment possibilities, advice as to with whom in the community the patient would adjust best; advice as to recreation; the need for a conservator; special warnings regarding the patient's behavior, and a final overall statement about release couched in the following language:

Check one of the following:

Patient should be released;

Patient could be released;

Patient should not be released because: he is (check one) homicidal, suicidal, sex problem, recurrent community problem, other;

However, we did not in all instances rigidly adhere to the rather elaborate arrangement of staff meetings and pre-parole investigations of the home set-up to safeguard the procedure of releasing and supervising cases. The several superintendents of the hospitals continued to exercise their right of what one of them aptly dubbed "the extemporaneous release of patients"; that is, the superintendent, upon having interviewed the patient and a responsible member of his family, effects an immediate discharge of the patient without recourse to some of the more formal procedures mentioned.

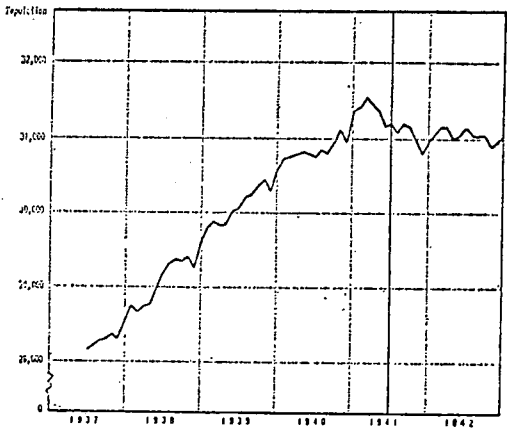
It was found quite profitable to extend cooperation to the association of former alcoholic patients called Alcoholics Anonymous. A close-working relation-

ship developed between those of our state hospitals in the vicinity of Chicago in which there is a strong and co-operative group of Alcoholics Anonymous. Selected members of this group spent many hours in our hospitals working with undeteriorated and not very psychotic alcoholic patients. The favorable results of this technique, especially at the Manteno State Hospital, have been described by McMahan.[3]

Other techniques may be mentioned which, however, were used too little or too late in this program to play more than a negligible role in contributing to the results. However, it is intended to make greater use of these techniques which include: group psychotherapy, an adaptation of Abraham Low's Recovery Association technique, and the treatment with hyperpyrexia and arsenicals of patients not yet psychotic, who are discovered to have positive spinal fluid complement fixation reactions. Fifteen hundred such patients have been discovered by the venereal disease clinics in Illinois; 600 patients are admitted annually to the state hospitals suffering from paresis; 3,000 beds are at present occupied in these hospitals by patients suffering from paresis. It is obvious that the pre-psychotic treatment of impending paresis or cerebral vascular syphilis is an important part of any program designed to restrict the increase of institutional population.

RESULTS

In interpreting results, one is immediately confronted by the fact that many factors other than the specific procedures already described, played an important role in reversing the trend of the population level in the Illinois state hospitals. First let us consider the actual variation in resident population in the hospitals during the four years preceding and during the 18 months of the program being reported. A precise examination of Graph 1 reveals that the actual reversal of the population trend began in April, 1941, and continued after July of that year. During the spring of 1941, our medical and social service staffs, aware of what was in the air, spontaneously liberalized their release policy. The decline stopped in 1942, and became a hilly plateau. On January 1, 1943, the resident population of the Illinois mental hospitals was 30,951 or almost 600 less than the peak reached in March, 1941 (31,548), and approximately the same as it had been in November, 1940. Whereas in this 26-month period there was no net rise in population, the average increase in patients for equal segments of time in previous years had ranged 1760 to 1950. This is a sharp change in trend.



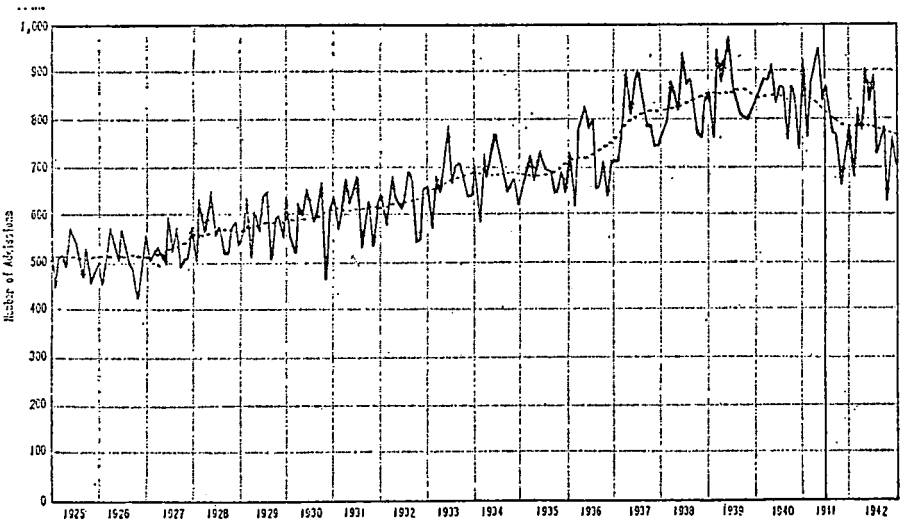
GRAPH 1.—Resident population in the major state hospitals, by months: 1937-1942.

[3] McMahan, H. G. The psychotherapeutic approach of chronic alcoholism in conjunction with the alcoholics anonymous program. The Ill. Psychiat. J., II: 2, 15.

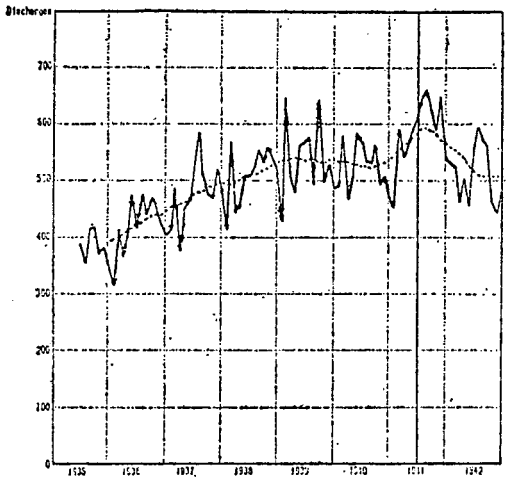
Next let us consider the variations in admissions prior to and during the 18 months of this study. Graph 2 shows the important role played by the change in the rate of all admissions to the hospitals. That social and economic factors of the type described by Neil Dayton played an important role, perhaps more important than the techniques described in reversing the trend in institutional population by lessening admissions is evident from the fact that admissions did not rise in 1939 (the first year in 15 without a rise); that the admissions declined slightly in 1940 and in the first quarter of 1941; and declined sharply in the last 9 months of 1941 and again levelled off during 1942. It will be a worth while endeavor, but beyond the scope of this paper to analyze the role played by this reversal of the usually rising admission rate. However, in 1942, the junior author showed that the number of patients given shock treatment and other psychiatric treatment in general hospitals had increased rapidly from 1935 to 1940. The number of psychiatric patients treated in general hospitals in Cook County in the latter year being three times those treated in 1935.

The variations of all discharges (direct and from parole and family care) prior to and during the period of study are considered in Graph 3.

Comparing the absolute number of discharges during the 18 months under consideration with a similar period, we find all discharges (direct and from parole) during 18 months beginning July 1939 to be 9,645; for 18 months beginning July 1941, 10,066. There was an absolute increase of 421 discharges during the new program. The results of the more liberal release program did not include an increase in re-admissions or a return to the hospital of patients on trial in the community. The re-admissions were as follows: re-admissions in 18 months beginning July 1, 1939, 4,168; in 18 months beginning July 1, 1941, 3,923.



GRAPH 2.—Admissions to the major state hospitals, by months: 1925-1942.



GRAPH 3.—Discharges from the major state hospitals, by months: 1935-1942.

Death played no role in reducing the resident population during this period. The death rate in the 18 months following July 1941 was the lowest since 1924 in the Illinois state hospitals.

COMMENT AND CONCLUSION

The rising tide of resident population in the Illinois state hospitals has been stopped, probably both by the specific efforts directed to that end and by favorable factors in the community. However, this paper raises more questions than it answers and must therefore be considered a preliminary report. The fears that a liberal policy of releasing mental patients would result in an unfortunate increase of anti-social behavior by or exploitation of released patients have not yet been justified. When large numbers of working mental patients are released from the institution the occupational and recreational therapy programs and other elements in the total push program of necessity must be accelerated to recruit from among idle patients new working patients to replace those working patients who have gone home. Hence, a liberal policy of release forces the mental hospital to enlarge its total therapeutic program. Several techniques used in this program have been listed and described briefly. However, the exact effectiveness of these techniques and the precise role played by each in reducing institutional population are yet to be studied and reported upon. For example, follow-up studies must be carried on for several years to determine the effectiveness of the co-operative working relationship with the Alcoholics Anonymous group before more definite conclusions can be reached as to the value of that particular technique. The same may be said as regards the Recovery Association, the preventive treatment of patients with positive spinal fluid findings, the use of family care techniques, pre-commitment services, and such accepted techniques as shock therapy.

A qualitative study of the kind of persons being admitted to our state hospitals at this time will reveal a large proportion of aged and infirm patients. Careful study needs to be given to this particular group to secure the proper proportion of community and institutional care for them. Additional time and study will also reveal whether the Illinois mental hospitals released patients who were the "cream of the crop" and to what extent the addition of more personnel engaged in the release of patients and their supervision will encounter the law of diminishing returns. We feel that it is the part of wisdom to avoid extreme swings of the pendulum in either institutionalization or community care for the mentally ill, that both fiscal and human values need to be considered and brought into balance in planning a mental hospital program. Continued careful evaluation of those social, economic and medical factors of the type emphasized by Dayton and critical statistical scrutiny of all the techniques employed in a program designed to prevent unnecessary institutional expansion are needed in wisely charting the future program.

ITEM 3. LETTER FROM ALAN J. METZ, ATTORNEY, JENNER & BLOCK, CHICAGO, ILL.; EXHIBITS FOR MR. DANIEL SLADER, ADMINISTRATOR, MELBOURNE NURSING HOME, CHICAGO, ILL.

JENNER & BLOCK,
Chicago, Ill., June 11, 1971.

DEAR MR. HALAMANDARIS: Pursuant to the request of the Senate Special Committee on Aging which held hearings in Chicago on April 3, 1971, I tender the enclosed documents and affidavits.

Exhibit A is a letter from Arthur J. Wolski indicating the amounts billed for dental services in 1970. Mr. Slader has informed me that Dr. Wolski has no records pertaining to prior years. With respect to the procedure for certifying dental bills, Mr. Slader informs me that he is required to certify only those bills pertaining to Mental Health patients, and that all bills certified are first submitted and approved by Miss Brock, who is an employee of the Illinois Department of Mental Health.

Exhibit B is a statement from Mr. Marvin Fox, accountant for the Melbourne Corporation, stating the food cost figures for the latest fiscal year.

