TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-SECOND CONGRESS

SECOND SESSION

PART 20—WASHINGTON, D.C.

(Access of Minority Groups to Nursing Homes)

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Part 1. Washington, D.C., July 30, 1969
Part 2. St. Petersburg, Fla., January 9, 1970
Part 3. Hartford, Conn., January 15, 1970
Part 4. Washington, D.C., February 9, 1970 (Marietta Fire)
Part 5. Washington, D.C., February 10, 1970 (Marietta Fire)
Part 6. San Francisco, Calif., February 12, 1970
Part 7. Salt Lake City, Utah, February 13, 1970
Part 8. Washington, D.C., May 7, 1970
Part 9. Washington, D.C., August 19, 1970 (Salmonella)
Part 10. Washington, D.C., December 14, 1970 (Salmonella)
Part 11. Washington, D.C., December 17, 1970
Part 12. Chicago, Ill., April 2, 1971
Part 13. Chicago, Ill., April 3, 1971
Part 14. Washington, D.C., June 15, 1971
Part 15. Chicago, Ill., September 14, 1971
Part 16. Washington, D.C., September 29, 1971 (Lil-Haven Fire)
Part 17. Washington, D.C., October 14, 1971
Part 18. Washington, D.C., October 28, 1971
Part 19. Minneapolis-St. Paul, Minn., November 29, 1971
Part 20. Washington, D.C., August 10, 1972

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[1] Senator Winston Prouty, Vermont, served as ranking minority member of the committee from September 1969, until his death September 10, 1971. Senator Robert T. Stafford, Vermont, was appointed to fill the vacancy on September 17, 1971.

CONTENTS

TRENDS IN LONG-TERM CARE

Access of Minority Groups to Nursing Homes

THURSDAY, AUGUST 10, 1972

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

The subcommittee met at 9:30 a.m., pursuant to call, in room 3110, New Senate Office Building, Hon. Frank E. Moss (chairman) presiding.

Present: Senators Moss, Fong, and Tunney.

Staff members present: William E. Oriol, Staff Director; David A. Affeldt, Chief Counsel; Val J. Halamandaris, Associate Counsel; Ben Yamagata, Professional Staff Member; Robert M. M. Seto, Minority Counsel; and Gerald D. Strickler, Printing Assistant.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. I welcome you here this morning as the Subcommittee on Long-Term Care of the U.S. Senate Committee on Aging meets to consider the important topic of the access of minority groups to nursing homes.

In its previous inquiries the committee has given some attention to this problem and has found data extremely scarce. With this hearing, we hope to focus on the problems of aged and infirm minority group members in a little greater detail.

No series of nursing home hearings would have been complete without adequate attention to these concerns and I am sure that all the members of the committee will look forward to reading the record we establish today.

The central question for discussion at this hearing is: Why are there no members of minority groups in nursing homes? It is a fact that comparatively few blacks, Asians, Indians, or Mexican-Americans are in nursing homes.

For example, Hobart Jackson has provided me with the information that only 3 percent of nursing home residents are blacks. There are perhaps no more than two dozen black nursing home administrators in the United States.

Paradoxically, a disproportionately large number of our 500,000 nursing home employees are members of minority groups. I ask: To what degree can this absence of minority group members be explained by differing social practices?

Is the cost of nursing home care a factor? To what degree is discrimination a bar to the access of minority group members to nursing homes?

With regard to discrimination, nursing homes clearly come within the purview of the 1964 Civil Rights Act. Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color or national origin in any institution which received Federal assistance.

According to former Surgeon General of the United States William H. Stewart, nursing homes receive financial aid from 50 Federal programs. I ask: Is title VI of the Civil Rights Act being enforced?

With regard to cost, I realize that minority groups make up a large segment of the country's poor. However, over 60 percent of our nursing home patients have their care paid for by Medicaid—the welfare nursing home program.

My question is: Might we not expect Medicaid to pay for the nursing care of a fair number of blacks, Indians, Asians and Mexican-Americans?

I hope the witnesses will address themselves to these questions this morning.

Unfortunately, I will not be able to stay for the whole hearing this morning, but I will ask for a representative of each group to come up as a panel before I have to leave for a markup executive session this morning at which I have to be present.

However, I am most anxious to hear from each minority present, with the understanding we will come back and hear them individually. So, I am asking Ron Moore, Jacquelyne Jackson, Sharon Fujii, and Homer Martinez if they would come to the table now and sit here.

I am glad to see that Senator Tunney has joined us. Glad to have you with us, Senator.

Senator TUNNEY. I have a markup session, but I did have some constituents here, and I did want to welcome my friends to your hearing on this important subject.

Senator MOSS. You look after my interest on the highway bill.

Senator TUNNEY. And you look after my senior citizens.