Exhibit C is a copy of page 2 of the 1970 partnership tax return indicating the requested figures on depreciation.

Exhibit D is Mr. Slader's affidavit with respect to principal and interest payments on the property.

With respect to the overall equity investment in the nursing home, Exhibit C indicates an investment of $413,071.06. To this amount, Mr. Slader believes, should be added losses which occurred between 1961 and 1963 in the amount of $145,549.97 [documents substantiating this figure were previously produced] making a total investment of $558,621.03. Mr. Slader informs me that no other documents with respect to this particular area are available.

Exhibits E, F, and G explain the true proportions of the "water incident" exploited by Pamela Zekman in her article appearing March 1, 1971 in the Chicago Tribune.

Sincerely,

ALAN L. METZ.

Exhibit A

CHICAGO, ILL, *April 12, 1971.*

JENNER & BLOCK,
Chicago, Ill.

DEAR SIR: As per request of hearing of Melbourne Nursing Home, I am submitting records of 1970 for dental services performed on patients residing at the above home. Public aid receipts amounted to $128.00 and Mental Health receipts amounted to $608.00.

There were many services that I performed and no fees or statements were submitted to either agency.

Yours very truly,

ARTHUR J. WOLSKI, DDS.

Exhibit B

FROST, RUTTENBERG AND ROTHBLATT,
Chicago, Ill., April 10, 1971.

Re: Melbourne Corporation Costs for the full year 11/1/69 to 10/31/70.

JENNER & BLOCK,
Chicago, Ill.

DEAR AL: For the fiscal year ended Oct. 31, 1970 Melbourne Corporation's total raw food costs as indicated by their books and records are $45,321.63. The total patient days as indicated by their books and records are 67,702. This would equate to raw food cost per patient day of $0.67.

If you should need any additional information please contact me.

MARVIN FOX.

Exhibit C

Schedule I—DEPRECIATION (See Instruction 20) Taxpayers using Revenue Procedures 62–21 and 65–13: Make no entry in column 2, enter the cost or other basis of assets held at end of year in column 3, and enter the accumulated depreciation at end of year in column 4. Note: You may (1) group depreciable assets in accordance with the categories specified below or (2) continue to list your assets in the same manner as in prior years. If you need more space, use Form 4562.

1. Group and guideline class or description of property	2. Date acquired	3. Cost or other basis	4. Depreciation allowed or allowable in prior years	5. Method of computing depreciation	6. Life or rate	7. Depreciation for this year
1 Total additional first-year depreciation (do not include in items below). (Enter here and allocate to each partner in line 4 of Schedule K) →						
Buildings		80000.00	42000.00	S.L.	20 YRS	4000.00
~~Furniture and fixtures~~ Improve	VAR	246223.21	100260.37	150% DB	25 "	8022.57
Transportation equipment						
Machinery and other equipment						
Other (specify) Furn + Fix	VAR	42687.58	30627.80	200% DB	VAR	3159.46
4 YRS (SL 142860)	VAR	11059.00	—	150% DB	3½ YRS	2460.00
Improvements	1970	11019.27	—	✓	5½ YRS	1652.89
LAND		20010.00				
2 Totals		493071.06				20094.92
3 Less amount of depreciation claimed in Schedules A and B						
4 Balance—Enter here and on page 1, line 20.						20094.92

SUMMARY OF DEPRECIATION

	Straight line	Declining balance	Sum of the years-digits	Units of production	Additional first-year (section 179)	Other (specify)	Total
1 Under Rev. Procs. 62–21 and 65–13							
2 Other							

Schedule J—EXPLANATION OF LINES 16, 17, AND 24 ON PAGE 1, AND OF COLUMNS 4 AND 5 OF SCHEDULE B

Line or column	Explanation	Amount	Line or column	Explanation	Amount
24	INSURANCE	900.00			
	LEGAL & AUDIT	3547.48			
	TRUST FEE	290.50			
	TOTAL	5031.98			
21	MORTGAGE COSTS				
	15,000.00 OVER 15 YRS	1000.00			

Exhibit D

STATE OF ILLINOIS
County of Cook, ss:

AFFIDAVIT

Daniel A. Slader being duly sworn on oath deposes and says:

1. The mortgage on the property at 4621–29 North Racine Avenue, Chicago, Illinois is in the amount of $375,000. There is presently due and owing on that mortgage an amount of $195,076.59 as of June 4, 1971. To date, the amount of $179,923.41 has been paid on principal.

2. Interest payments on the above described property have been made over the years in the below described amounts:

Calendar year:	*Interest Amount*
1962	$24,294.46
1963	21,548.96
1964	22,058.64
1965	22,307.17
1966	21,860.03
1967	21,069.37
1968	14,590.59
1969	17,295.18
1970	27,032.45
Total	192,056.85

DANIEL A. SLADER.

Subscribed and sworn to before me this 11th day of June, 1971.

ROSEANN FARINA,
Notary Public.

Exhibit E

NORTH SHORE SEWERAGE & DRAINAGE CO.

Licensed, Bonded and Insured Sewer Builders — Flooded Basements Gasoline & Electrically Pumped

Catch Basins Cleaned :: Sewers Rodded, Repaired and Built

ELECTRIC POWER ROOT CUTTING SEWER RODS USED WHEN NECESSARY

CALL YOUR NEAREST OFFICE

MAIN OFFICE
1127 FOSTER AVENUE
SUNNYSIDE 4-4500

LOUIS CARUS, Prop.
2665 LINCOLN AVE.
LINCOLN 9-4900

EVANSTON OFFICE
624 ASBURY AVE.
UNIVERSITY 4-8500

CHICAGO, Feb. 4, 1971

TO Melbourne Convalescent Home
4621 N. Racine Ave.
Chicago, Illinois 60640

INVOICE 49827

ALL BILLS PAYABLE AT MAIN OFFICE

2/3/71	To rod, flush and release stoppage in building main sewer, rodding from rodout basin in parkway and from 4" overhead line in basement, using big electric rod and hand rod. Had to go through stoppage several times before sewer would release.		
	Sewermen's time and use of electric rod.		83 50

QUANTITY-UNIT PRICE-QUALITY O.K.
EXTENSIONS & FOOTINGS O.K.

Exhibit F

This Ticket must be turned in immediately after work is completed

North Shore Sewerage & Drainage Co.

JOB TICKET

Truck No. _____ ☐ New Acc't. ☒ Old Acc't.

Day & Time Wed. Office Main

Date Wanted 2-3-71 Maintenance Job No.

Work at 4621 N. Racine Billed to Mellbourne Nursing

Name and Size of Building Agent or Ordered by Home

Job Phone 334-0900 Address

See Info. Desk ask for Pritchard Phone

Clean Basin	Check for Sewer Gas	Give Price & Collect	◊ ◊ Don't forget to run hot water while rodding sink sewers from the apartments above as well as below from laundry tube Flush out all fluer drains with hose. Don't forget to put sticker on job and give business card each customer, manager and janitor.
Rod Sewer	Estimate Only	Leave Bill with Customer	

Work Done Bu —

2 men

WORKMAN							
Time Started to Job	12:15	12:45					
Time Left Job		1:00					
Returned to Shop							
MAN-HOURS							

Work Completed

Done by

Have Ticket Signed by [signature] 2-3-71

Remarks

Exhibit G

STATE OF ILLINOIS
County of Cook,

AFFIDAVIT

I, James Stickney, 4348 North Winchester, Chicago, Illinois, do hereby swear and affirm as follows:

1. On February 3, 1971, I was employed by the North Shore Sewerage and Drainage Company located at 1127 Foster Avenue, Chicago, Illinois;

2. On February 3, 1971, I and one additional sewer man, whose name I do not recall, were directed by our employer to make sewer repairs at the Melbourne Nursing Home located at 4621 North Racine Avenue, Chicago, Illinois;

3. We worked at the Melbourne Home for approximately four hours and succeeded in freeing a clogged sewer line. To the best of my knowledge, we were the only two sewer men employed to unstop the sewer pipe;

4. There were no broken pipes involved, although a small amount of water collected on the first floor because of a clogged toilet.

I have viewed the bill for our work, which was sent to the Melbourne Home, and believe that the $83.50 represented on that bill is the total amount billed to the Melbourne Nursing Home for the described work.

JAMES STICKNEY.

Subscribed and sworn to before me this *10* day of *June*, 1971.

MARY C. HESS,
Notary Public.

EXHIBIT H

STATEMENT BY DANIEL A. SLADER, REFERENCE TO LAND TRUST OWNERSHIP

Re Melbourne Nursing Home.

Chairman, Senate Committee on Aging,
Washington, D.C.

DEAR SIR: You have caused inquiry to be made of me, as to the reason why ownership of the land and building occupied by Melbourne Corporation (operating a nursing home at 4621–29 North Racine Avenue, Chicago) is held in a land trust, the beneficiaries of which are Dr. Wolski and his wife, and my wife and myself, instead of having such ownership in Melbourne Corporation, the operator of the nursing home.

I referred the inquiry to counsel who had organized the corporation, and had caused the land trust to be created.

The information furnished me by counsel is as follows:

The real estate was acquired in mid-1959. The property had been operated as a hotel. Melbourne Corporation was organized on May 3, 1960, for the purpose of operation of a nursing home. Looking forward to a time when the nursing home operation might become a profitable venture, and be sold, it was considered desirable that the real estate be not contributed as part of the capital of the corporation; the lesser capital investment would make the corporate business more readily salable; likewise, the real estate could be held as an investment, deriving rental from a nursing home tenant. Additionally, if the nursing home were to be retained, after becoming a profitable venture, the real estate could be sold, with the nursing home as a tenant on a long-term basis. These business considerations were urged by counsel at the time, in keeping the land and the business operation separate.

Very truly yours,

DANIEL A. SLADER.

EXHIBIT 1

RECAP—GROSS EARNINGS ONLY

Calendar year	Daniel A. Slader	Leah W. Slader	Arthur J. Wolski	Virginia B. Wolski	Total for year
1961	None	None	None	None	None
1962	None	None	None	None	None
1963	None	None	None	None	None
1964	None	322,500	None	None	322,500
1965	None	540,000	None	None	540,000
1966	None	600,000	None	None	600,000
1967	None	None	None	None	None
1968	None	None	None	None	None
1969	6,000,000	1,500,000	1,350,000	None	8,850,000
1970	780,000	780,000	1,350,000	None	2,910,000
Total	6,780,000	3,742,500	2,700,000	None	13,222,500
Total divided by 9	753,333	415,833	300,000	None	1,469,166

ITEM 4. DR. ALBERT J. GLASS, ACTING DIRECTOR, STATE OF ILLINOIS DEPARTMENT OF MENTAL HEALTH

STATE OF ILLINOIS,
DEPARTMENT OF MENTAL HEALTH,
Chicago, June 14, 1971.

DEAR SENATOR PERCY: In keeping with your telephone conversation with Mr. Lanier, I am providing you with supplementary information to the testimony given to the Senate sub-committee hearing on Saturday, April 3, 1971.

On page 1280 of the transcript of my testimony. I refer to the national curve on mental illness. Chart #1 shows the trend in resident population, total admission, readmissions, and first admissions in the State of Illinois and chart 2 shows the comparison of the resident population trends between Illinois and the United States.

Your second question concerns the number of geriatric patients placed in nursing homes referred to on page 1302 and 1303 of the testimony. During Fiscal Year 1970, approximately 2,400 patients between 65 years of age and over were placed in long term care facilities.

In chart #3 entitled Flow of Geriatric Placement Procedures I have indicated the procedures and criteria for placing geriatric patients referred to on page 1308.

The additional information I have referred to on page 1309 is in regard to the attached census summary, by the categories of placement and location of patients 65 years of age and over placed by the Department of Mental Health and currently in long term care facilities.

Sincerely,

ALBERT J. GLASS, M.D.

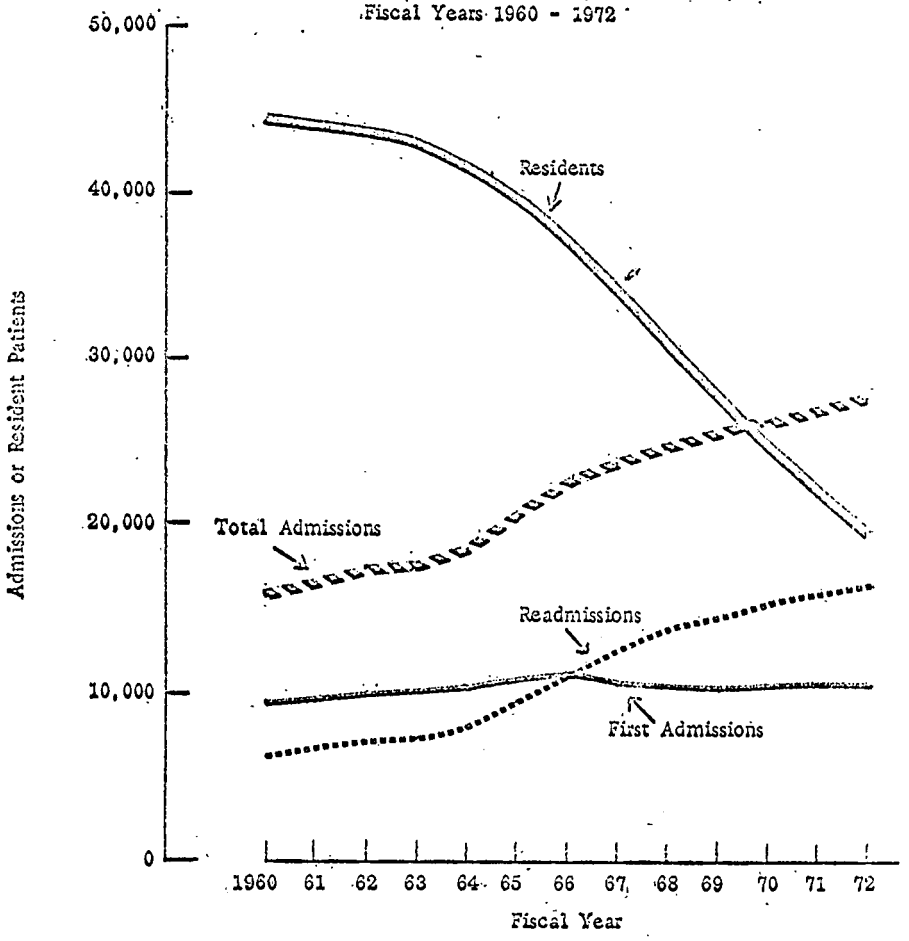
[Enclosures]

Census summary of patients by category of placement and location 65 years of age and over who have been placed by the department of mental health

City of Chicago:	
Nursing Homes	304
Sheltered care homes	791
Homes for the aged	54
Subtotal	1,149
Remainder of the State of Illinois:	
Nursing homes	1,526
Sheltered care homes	1,367
Homes for the aged	32
Subtotal	2,925
Grand total	4,074

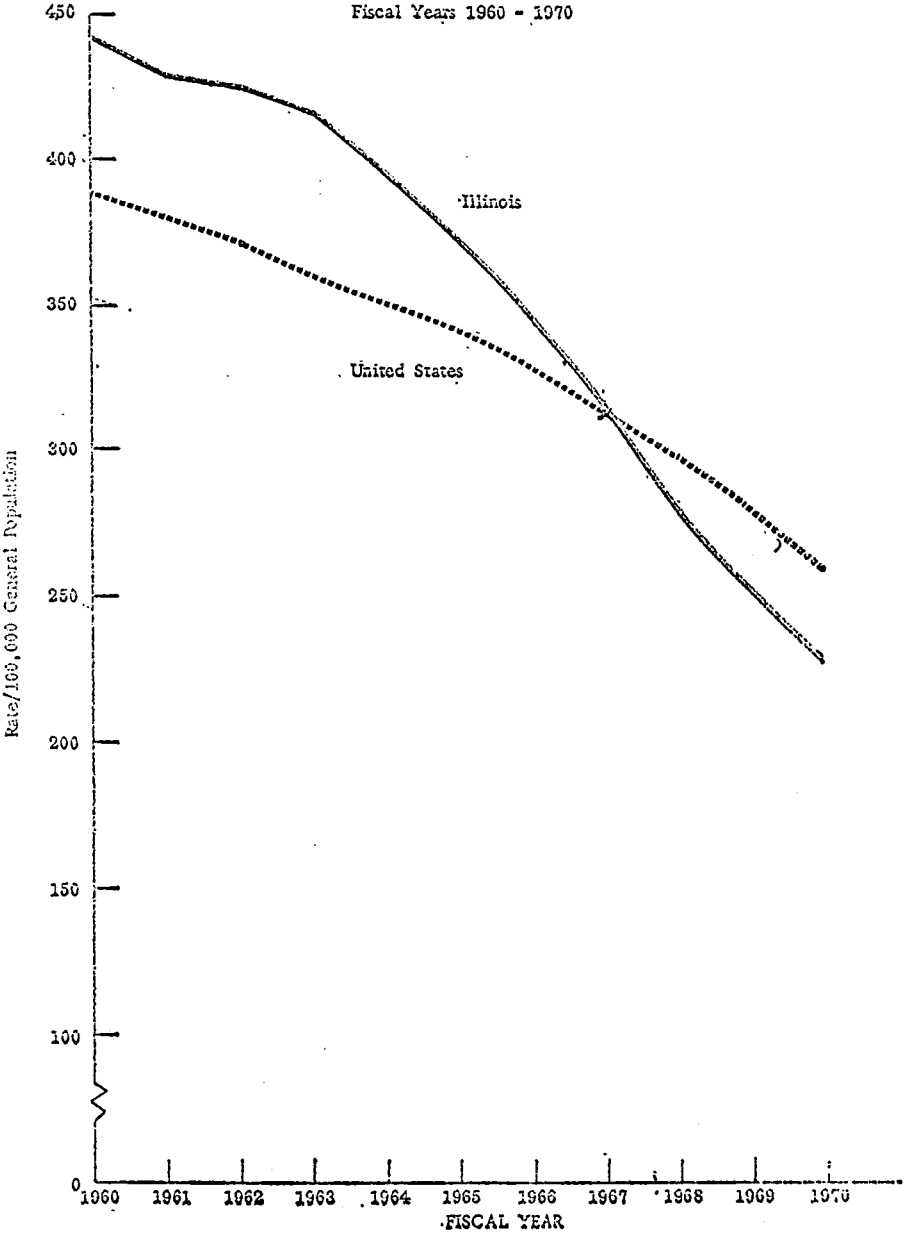
ADMISSIONS AND RESIDENT PATIENTS

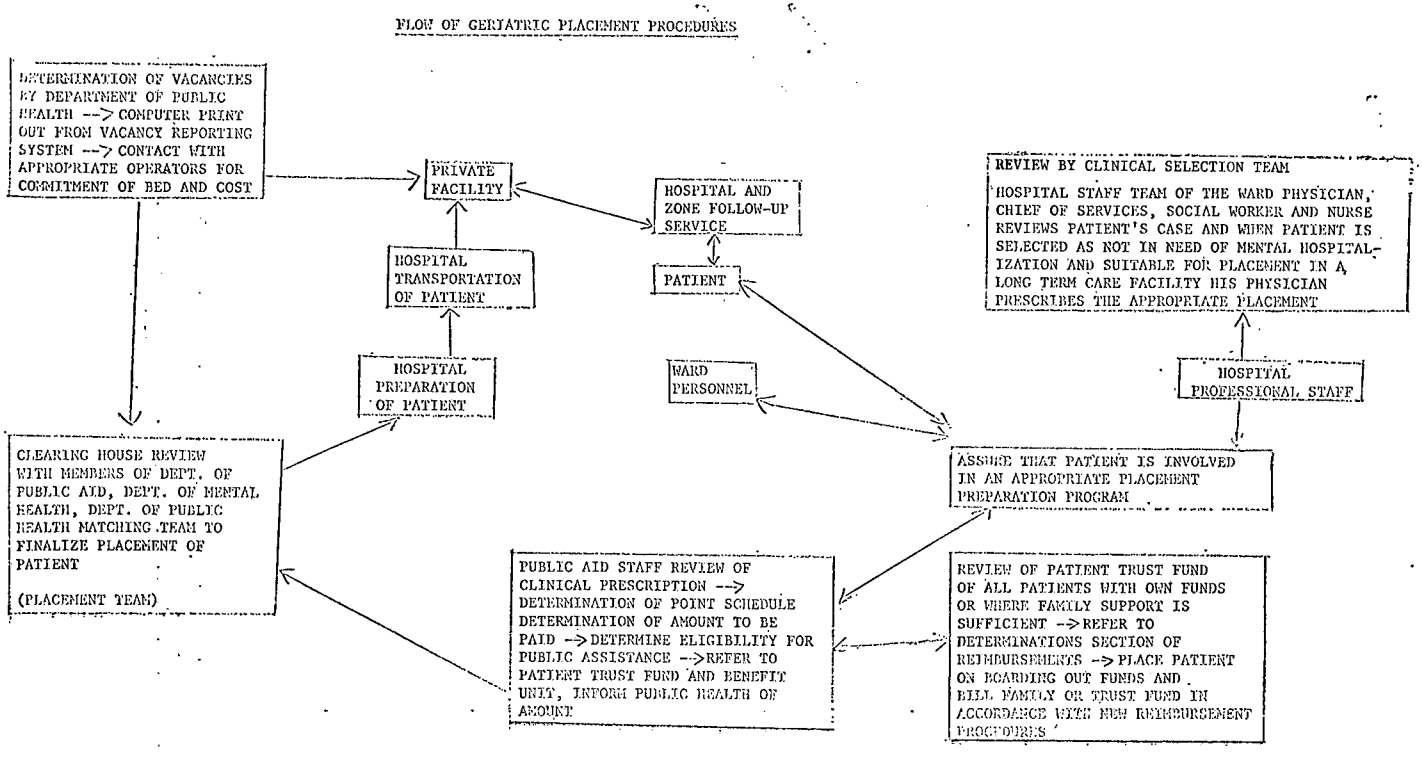
Illinois Department of Mental Health Inpatient Facilities.
Fiscal Years 1960 - 1972