Senator MOSS. We are very pleased to have you each representative of various groups to appear in panel. I would like to have a brief opening statement from each of you.

STATEMENT OF RONALD MOORE, CHAIRMAN, ADVISORY COUNCIL ON ELDERLY AMERICAN INDIANS

Mr. MOORE. Thank you for the opportunity of meeting this morning. I would like to preface my remarks on long-term care for the first American people.

I realize that with changes in society, the Indian people are going to more and more become involved with institutional care. Since I am an Indian, I would like to address my remarks to that minority group. Since I am from Arizona, I would like to focus my attention on Arizona. Arizona has 19 reservations within the State boundaries. On these reservations live 114,000 Indians. According to the 1970 census, this does not include the 50,000 other Indians in the cities.

Out of 220 Indians in nursing home care, we have 20–22 nursing home facilities in Tucson and other metropolitan areas in Arizona. There are only two in Arizona run by Indian people and a job, population, operated nursing home—100 people.

Taking care of the elderly by family still lingers. There is a need for nursing home facilities. Federal money is needed. Nursing homes to be on Indian property have been refused licenses.

On most reservations, you must have a minimum number of people to make it economically feasible to develop. We should start talking in terms of human needs rather than economic needs.

Within the last 2 years, one elderly person, living by himself, got sick one stormy day and was found several days later with pneumonia. One woman who worked with me who died on a Thursday or Friday was not found until the following Tuesday.

Indians refuse to go to nursing homes because they are many hundreds of miles from home reservation.

Senator Moss. Thank you for your opening statement. You indicated that the traditional family life provided that the elderly were taken care of in the family unit.

Is this beginning to change? Is the low number of Indians in nursing homes because of discrimination or because of Indian choice?

Mr. MOORE. This is not discrimination. Indians are not willing to go. They are not willing to assume the financial responsibility. Those in nursing homes now are financed by BIA.

Senator Moss. No nursing homes on the reservations themselves?

Mr. MOORE. One that I know of.

Senator Moss. We will come back to a panel of other Indians who will sit with us later, so I will move along at this time.

I appreciate your giving us a summary of what we may expect later on. I am delighted that Senator Fong has joined us, and I hope he will be able to stay through all of the testimony this morning. I have some markups this morning.

Senator FONG. I have to go to a markup session at 11 o'clock.

Senator Moss. You will find us all under the same kind of compulsion.

Senator FONG. May I ask Mr. Moore one question?

Senator Moss. Surely.

Senator FONG. What was the gist of your statement as far as those Indians outside of reservations in nursing homes?

Mr. MOORE. They are financed by the BIA.

Senator FONG. Do you believe that the Indian Advisory Committee should have some jurisdiction over the matter to take care of the cost? And what is the responsibility of the BIA in regard to those Indians who do not live on reservations?

Mr. MOORE. The Federal Government has made commitments to the Indian people, and those off reservations should be taken care of as well as those on.

Senator Moss. Miss Fujii, will you go on with your statement?

STATEMENT OF SHARON FUJII, CONSULTANT TO KAWABE MEMORIAL HOUSE; DOCTORAL STUDENT, HELLER SCHOOL, BRANDEIS UNIVERSITY

Miss FUJII. I would like to present a general statement about elderly Asian-Americans and nursing home accessibility. I would like to stress very strongly that language and communication play a serious role here.

Most elderly Asian-Americans came as immigrants. They were subjected to many discriminations and they retained foreign languages. As a result, they have really not been able to communicate, to understand, or to be understood.

They have been able to survive perhaps because of this, but at the same time, they have not been able to benefit from many of the services which senior citizens can now utilize. For those who are in nursing homes, they are subjected, because of language, to insensitivities by workers having no understanding of the language or its people. And in some nursing homes where elderly Asians have been found, the absence of bilingual staff contributes to patient neglect, personal frustration with individual ability to function within institutional settings.

In many regards, it is much more desirable to die in one's own apartment or home. Even though skilled nursing care is necessary, it often seems to be much more dignified or preferred among elderly Asian-Americans to die in a hotel room. It is rather unfortunate that the choice should be so limited between dying in a dismal hotel room as opposed to going to a nursing home and receiving skilled nursing care.

We recommend that the following be considered: That there is Federal, State, and local support for research studies so that we can learn more about the problems of elderly Asian-Americans.

Special Demonstration Programs

Along with the need for research, there is need for funds for special demonstration programs to develop and test various long-term care service delivery methods that take into account culture and language. Related to this, there is the need for special demonstration programs for developing alternatives to institutional care. This would include home care programs that offer a range of supportive services to group homes, foster homes for adults, and home delivered meals. These alternatives will enable elderly Asians to remain in the community. Alternatives such as these are more compatible with the cultural tradition of the Asian family.

Added attention should be directed to training nursing home personnel at all levels about minority elderly, and to recruiting bilingual and/or bicultural staff.