RESIDENTS PER 100,000 GENERAL POPULATION

Department of Mental Health Facilities and U.S. Facilities
Fiscal Years 1960 - 1970




FLOW OF GERIATRIC PLACEMENT PROCEDURES
DETERMINATION OF VACANCIES BY DEPARTMENT OF PUBLIC HEALTH --> COMPUTER PRINT OUT FROM VACANCY REPORTING SYSTEM --> CONTACT WITH APPROPRIATE OPERATORS FOR COMMITMENT OF BED AND COST
PRIVATE FACILITY
HOSPITAL AND ZONE FOLLOW-UP SERVICE
REVIEW BY CLINICAL SELECTION TEAM
HOSPITAL STAFF TEAM OF THE WARD PHYSICIAN, CHIEF OF SERVICES, SOCIAL WORKER AND NURSE REVIEWS PATIENT'S CASE AND WHEN PATIENT IS SELECTED AS NOT IN NEED OF MENTAL HOSPITALIZATION AND SUITABLE FOR PLACEMENT IN A LONG TERM CARE FACILITY HIS PHYSICIAN PRESCRIBES THE APPROPRIATE PLACEMENT
HOSPITAL TRANSPORTATION OF PATIENT
PATIENT
HOSPITAL PREPARATION OF PATIENT
WARD PERSONNEL
HOSPITAL PROFESSIONAL STAFF
CLEARING HOUSE REVIEW WITH MEMBERS OF DEPT. OF PUBLIC AID, DEPT. OF MENTAL HEALTH, DEPT. OF PUBLIC HEALTH MATCHING TEAM TO FINALIZE PLACEMENT OF PATIENT
(PLACEMENT TEAM)
ASSURE THAT PATIENT IS INVOLVED IN AN APPROPRIATE PLACEMENT PREPARATION PROGRAM
PUBLIC AID STAFF REVIEW OF CLINICAL PRESCRIPTION --> DETERMINATION OF POINT SCHEDULE DETERMINATION OF AMOUNT TO BE PAID --> DETERMINE ELIGIBILITY FOR PUBLIC ASSISTANCE --> REFER TO PATIENT TRUST FUND AND BENEFIT UNIT, INFORM PUBLIC HEALTH OF AMOUNT
REVIEW OF PATIENT TRUST FUND OF ALL PATIENTS WITH OWN FUNDS OR WHERE FAMILY SUPPORT IS SUFFICIENT --> REFER TO DETERMINATIONS SECTION OF REIMBURSEMENTS --> PLACE PATIENT ON BOARDING OUT FUNDS AND BILL FAMILY OR TRUST FUND IN ACCORDANCE WITH NEW REIMBURSEMENT PROCEDURES

Appendix 2

STATEMENTS SUBMITTED FOR THE RECORD

ITEM 1. PREPARED STATEMENT OF DAVID L. DANIEL, DIRECTOR, COOK COUNTY, DEPARTMENT OF PUBLIC AID

In presenting testimony to you today, let me first outline the extent of the nursing home program in the county of Cook. At the beginning of March, we were responsible for the well-being of some 11,366 recipients in 176 nursing homes, 44 homes for the aged and 31 sheltered and residential care centers. During the past year, expenditures averaged some two and one-quarter million dollars a month.

Now, in administering this program our responsibilities are manifold. Let me say immediately that we do not narrowly define our responsibilities. Just because the law says that we must do such and such, it does not follow that we should not keep our eyes open to other aspects. Our responsibility is the welfare of these people—in the broadest sense of that term. Nevertheless, we are limited by the magnitude of the job, our staffing situation and, quite simply, the type of expertise of the staff.

Basically, we carry out our responsibilities through periodic visits to these group care facilities. The frequency of these visits varies with the number of homes carried by each caseworker, workers attempt to visit each home at least once a month. This however, cannot always be done, for instance, last year, retroactive changes in social security payments required that thousands of cases be completely re-budgeted. This meant that normal work procedures had to be suspended. In addition, the frequency of visits varies with the size and nature of the facility. Some of the larger facilities are visited several times a month. The smaller facilities every two or three months. In the private institutions, visiting need not be this frequent due to the stable residential population, excellent staffing, services provided, care rendered and programs available for the residents. (see attachment 1).

As an example of caseworker visits to these homes, let me take the 20 licensed facilities that have recently been under discussion. *(see attachment #1.)* The largest with 171 patients has been visited weekly; the same holds true of the next largest with 113 patients, in another large home, our records show very regular monthly visits. Those with less than a hundred but more than fifty patients have in all but one case received monthly visits. The one exception was visited in December, 1970 (although it has been visited now). In all of the smaller institutions, the visits have ranged from monthly to two to four times a year.

Now in making these visits, the primary responsibility of the caseworker is to examine eligibility and continued eligibility for assistance and, most important, to examine the records so as to ascertain that services agreed upon are being given. This is no simple task. (see attachment 2, item II, A and B). Since the services are frequently complicated and because they vary from month to month, a great deal of time is also taken up with a rather complicated point system that determines the payments to be made. Not only is it complicated but because of its complexity a great deal of time is taken up by appeals as to the accuracy of the computation. (see attachment 3). This, of course, increases the burden of an already over-burdened staff.

However, the most important of these actions is to observe the care, the adequacy of the service and the general care and upkeep of the facility. If deficiencies are noted that are in violation of standards and requirements as well as violations of the Department of Health requirements. *The caseworker, upon returning to the office,* initiates action to bring these facts to the attention of the proper authorities. This is something we have done in the past and will continue to do. (also see attachment 2, item, C, D, and E.)

But, in carrying out this program we do work under a number of limitations.

A. We just do not have sufficient staff trained in many of the technical aspects of this operation.

B. Referring to the point system again, a great deal of time is taken up by the technical paper work involved. We are not saying that the point system has no merit. I think it has much merit, but does present some problems. (see attachment 3).

C. Most important, though, is the problem of the patients themselves. In large numbers of cases, the patient is so ill or so senile that he cannot complain. For that matter, they may not even remember if they received their proper medication that morning. In some cases, we suspect that they do not complain because they fear reprisals.

D. My staff is limited to day-time visits, this is important in view of the fact that the conditions recently reported in the papers were, in many cases, the results of round-the-clock surveillance of the operations by persons who had joined the nursing home staff.

E. We have also had our problems increased by the fact that the Department of Mental Health has transferred many patients to these facilities. For example, in January of this year, we received 89 such cases and in February another 79 such cases.

F. In addition to all these tasks we, each year, face a number of special projects and special problems. (see attachment 1).

It is in this context that we have always carried out our administrative duties. Let me emphasize again that we constantly refer questionable practices to the board of health and frequently, as will be seen below, we have removed patients from these homes.

Nevertheless, the cases reported in the newspapers were shocking and we took immediate action. Within a few days we placed 30 investigators in the field to make our own thorough investigation and also to work closely with the Better Government Association and the Chicago Tribune in documenting the facts they reported. As a matter of fact, we are examining all of these facilities, as an added safeguard, we have assigned at least for the time being a team of two investigators to the nursing home service so as to continue this more thorough investigation.

In addition, I would like to point out that once the department of health notified us of a closure (and I emphasize that we need such official notice).

We took immediate action to remove the patients for whom we were repsonsible On Friday, March 5th we received a notice and on Monday, March 18, 71 recipients were moved. On March 8th we received three notices and two days later we removed 37 recipients from one facility and the next day 75 recipients from the other two facilities. On March 17th, the Illinois Department of Public Aid based on information from the Illinois Department of Health requested removal from one facility and the next day 29 recipients were moved. Most recently, at 4:30 P.M. on Friday, March 19th we received a telephone notice from the Chicago Board of Health and the next morning 27 patients were moved. Once notified, we act to move our recipients.

Let me point out, however, that in addition to the need for notice there are other important considerations. State Department rules and regulations state that "The County Department has neither the right nor the responsibility to move a recipient from a facility which is no longer approved. The county Department has a responsibility to assist a recipient, his family, and his physician is making other arrangements for care, when this is requested." Our logic in carrying out the removals I have outlined is that, in these cases, there was no one to make the formal request and so we acted.

Nevertheless, it is quite obvious that some improvements are needed in the system, consequently, let me conclude by briefly outlining some recommendations, the first two of which are directly applicable to the federal government.

1. Establishing a national uniform method of determining the rate to be paid for nursing home care with consideration being given to payment on the basis of a system of classifying homes in accord with the level of care they are licensed and equipped to provide.

2. Providing Federal grants to public and voluntary hospitals to establish chronic care units for the purpose of providing long-term care to seriously disabled persons who require skilled nursing care.

3. I believe that existing State laws or regulations be changed so that the responsibilities of the various State, County and City Departments of Health are more clearly defined.

4. Pending action on the first recommendation, I believe that we may wish to reconsider the use of the point system here in Illinois. Although this sytem is the best plan we have been able to develop. It does not solve some questions. For instance, it does not solve the contention of the nursing home operator that payments are reduced in cases where through their efforts the patient's physical condition improves and his need for some types of care is lessened.

5. I would suggest further examination of the proposal already put forth whereby a public administrator might be assigned to a home to assist it in upgrading its standards.

6. On the administrative level, I would strongly support what I understand is being considered on the State level whereby nursing home bills will be paid by machine processing in the Springfield payment office of the Illinois Department of Public Aid. Alternatively, if the present system is continued, the due dates on bills should be staggered throughout the month. Under the present system, we have only three working days in which to process bills for some 12,000 recipients.

7. I would also hope that the department of mental health on the local level would help to improve coordination between mental health and public aid when they release patients from institutions for their placement in group care facilities.

8. Finally, I would recommend consideration of the possibility of regulating the percentage of patients, directly discharged from State mental hospitals. Who may reside in a shelter care home at any one time. This, for instance, might be limited to a maximum of 50 percent of the total census of patients discharged from State Mental Hospitals.

Most of my presentation today has been limited to the problems we face in helping recipients in these homes. But the problem is broader than just that of recipients and must be considered in that broader context.

Attachment 1

MEMORANDUM

REPORT ON NURSING HOME INVESTIGATION

The following information explains the activity of the Nursing Home Service Office prior to and following the Nursing Home Investigation:

I. FREQUENCY OF CASEWORKERS' VISITS TO GROUP CARE FACILITIES

The frequency of visiting each home by our staff varies with the number of homes carried by each caseworker and if the caseload has coverage. Workers attempt to visit each home at least once a month. However, authorizations of payment have taken priority over visiting. In the Sheltered Care facilities, visits to the facility average three (3) times per month. Although four (4) have not been visited since September 1970, one (1) since October 1970, and four (4) since December 1970. For the larger facilities (100 or more recipients) some are visited several times a month. For the smaller facilities, once every two or three months. In the Private Institutions, frequent visiting is not that essential due to the stable residential population, excellent staffing, services provided, care rendered and programs available for the residents.

Insofar as the proprietary Nursing Homes are concerned, where the caseloads are covered by workers with even minimum experience, our records indicate that visits have been made at least once per month. With large facilities where there is a greater degree of patient mobility as in the ECF homes, visits are made two and three times per month or more. We have two large homes that have two workers assigned and visits to these homes are more frequent. One home (Burnside—43 patients) has not been visited since July 1970. This caseload has been uncovered for one year. A visit to this home is scheduled for March 8, 1971. The other homes have been visited at least once within the past three months. There are some homes located in less desirable neighborhoods where there is a reluctance on the part of some staff members to

visit with any degree of regularity. It has been difficult to assign caseworkers to such caseloads.

In these instances, alternate plans are devised where another caseworker or two (2) or a supervisor will make a visit. However, these visits also are not made with any regularity. We fully recognize that very often these are the homes that require more frequent investigation of conditions due to the fact that these facilities are older and less adequately staffed.

In an effort to cope with this problem, our current plan provides for the investigators assigned to Nursing Home Service to acccompany the worker on these visits when they do not feel secure in making these visits alone.

Frequency of Caseworkers' Visits to Group Care Facilities Mentioned in the Investigation Report:

Name of home	*Number of recipients*
Approved homes, visited monthly	70
Balmoral, last visited in Dec. 1970	74
Beacon Hill, visited monthly	33
Bee Dozier, visited 4 times in 1970	20
Belmont, visited 2 times a month	20
Fullerton, visited weekly	113
Howard Nursing Home, visited monthly	32
Kenmore, visited monthly	101
Largent's visited monthly	31
North Shore, visited monthly	38
Rogers Park, last visited Oct. 1970	54
Royal Oak, 8 visits in 1970	17
Villa Marie, monthly visits in 1970 through Oct. 1970—last visit Jan. 1971	49
Winston Manor, visited weekly	172
Melbourne, visited 2 times a month	77
Park House, monthly visits in 1970 through Oct. 1970—last visit Feb. 1971	71
Monterey Drexel, visited in Dec. 1970 and on Mar. 4, 1971	46
La Grange Convalescent, visited monthly	12
Austin Congress, last visit in Dec. 1970, previous visit June 1970	38
White Haven, 4 visits in 1970	24

II. CASELOAD COVERAGE AT NURSING HOME SERVICE OFFICE

Number of caseloads	*Number uncovered*
Nursing Home and Private Institutions Field Section (41)*	6
Sheltered Care—Field Section (15)	3
Total Field Section (56)	9
Chicago State Hospital Unit (4)	1
Intake Unit (6)	0
Placement Unit (2)	1
Total (68)	11

* Field Sections are the sections composed of caseworkers who actually visit Group Care Facilities. All other units are stationed within the office performing the special functions which are indicated by their titles, i.e., Intake Unit processes new applications; Placement Unit makes arrangements for the placement of all patient recipients into medically licensed Group Care Facilities.

NOTE: Nursing Home Service has an allocation for 16 supervisors. As of September 1970, we have been short two (2), thus creating two uncovered units.

III. NUMBER OF PUBLIC ASSISTANCE RECIPIENTS BY TYPE OF FACILITY AS OF MARCH 1, 1971

Number and type of facility	*Number of public aid recipients*
176, Nursing homes	6, 964
44, Homes for the aged	1, 655
31, sheltered and residential care	2, 747
Total	11, 366

IV. NUMBER OF PATIENTS TRANSFERRED FROM DEPARTMENT OF MENTAL HEALTH

It is extremely difficult to provide even an accurate estimate of the number of residents residing in our facilities that have been placed by or have been transferred from the Department of Mental Health. Therefore, we can only furnish a rough estimate.

1. Sheltered and residential care homes, approximately	2,500
2. Nursing homes, approximately	1,000
Total	3,500

We receive many cases from Kankakee, Kane, Lee and Logan Counties in which State Mental Hospitals are located. In January 1971, we received 89 cases and in February 1971, 79 cases.

V. ENUMERATION OF PROBLEMS AND INCREASED WORK LOAD AT NURSING HOME SERVICE OFFICE SINCE JANUARY 1970

1. Social Security increase in April 1970 retroactive to January 1970 resulting in new "authorizations of payment" on all cases so affected—approximately 5,000 cases.

2. Change in Standards promulgated by Illinois Department of Public Health effective July 1, 1970:

a. Required new revised "Evaluation of Need for Group Care," DPA 184, to be completed in July 1970 on approximately 11,000 cases.

b. Resulted in new cost standard for each patient in Group Care Facility, requiring new authorization of payment on each case to be processed by end of that month.

c. Classification of Group Care Facilities into three levels of care providing for three different rate schedules. This created situations where people were in beds licensed for a higher level of care than patient actually required. In accordance with DPA policy, facilities and patients were notified by letter throughout the latter half of 1970 that this was considered an "Inappropriate Placement" and the rate needed reduction or patient replaced. This also entailed submitting a monthly report to Medical Administration, IDPA, of each case name, case number, current rate and appropriate rate. In August 1970, there were 2,600 inappropriate placements. Although the number of such situations has been markedly reduced, Nursing Home Service is still currently involved in a number of inappropriately placed patients.

3. Transfer of 1,060 active cases in eight residential care homes from district offices to Nursing Home Service in July 1970.

4. Subsequent transfer of six additional residential care homes to Nursing Home Service during latter part of 1970 and beginning of 1971.

5. Conversion to direct payment—vendor billing for cases in Sheltered Care, Residential Care Homes and Homes for the Aged in August 1970 and September 1970 of approximately 4,000 cases residing in 75 Group Care Facilities. This represented a 63% increase in the number of cases handled by direct billing.

6. Medical Review—Transmittal of Medical Information to the Board of Health on 62 homes for 2,450 patients from November 1970 through February 1971 to date. This type of review will be needed on all licensed medical facilities and will be on a continuing basis.

7. Title VI Review (Done in compliance with Title VI of the Federal Civil Rights Act of 1964)—Completion of 228 "On Site Reviews" during 1970. This is an annual requirement.

8. Increasing number of referrals received for placement in Nursing Homes by Placement Unit: December 1970, 317; January 1971, 459; February 1971, 539.

9. Increased caseloads since January 1, 1970 due to opening of new facilities and the agreement of already existing facilities to accept public assistance cases that formerly would not accept them. No additional staff has been allocated since.

New facilities licensed during 1970

Facility	*Number of public assistance patients*
Four Seasons Nursing Center of Hazel Crest, Ill	100
Hyde Park Nursing Center, Inc	131
Briarwood Nursing Home	72
Approved Homes, Inc	70
Belden Annex	47
Bethany Terrace	17
Hearthside Nursing Home	45
Royal Oak Convalescent and Geriatric Center	6
Fellowship House	2
Fleetwood	45
Old Orchard Manor	0
Wellington Plaza	3
Carlton House	0
Niles Manor Nursing Home	0
Normandy House	3
Birchwood Pavilion	50
Michigan Terrace	0
Michigan Manor	16
Edgewater Manor	5
First Church of Deliverance	0
Bethune Plaza	200
Total	812

10. Many problems in processing vendor billing authorizations and payments continue to exist. Currently, we are making payment on approximately 12,000 cases and in order to do so, process at least 6,000 "Payment Authorizations" per month through our Financial Unit in order to provide valid information to 249 facilities for payment for 13,000 public aid clients and our office processing unit. Of the 6,000 authorizations processed, approximately 4,500 per month are authorizations for 8,897 clients in 189 homes for the aged, sheltered and residential care homes and proprietary nursing homes whose payments are made on a list billing and forwarded from Nursing Home Service to our Springfield Office for payment. Approximately 1,500 of the 6,000 authorizations per month are for 4,222 clients for which 60 certified Extended Care Facilities are entitled to payment through a fiscal intermediary.

Although the number of inexperienced financial processing clerks has been at an all-time high for this office due to resignations and transfers due to reclassifications, bills received each month for approximately 9,000 clients are still being processed for validation of general accuracy, eligibility, correct case I.D. number, and name spelling, point count and computation of pro-rated costs for partial months. This must be done within the 3 working day allotted period, as they are due in Springfield by the 5th working day.

11. Staff in the Unit at Chicago State Hospital has cooperated with the Geriatric Placement Pilot Project in the placement of 669 persons from the hospital into the community since November 1969.

Intake in that Unit has risen 43% thus far in 1971 over 1970.

12. Intake has increased 30% in the period September 1, 1970 through February 28, 1971 over February 1, 1970 through August 31, 1970 with no increased allocation. An additional worker, therefore, had to be transferred to the Intake Unit from the Field Section.

Attachment 2

March 22, 1971

Mrs. Margaret W. Childs,
Chief,
Bureau of Medical Assistance Services
Mrs. Leona M. Levin,
Supervisor,
Nursing Home Service

Description of Field Caseworker's Job at Nursing Home Service—Public Assistance Division—Bureau of Medical Assistance Services.

I. TYPES OF CASES CARRIED AT NURSING HOME SERVICE

A. Public Assistance recipients and applicants residing in a nursing home licensed as a medical facility by the Illinois Department of Public Health.

B. Public Assistance recipients and applicants residing in a Sheltered Care Facility licensed as above. This group also includes facilities that qualify for the Sheltered Care rate and have met all requirements for licensure except for zoning.

C. Public Assistance recipients and applicants in non-profit nursing homes and Homes for the Aged Licensed as a medical facility. These homes may have a sheltered care section and/or a nursing section.

D. Public Assistance recipients and applicants over age 65 residing in a state mental hospital or TB hospital.

E. Public Assistance recipients requiring nursing or sheltered care in a private home "not subject to licensing."

F. Adult retardates now residing in group care facilities outside the state.

II. CASEWORKER'S RESPONSIBILITIES

A. Visit to Patient In Group Care Facility

1. Interview patient as part of determination or redetermination of eligibility.

2. Determine need for special items relative to glasses, dental care, special appliances; etc.

3. Inquire of patient as to his receipt of his personal allowance, impressions of adequacy of food, frequency of doctor's visits, socialization needs, contact with relatives, and general overall adjustment in the home.

B. Caseworker's Collateral Contacts in the Facility

1. Reading of Patient's Charts:

a. Check for name of doctor and frequency of his visits, and if doctor makes notations on charts, regarding diagnosis, medications, changes in patient's condition, recommendations for rehabilitation and therapy, injections, special diets, oxygen, dressings, etc.

b. Check nursing notes to determine that medical recommendations are followed up and charted, and special needs and problems of patients regarding assistance with feeding, dressing, walking; problems of incontinence, and behavior which require greater supervision and care of patient.

c. Interview with head nurse for assistance in reading and interpretation of the medial records—discussion of patient and problem areas.

2. Evaluation of Need for Care—DPA 184:

a. Based on documented medical data and caseworkers observations of patient, a point count is arrived at and a determination made of the Level of Care required, (Skilled, Intermediate, or Sheltered Care using one of three different rate schedules).

b. Required at least every 90 days for skilled care, six (6) months for others.

3. Interview with Administrator:

a. Discussion of new admissions, dates of discharge, deaths, hospitalizations and problem patients.

b. Discussion of patients income such as Social Security, VA benefits, etc., and the facilities shared responsibility with agency to notify any representative payee or relative who is handling the funds that the income is to be applied to cost of care.

c. Discussion and examination of the homes's record keeping regarding the handling and disbursement of clients monthly personal allowance.

d. Discussion and interpretation to home regarding keeping accurate financial records, to insure submittal of correct billings, admission dates, medical charting, prompt submittal of correct information regarding income, etc.

C. Recording of Visit in Recipient's Case Record

D. Recording in the Home Record Folder

1. Periodic entries need to be made regarding problem areas, complaints received, caseworker's observations, particularly if unsatisfactory regarding quality of nursing care and supervision provided, with administrators, poor hygiene, insufficient staff, health and safety hazards.

2. Evaluation of whether services being paid for are actually provided i.e. rehabilitation nursing and activity programs.

E. Follow-Up in Office

1. Complaints regarding the facility may require:

a. Private interview with administrator and our administrative staff in office or in field.

b. Notification to Health Department by telephone and confirmed by letter.

2. Submit DPA 184 to Medical Department for initial approval of point level determination or for replacement of patient.

3. Upon receipt of returned DPA 184, caseworker will immediately initiate CCPA Form 551 or DPA Form 311 which is our notification of payment rate to the facility.

a. DPA Form 311 must be received by facility by the end of the month as they cannot submit bill to fiscal intermediary any later than the fourth day of the following month in order to receive payment within that month: 311 prepared in quintuplicate—one (1) to facility; one (1) to DPA; one (1) to Fiscal Intermediary; one (1) to Financial for ECF file; one (1) for case record.

b. CCPA Form 551 prepared in duplicate—one (1) to facility and one (1) to Financial. Form 551 must be received prior to end of month to be included in billing to Nursing Home Service due the first working day of the following month.

4. There is a heavy and continuous flow of payment authorizations initiated by the caseworker. A new payment authorization is required for each patient for:

a. Entry into and return from hospital.

b. Discharge from facility.

c. Admission to another facility.

d. Change in standards for the Personal Allowance.

e. Change in income available.

f. Decrease or increase in cost standard.

g. Approval or loss of "shelter factor" allowance—approval is usually retroactive.

h. Approval or loss of rehabilitation nursing and activity allowance approval is usually retroactive.

i. Approval or loss of social rehabilitation allowance.

j. If a facility becomes decertified for medicare, new payment authorization form is necessary as 551 replaces 311 for each patient.

k. Patient whose medicare benefits in nursing home are exhausted and goes on to a point count.

l. Mass increase in Social Security Benefits.

III. SOME MAJOR PROBLEM AREAS CONFRONTING NURSING HOME SERVICE CASEWORKER

A. *Point Count System.* This has been a major source of conflict between the facilities and our staff. We find that many of the homes that are generally known to provide excellent to superior care are unwilling to take a patient who does not have a relative high point count. The bulk of patients fall into just basic nursing care.

Then some administrators attempt to convince caseworkers of need for high point count without adequate documentation on medical forms. If higher point count not received, then home asks that patient be placed elsewhere.

B. *Request for Re-evaluation.* Many homes persistently request re-evaluation of point count immediately upon placement of patient in their facility.

C. Inadequate or inefficient bookkeeping methods by the facility creating errors in billings, combined with homes failure to collect Social Security income of patient which we have budgeted. Since many homes do not make an effort to collect income and consider this income unavailable, the caseworker is badgered to authorize the deficit in payment.

D. Due to physical and/or mental disabilities many patients are unable to adequately communicate either their needs or factors affecting their eligibility to the caseworker.

Attachment 3

INTER-OFFICE MEMORANDUM

MARCH 24, 1971.

COOK COUNTY DEPARTMENT OF PUBLIC AID PUBLIC ASSISTANCE DIVISION

To: Mr. Jerome Gross, Adm. Assistant.
From: Mrs. Margaret W. Childs, Chief.
Subject: Information for Legislative Hearing on Nursing Home Care.

On February 1, 1968, the Illinois Department of Public Aid instituted a point-count system for determining the kind and amount of care required by each recipient in nursing homes and the amount of payment to be made. This system was extended to licensed sheltered care homes and Homes for the Aged, (the latter having been previously paid on a cost basis) in July 1970.

The point-count method provides for the assignment of a point value for each item of care, from assistance with feeding and ambulation to suctioning, oxygen and comprehensive dressings for abrasions, sores, etc. A dollar figure is assigned to each point with a differential of $6.00 per point, and the total point count supposedly accurately reflects the kind of care required and definitely determines the amount to be paid for the patient's care. In addition to the amount paid on the basis of the total points given, an extra amount is added to the payment for each patient and paid the Home for what is called "a shelter factor cost" when the Home has been certified by the Department of Public Health as meeting certain criteria. Another additional payment is made on each case to homes that have a Health Department approved Activity Program. These additional allowances are over and above the amount computed on the point-count system. The Base rate for Homes that are certified by the Health Department as having a Rehabilitation Nursing and Activity Programs is higher than other homes. although the same $6.00 differential per point applies. O. B. 70.38 giving instructions regarding the use of the system and copies of Form 184, Evaluation of Need for Group Care attached.*)

The initiation of the point-count system created and continues to produce problems for the County Department staff and for the nursing homes. It has led to continuous haggling and bickering on the part of many nursing home operators over small items such as whether a patient requires minimum assistance with feeding (which is a 1 point count) or requires part-time assistance with feeding by staff (which is point 2). Since many infirm and/or senile patients may indeed feed themselves one day and require considerable assistance from staff on another, this can be argued indefinitely. Likewise, the behavior of a patient may fluctuate back and forth from requiring occasional supervision to requiring frequent or constant direction and guidance, hence creating a basis for protest of the lower point-count.

The caseworker's assessment of the point count care is based upon her review of the nursing home chart along with her observation of the patient, and her discussion with him regarding the care being provided. Unless a high-point care count, is given resulting in payment of over $300.00, many nursing home proprietors always object to the total point count and request an immediate re-evaluation of the patient's condition and the care required. This results in the caseworker having to re-evaluate the same case many times and frequently also necessitate sending a special team of the Supervising caseworker or Assistant D. O. Supervisor, the Medical Social Worker or our Nurse II to the home to review the case and discuss the point counts with the Nursing Home operator. In addition. it produces numerous telephone calls and letters of protest from the Home to the Supervisor of Nursing Home Service and all other administrative staff.

The net result of the activity occasioned by the use of the point-count system is that the caseworker is placed in the position of spending most of her time dealing with the Nursing Home operator about the point count and payment rate rather than providing services to the recipient-patient. The amount of paper work involved and physical effort involved in recomputing and re-evaluating the point count assigned to patients in home has been and is tremendous.

*Retained in committee files.

Another complicating factor is the requirement that each patient always be in a "bed" licensed to provide the level of care he requires and that when a patient requires care at a level different than that for which the facility (or in multiple level homes, the bed) is licensed to provide, he be moved to a facility or bed licensed for the level of care he needs. This is not such a problem when the patient's condition deteriorates and he needs more care and thus has to be moved to a home that can provide more intensive nursing care. It does, however, become a real problem when his condition improves. Although policy provides that in such instances he may remain in the home and/or in bed if the facility is willing to accept a reduced rate of payment from the Department, as occasioned by the changes in the point-count, few homes feel that they can afford this and, therefore, ask that the patient be moved. This means, of course, that a patient who enters a nursing home and improves, must be moved from this facility when his condition improves to the point that he needs only shelter home care, even though he may have adjusted to the facility, made friends with staff and other patients and want to stay put. Such moves create problems not only because of the shortage of beds in the community, but also it results in shipping patients about like cabbages or luggage without regard for their psychological and emotional welfare.

ITEM 2. PREPARED STATEMENT OF JEROME M. COMAR, PRESIDENT, JEWISH FEDERATION OF METROPOLITAN CHICAGO

The Jewish Federation of Metropolitan Chicago is pleased to forward to you this statement which represents our views concerning the care of the aged rendered by nursing homes in Chicago.

As a philanthropic agency that provides nursing care to over 600 older persons, and specialized services to thousands of other elderly persons, we hope that we can provide additional insight concerning this complex problem.

The Jewish Federation of Metropolitan Chicago shares the concern of our community about the abuses ina number of Chicagoland nursing homes. We urge that every effort be made to correct these situations and that the resources of this city, this state, and the nation be mobilized in an all out effort to provide to our older citizens those economic, social, and health programs that will enhance their lives and help them remain independent and functioning members of our community.

THE PROBLEM

The Jewish Federation operates three Homes for Aged. One of these Homes, the Drexel Home, is celebrating its 80th year of providing service to the elderly.

We are the first to recognize that we too could improve our service, but we have reason to believe that we do provide some of the best long term care programs for the elderly in this state, because we try to concern ourselves with the total needs of the older person. In meeting these needs we have tried to develop social and medical programs of the best possible standards, maintained by a highly qualified staff under full time medical and administrative supervision.

The issue is not one of supporting super-deluxe care, but realistically financing the cost of modern humane care as provided by agencies and organizations that are committed to such standards. While the State agencies sometimes point to our program as a model program, they remind us that we must compete under their "point" system, with the much more limited community nursing programs, some of which are under investigation today for providing substandard care. The State naturally welcomes our efforts to serve the poor older person, but progressively places more and more of the burden for the delivery of decent care on charitably funded agencies like the Federation. In 1966, prior to Medicare and Medicaid, the Jewish Federation appropriated $845,975 to meet the deficits of the three Federation Homes for Aged. In 1971, the Federation expects to appropriate in excess of $1,800,000 to meet the deficits of the Homes for Aged with no real change in standards of service. With ¾ of our residents on public assistance and the rest having incomes at the poverty level, we are in effect, buffering 600 older people against a state supported sub-standard program of care for the elderly poor.

Just recently the State Department of Public Aid has made retroactive reductions in rates of subsidy for aged patients to January 1971. In addition, Medicare continually alters its regulations so as to reduce the level of subsidy, and has even requested from the Federation Homes for Aged some retroactive reimbursement going back as far as 1967. Although Medicare officials believe they are technically correct in their interpretation of administrative rules, they are actually asking Federation to increase our subsidy for 1967 for which we already allocated $1,108,551.

The community is demanding that abuses be corrected, but the state and federal government are forcing many charitably funded programs either to reduce services and provide something less than modern humane care, limit the number of public aid recipients that can be admitted to the program, or close the doors of their institutions completely.

The Jewish Federation of Chicago has had to reduce some of its services to the aged since we are indeed hard pressed by these circumstances, in view of our many other health and welfare responsibilities in this community.

For several years the Federation has attempted to resolve many of these financial and administrative problems. We have been aware that in allocating such large sums to long term care facilities, we were not providing adequately for the needs of the thousands of elderly who are attempting to stay out of nursing homes and homes for aged. Therefore, without denying the need for long term care programs, the Federation initiated an extensive study to determine the best way of providing care and service to the elderly.

We have developed a Jewish Community Plan for the Elderly, which links together the skills and resources of the Federation and its affiliated agencies, to provide to the elderly such community based services as home medical care, housekeeping services, meal services, and telephone reassurance services. The Plan will provide for various types of housing, including small Group Living Homes, and a variety of personal assistance programs that will make it possible for the elderly to remain in the community. The Plan offers evaluation services and comprehensive professional services involving both health and social service personnel. And finally, the Plan spells out the development of a comprehensive health care program—both inpatient and outpatient, short term care and long term care, with an orientation towards preventive care.

Although the Plan is yet to be tested, we are convinced that we shall be able to develop a unified policy concerning service to the elderly, avoid duplication of effort, and better utilize the resources available to us in serving the needs of the elderly. We also believe that we can provide a new model for caring for so-called chronically ill older persons. Of singular importance is our commitment to individual planning for and with the older person.

The Jewish Federation is committed to implementing this new program, but we are also aware that the low priority given to the needs of our elderly by our national, state, and local government units will make this task difficult.

In exposing the abuses in nursing homes, the media have pointed to the poor quality of staff serving elderly in these nursing facilities.

Federation and other private agencies spend vast sums of money on training programs which include ongoing in-service training programs for staff. Yet, the Department of Public Aid will not reimburse us for such costs even though in the long run, this is the only way to assure better care for the elderly.

At this very time we understand the Federal Administration has proposed cuts in training programs from $2½ million to $1.8 million. It should be noted that the authorization for research and development in the Older American Act for 1972 was $20 million but only $6.6 million was appropriated in the current budget year for research and training.

If we do not create additional service resources for the elderly (low cost housing, some health services, home assistance services, transportation services, new types of in-patient nursing and health care programs, etc.) we can anticipate a substantial increase in the number of older persons who will require institutional care in the near future.

Shifting older persons from one institution to another institutional type facility (i.e., so called halfway houses) does not solve the basic problem.

We suggest that even as we take measures to eliminate the abuses in nursing homes, we recognize the problem for what it is: the failure of our country, our state, and our community truly to meet the needs of our elderly.

ITEM 3. PREPARED STATEMENT OF JANE GARRETTSON, DIRECTOR, SERVICE FOR AGED, FAMILY SERVICE BUREAU, UNITED CHARITIES OF CHICAGO

I am the Director of the Service for the Aged of the Family Service Bureau of United Charities of Chicago. United Charities is the oldest and largest non-sectarian voluntary family agency in the city.

Since its founding in 1953, Service for the Aged has provided planning and counseling services to thousands of aged people and their families. Many aged people come to us when they are having medical problems and are having difficulty managing independent living outside a nursing home. Our goals are always to help aged people remain in the community and often this is not only possible but the best solution to the problems they are having. In some instances, however, our service involves helping them to decide and plan a move to a nursing home, and to continue casework after the move has been made. We thus have had many opportunities to look at the problem from both sides.

Over a period of years we have served aged people in the best and in the worst of nursing homes. We deplore the poor as well as mediocre care in many nursing homes in Chicago. The Board and staff of United Charities are committed to good services to the aged, both in and out of nursing homes. They affirm that medical concerns, while major, are only a part and not the totality of the lives of the aged. Life goes on for them—with daily cares, daily responsibilities. The question is: How can we make these lives meaningful?

We have sought this opportunity to be heard by the Senate Committee because we believe that the time has come when there must be a concerted effort for improved care for the ill aged. We wish to participate in this endeavor. We wish to make it clear that ours is a community service. We have no vested interest in any nursing home or institution.

I have chosen to use my limited time to speak of social services as one important component in good nursing home care. Such care is not and should not be considered as merely custodial and overwhelmingly medical in its concerns. United Charities has experience and expertise in social services. We are afraid that the role of social service might go unnoticed in the presure of the many serious issues under consideration at these hearings.

Through social services we draw upon our knowledge of the human and psychological needs of each individual so that, illness notwithstanding, he or she is able to understand and cope with the problems of daily living and to make the best life that he can in a nursing home. These services offer many of the aged ill chances to overcome in part their lives of protracted loneliness, ineffectuality and despair. When we fail to provide them, we are not caring for them: We are condemning them.

In recent years, as never before, social workers in Chicago and across the country have been doing some creative and valuable work in institutional care for the aged. In non-profit homes, in a few proprietary nursing homes, social work consultation has made significant contributions towards training staff in the non-medical needs of the aged. Recently in my own Department and in some instituions and agencies there has been development of new skills and services that have great potential for improved services to the aged and their families.

The terrible stress of a move to a nursing home for an ill aged person is well known. There is now evidence that this stress may contribute to a high death rate. The social worker helps the aged person grapple with this stress. She helps the aged person take charge of his affairs to the top of his ability even though he may be bed-ridden. She works to bend the institutional setting to accommodate to the life style of the individual patient. We believe that such social services make significant contributions to mental health.

To my certain knowledge proprietary nursing homes in Chicago, except for two or three rare exceptions, have made no genuine effort to incorporate social services into their programs. There has been only token compliance with Federal regulations requiring social services in Medicare approved homes.

I can only sketch out here some of the contributing factors to lack of social services in nursing homes and poor care generally.

Federal regulations requiring social services in long term care facilities for certification for Medicare, and now the new State regulations requiring social services in all nursing homes are so ambiguous that they invite poor standards in social services, and token compliance.

Any number of good regulations and the most conscientious and trained inspectors will fail until the nursing home industry gets the message loud and clear that the public demands a full range of good quality care for the ill aged. Only then will there be trained knowledgeable administrators in a position to seek out the best of medical care, nursing care and social services.

Public interest in good nursing home care is illusive. All of us have heard a great deal about the low priorities assigned to the aged in this country. I believe that this is true. Yet any one of us or members of our family could at some time require nursing home care. It puzzles me that we are not even able to act on self-interest. Public information and education on this vital issue must be forthright, thorough and continuous. It cannot be left to brief periodic newspaper exposes at 10-year intervals, as in Chicago. Good nursing home care is costly. A substantial part of the payment for nursing home care must come from public funds. Only informed concerned taxpayers will be willing to pay for good care.

I am obliged to add that my own profession, like other professions, has not given priorities to services to the aged. United Charities has taken leadership in this community in stimulating an interest in good services to the aged, but this is one small effort. On a national, state, and local level the social work professional must be encouraged, must be pressed, must be needled, must be drafted to the field of aging. I might add that as with all other disadvantaged groups, new and experimental social services to the aged will have to be subsidized.

We are here today because we believe that Federal and State Legislators, public officials and agencies, provide agencies and organizations, and more important, concerned citizens groups must join forces and work for not mediocre, but good care for the ill aged. United Charities is seeking allies and any avenue in which our expertise and commitment to good services can be effectively used in this cause

I have one specific suggestion to the Committee for immediate action. Poor nursing home care is a national problem. In the coming months there will be regional and state meetings throughout the country in preparation for the White House Conference in Washington in November of this year. This Committee could recommend that the Administration on Aging make the Health Section of the local and state meeting an open forum for discussion of the need for good nursing home care. You have an opportunity, I believe, to make the White House Conference in November a national forum for discussion and public education and for recommendations for action. I urge you to take advantage of it!

ITEM 4. PREPARED STATEMENT OF WM. L. RUTHERFORD, PROBLEMS OF THE AGED—THE NURSING HOME PROBLEM AND OTHER PROBLEMS OF THE AGED

Your effort is quite well anticipated by the position paper of the Technical Section on Planning for the November 1971 White House Conference on Aging of which section I am chairman. A copy is attached in the hope it will be useful in this and in longer range similar matters that will surely come before you. (Exhibit 1).[1]

We are indeed grateful that you will give your time to carefully inquire into this meaningful, complex and timely subject. Because of your personal integrity, we are willing to believe that it will be more than the usual whitewash with contorted outpourings of platitudes, unresponsive regulations and statutes that usually serve other purposes in the guise of a social correction. We respectfully urge that the problem of the nursing homes is but a tip of the iceberg that discloses the presence of vastly greater and more complicated unspoken problems and reasons for them. We respectfully urge the inquiry not be with tunnel vision at an isolated thread in the cloth, but instead recognize the enormous impact of the loss of public confidence in government, the impositions from a number of agencies and a recognition of the even worse that is to follow.

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[1] The work paper is not included, but if requested can be mailed under separate cover, because it was due to be printed on January 13, 1971, as the committee action was completed December 31, 1970; but as often happens with Federal government programs the government does not respond on the time given to citizens.

Important as the subject is, many of us would not personally have wanted to respond were it not for our confidence in you personally and your sense of fair play.

The problems such as licensing, determination of quality and quantity of staff, the desolate living for unfortunate individuals, cruel opportunism, including probable syndicated criminal involvement are symptoms of the disease and not the causes of the real problems that must be exposed and already difficult because of the great general apathy and the ususal pursuit of publicity and political purpose.

To seek information or solutions on nursing home problems without recognizing the other factors of which they are a part is like curing only the little finger of a leper.

Others, more expert and closely related to the immediate operating problems that I, can better inform you on the location, size, management and conditions of particular institutions. My principal concern is to be sure that all understand the enormous impact upon this problem because of the misuse of government in surprising places. It includes exploding awareness and public loss of faith in governmental processes, even including some that are decent and undeserving of fear. The expenditure of greater sums of money by government to hire more people, print and promulgate more un-understandable regulations and buck passing will no longer suffice. The only hope for nursing home and geriatric problems generally lie in compassionate intelligent activity by concerned citizens at the grass roots where the human problems exist—with support instead of hindrance from governmental sources.

Let me illustrate. I quote the attached statement (Exhibit 2)[2] of the Federal Commissioner on Aging, Mr. John Martin, very correctly pointing out an excellent form of service to the elderly with greater humaneness, with vastly less cost to the individual or the taxpayer, and in many cases eliminating dependence and individual bankruptcy attendant with long physical custodial care. It is Home Care such as given by the Visiting Nurses Association. The Federal government itself incurred services and then avoided payment of its medicare obligations. Exhibit 3* points out how this resulted in agencies being forced into virtual bankruptcy in the fall of 1970. Visiting Nurse staffs are already cut in half as a result. Either there will be no care for many needy individuals or the care will be given in institutions at many times the cost of the Visiting Nurse service—and with less effectiveness and less humanity. (Exhibit 4)[2] . Add these to the incomprehensible "Tax Reform Act" which the American Bar Association describes as the death of American philanthropy within the next ten years. The result is already chillingly evident that the private donations to many forms of charity are shriveling up. We have a needless crisis and shortage at a time we need support the most. The problem is increased by government rather than helped.

The foundation I have known since 1939 in Peoria, Illinois, has bulwarked the Visiting Nurse Association of Peoria for much of 20 years, including programs that have been copied on state and national levels in the assistance of better rehabilitation care, not only in Home Care under VNA but in nursing homes and county institutions as a demonstration project for the federal government office of Vocational Rehabilitation under Miss Mary Switzer and the Illinois Department of Public Aid. This sort of innovative cooperative accomplishment is now virtually illegal under the new Tax Law changes. To assist other groups and undertake innovative effectual action not only destroys a foundation's "Operating Foundation Status" with serious penalties to the foundation and its donors, but the tactics of some agents of the Treasury Department of the United States further guarantees timidity and bureaucratic non-accomplishment as the only way to foundation survival.

May I respectfully submit, Senators, copies of my earlier correspondence with Senator Percy on this subject which illustrate in greater breadth from operations in Peoria, Illinois, what the Tax Reform Act is doing to philanthropy. (Exhibit 5)[2] The Peoria Foundation was the first foundation in America whose major focuses were the aged and handicapped. It is clear no such organization can today expect to survive in the face of current federal pressures.

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[2] Retained in committee files.

It is impossible to overstate the case. For most human beings the impulse to give to charity, of time and money is all too easy to discourage. The crisis in our American Universities is well publicized and is a cross section of American philanthropy at the moment. To lose donors, to literally penalize and treat them far worse than any criminal today is treated, most effectively discourages giving and participation. A nation's worst enemies could not better plan or hope for more than the Tax Reform Act and the conduct of the United States Treasury Department in too much of its current operations in America.

On this latter subject, upon which most people are literally terrified to speak of for fear of further examinations and recriminations, you must not ignore. It is *not* removed from the investigation of deplorable conditions of the care of elderly people and the inadequacy of clean, decent, kindly, fairly priced nursing homes and custodial facilities. The concern about organized crime's participation in the care of the elderly will not be solved until the alliance between organized crime and the Federal Treasury Department is honestly exposed and corrected. This is the "primary cancer" and the appearance of these undesirable problems in the nursing home field is but the metastatic lesion that has followed. It has grown hidden in the combination of patronage, politics, political corruption and U. S. Treasury Department behavior. No person who practices law as I have since 1939 or who has thought about the continued growth of crime in America can reasonably believe there are not cozy relationships between organized crime and the U. S. Treasury Department. Observe the abusive behavior toward witnesses and taxpayers, alike, including terrified old widows and widowers that I have watched subjected to inquisitions—and at the same time no criminal element in our community is ever tried on tax matters. Crime could not exist if the expenses and deductions were audited as are the ordinary non-gun-carrying citizens. There is no shortage of agents when it comes to examining the decent people. That same agency has for over 30 years had the responsibility of narcotics control and the absence of arrests, absence of prosecutions, absence of any effective protection of the public typifies its stewardship. The public belief that organized crime participates in narcotics does not seem unreasonable and the results horrendously evident to even the most calloused and indifferent. These are the things the public sees that brings about the mistrust in government, the same public that sees the trickery of change of rules in the middle of the game, and harsh pressure to extract the last dime from the citizen, and complete indifference toward government misuse and waste without accountibility or personal responsibility.

A voter need not have reasons; he can vote his feelings. With the many failures by government in the social fields where can you look at any subject with any satisfaction? Boil things down to simple understandability. What is the problem, how much money has been spent, who has really been benefited and how much real good has been accomplished. Except for those that sell services, equipment and get jobs themselves and for their friends, and temporary political expediency, what social problem can anyone find that has been benefited by the Federal bureaucracy? How have the staffs and the budgets mushroomed?

As the White House Conference on Aging position paper states, what purpose is there to legislating new standards and regulations with no attention to adequate supply of trained staff, for example.

Aside from immediate governmental relationships, look at medical malpractice insurance problems. An answer must be found at the legislative level for reasonable standards of protection for patients and the elimination of the astronomical increase—to racket proportions—of malpractice claims. Against hospitals, physicians and medical professionals alike. Not only do these malpractice problems greatly increase the cost of medical care, they are reaching the point where care will be denied deserving people because of such dangers of unfair malpractice claims. I am told such insurance cannot even be purchased by physicians in Hawaii and several states already. The cost of insurance is sky-rocketing elsewhere. The cost is added to the patient's expenses. A physician is almost forced to avoid taking care of a high risk patient. It is commonly understood that many extra days of patient care, many needless examinations and laboratory procedures are ordered as precautionary defensive measures by physicians. These clutter the hospitals and the laboratories, great add to cost whether borne by governmental or insurance or individual patients and deprive other patients of the time the physician could be giving to the

practice of medicine rather than defensive maneuvering. This danger is discouraging good young people from entering the medical field. I personally know of some well-trained, brilliant young doctors and medical students that have decided not to treat patients but to go into other vocations. The monetary rewards in the practice of medicine are still great for those who seek *only* that. The sensitive, dedicated person who does not desire to partake of the rough game of high charges and high risk is foolish to risk his life savings, his personal reputation, and the satisfaction of helping others by simply being the target of an unscrupulous attorney and an ungrateful patient. Even threats of malpractice are used to avoid the payment of legitimate bills. These factors contribute greatly to the decreased quality and availability of medical care especially for those in later years and of more modest means.

Government itself is on trial. Few people believe that even lip service is given to "government for the people". Government pronouncements of intention and action alike are considered as self-serving window dressing and half truths at best. For every dime that gets put to some form of use, dollars have been extracted from people's savings. The elimination of needless layers, not the imposition of new ones, should be a realistic objective. Even the simplest obligation of government, physical safety of innocent citizens on the street, has been abandoned. Public confidence is past and public patience is almost there. An effective house clearing at all governmental levels is long overdue. A simple first step in the right direction will be the day governmental agencies must respond to taxpayers in the same timetable taxpayers are required to respond to government. When penalties against the misuse of tax dollars are as treat as the penalties against tax fraud. In short, when the taxpayer gets fair value for his money, there are responsibilities and stewardship with full disclosure of all governmental levels, and the relationships between crime, its patronage aspects and politics instead of good government shall have been corrected. At this point there is very little that points toward encouragement or confidence.

Testimony of Wm. L. Rutherford, Attorney at Law, Peoria, Illinois, in his individual capacity. Experience in the field includes: Chairman of the Technical Committee on Planning for the 1971 White House Conference on Aging; Participant in the two previous White House Conferences on Aging; Previous Member of the Illinois State Legislative Counsel on Aging; Chairman of the Governor's Advisory Council on Aging under Governors Stevenson, Stratton, Kerner and Shapiro; Co-Founder and Director of the Institute of Physical Medicine and Rehabilitation of Peoria; Chairman of the Planning Committee of the Institute of Physical Medicine and Rehabilitation; Member of Joint Operating Board of Forest Park Home, St. Francis Hospital, Peoria, Illinois; 1960–1968 Member State of Illinois Board of Vocational Rehabilitation and Education; Previous Member Illinois Public Aid Commission; Chairman, Illinois Public Aid Commission's Investigative Committee of Nursing Homes in Illinois; Frequent consultant in hospital rehabilitation, geriatric and community planning; Attorney, Director and managing officer of a Peoria, Illinois, Foundation (active since 1939 in research, care, treatment and facilities of geriatric and rehabilitation character and the sponsor of Nathan Shock's three volumes of *Bibliography on Gerontology and Geriatrics*, the book—*Trends in Gerontology*, the book—*Housing for the Elderly, European Approach*), etc.: Trustee, Peoria County Board for the Care and Treatment of Mentally Deficient Persons; Chairman, AFL-CIO Local 327 Committee on Chronic Disease under President Eisenhower.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

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

"If there had been time for everyone to speak at the hearing on "Trends in Long-Term Care" in Chicago, Illinois, on April 2 and 3, 1971, I would have said:

NANCY CHISWICK, CHICAGO, ILL.

I believe nursing care should be available at low cost that means more Government support. But, this would have to include a program of stricter regulations and standards. I don't trust individual Medical people to provide good and fair care.

JOHN R. FABRY, CHICAGO, ILL.

The problem facing our public officials on the subject of "Trends in Long-Term Care," is grave. I had the occasion to enter upon homes for the aged because of my profession: I am a Chicago Police Officer. Conditions in these homes are not what I expected to see when I arrived at the scene. I was disgusted when I saw patients just laying on the floor, not being able to get up and not being assisted by the staff of the home. Police service has many facets and when persons in this city call upon us we must respond. But the people who called *were not* staff personnel but *patients* who had been beaten to suppress their efforts to be serviced by the staff. I just feel that if these people are elderly and there are no people to take care of them at their own homes, then it is up to the people in the U.S. to provide for their well-being, and make sure that they are able to be cared for in conditions that are well above the standards that existed in homes I had the occasion to visit. It is a necessity if we are to consider ourselves when we look in the mirror every morning, *Human Beings.*

CAROLEE KAMLAGER, CHICAGO, ILL.

It seems atrocious the mismanagement of funds. More importantly it is a direct contradiction of American goals which Federal, State and local government allow to exist in nursing homes. It is tragic that it took so long to expose this crime against human dignity.

Coming from a small town in central Illinois I know this is not just a Chicago or Cook County problem.

I don't feel Federal control is the answer but rather an intensification of quality on the part of the State board. Quality not quantity is needed. There seems no excuse to pass off the problem as a money-problem, that no funds are available. As the BGA stated some homes manage well on the same amount of money that the poorer managed homes use.

Definitely a crackdown needs to be taken. Ideally I would like to see all nursing homes under Government management but the possibility is minimal. Human life must be respected.

ARTHUR J. LEARY, RIVERDALE, ILL.

Congratulations on your good work! I am sure that Federal legislation and control is sorely needed to solve the nursing home problem. The costs of nursing home care is beyond the reach of the average citizen. My mother has been in nursing homes for ten years. The annual cost for this service is presently at about $7,000. The care she is receiving is very limited, and in some cases, nonexistent.

The fire danger is great. From building, old, no sprinkler system, narrow halls and stairways, non ambulatory patients on second floor—no elevator. Approved by State of Illinois, despite violation of standards. Colonial Convalescent Home, Route 6, South Holland, Illinois.

LAURINA MCNEILLY, CHICAGO, ILL.

It is indeed sad that such an attempt to better the conditions for the aged should be reduced to merely recitations of personal experiences and endless statements of each witnesses qualifications. While I cannot recommend we rush blindly into "cleaning out" and "fixing up" of our nursing homes, I cannot see the value of the senseless ritual that took place this April 2. We surely recognize we have a terrible problem but how can one see the value in such formalities of address, etc. Perhaps the only valuable testimony was the content presented by the BGA. Much of the remainder was purely generalization and speculation and "hot air." Is this the process by which America "solves" her problems?

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