There is, as well, a great need to increase the quality of existing health care services. Unfortunately, there is, in section 207 of H.R. 1, now pending before the Senate Finance Committee, a provision which will reduce matching funds to States by one-third for skilled nursing care after 60 days.

I am seriously opposed to this because I think it would affect the quality of care. And if anything, we need more funds to upgrade the quality of care for people who require nursing home care. There should be additional allocations to finance coverage of restorative or therapeutic services and activity programs for patients who have to go to nursing homes. Incentives should also be provided for the construction, rehabilitation or upgrading of nursing home facilities.

In Seattle, for example, there was a nursing home which was in existence since 1945, and primarily served elderly Japanese and Chinese. The facility was forced to close in late 1969 for failing to

meet Washington State safety standards. Had attempts been made to assist this particular nursing home to meet State regulations and had funds been available to cover the costs for improving the physical structure, the closure would have been unnecessary.

In conclusion, nursing homes and other social services are available, but have not been readily accessible to elderly Asian-Americans because of language, cultural differences, and racial discrimination. American society through its institutions and racial discrimination has helped to reinforce these barriers by perpetuating the myths that (1) we, Asian-Americans, have no serious problems; and (2) that we through the extended family system are capable of caring for our elderly. With regard to the latter myth, Asian families have historically cared for their own; however, the complexities of American society, assimilation and racial discrimination have drastically altered our ability to do so.

Senator Moss. Thank you very much, Miss Fujii. I am very interested in your testimony, and am looking forward to the fuller panel discussion, but at the end of your statement you spoke of it being a myth, that Asians take care of their elderly, and I thought you said that some of the older people just died, alone in their flat rather than have to go to a nursing home. In a new setting, which is nonrural now, it is impossible in some cases for the family actively to take care of the elderly members of the family?

Language and Culture Are Definite Barriers

Do you find that primarily the reason that the Asians are not numerous in nursing homes is the language block and cultural block rather than just discrimination of being turned away by the nursing homes?

Miss Fujii. I cannot answer your question conclusively. It is correct that Asians have not actively sought out the services of long-term care facilities. This may be due to a combination of reasons: language and culture, the impersonal character of nursing homes, and subtle racial discrimination. We need to more fully ascertain the nature and extent of racial discrimination as a deterrent to nursing home utilization.

Senator Moss. Your observation is that the small number really stems mostly from the failure of the Asians to go from their side as applicants, and does not occur on the other side of their not being accepted.

Miss Fujii. Well, that is partially accurate. I would say that nursing homes have failed to a certain degree. There are large concentrations of Asian elderly, particularly in California and Hawaii, and I think the nursing homes do have a responsibility to aggressively reach out to the community around them to make sure that their patients are representative of the older Asians.

Senator Moss. One of the things we should probably emphasize is the language barrier, because some of the older Asians that are immigrants have really never learned to use the English language. Well, I will not comment further, because we are going to hear from you further with the others on your panel.

Senator Fong. I was interested in your statement here, during the White House Conference on Aging in 1971, that $32 million had been appropriated between 1969 and 1970 for community projects for the elderly.

In quotes, "Not one dollar was given to the Asian-American communities for their aged; the reason, according to Government officials, was Asian-Americans don't have problems." You do not know whether that is true or not, do you?

Miss FUJII. That was a statement which was based on information gathered for the Special Concerns Session on Asian-Americans. As far as we could tell, funds had not been appropriated to Asian communities for elderly Asian projects.

Senator FONG. Specifically for Asians?

Miss FUJII. Right.

Senator FONG. In the overall stress of these problems, Asians were included, were they not?

Miss FUJII. Right. For example, we know Asians receive Social Security benefits and old age assistance grants.

Senator FONG. Do you believe that the special projects should be directed specifically for Asian-Americans to find out whether they really do need the services?

Miss FUJII. Yes, I agree, we need to clearly determine what difficulties elderly Asians have in order to develop appropriate programs and to redesign existing services so that they are more responsive to our needs.

Senator FONG. We should really study the problem first to see what the problem is?

Miss FUJII. Right.

Senator FONG. I do agree with you that some money should be spent.

Senator MOSS. Thank you. We will now hear from Mr. Homer Martinez.

STATEMENT OF HOMER T. MARTINEZ, REGIONAL REPRESENTATIVE, NATIONAL COUNCIL ON THE AGING; MEMBER, ADVISORY COUNCIL ON ELDERLY MEXICAN-AMERICANS

Mr. MARTINEZ. It is a privilege to be here. This is my first occasion to be in this situation I find myself in, so I am really looking forward to it.

First, I would like to discuss health care as it exists now, and then perhaps using the structure of the family as far as trying to determine some of the reasons why nursing homes and extended-care facilities would not be accessible to the Mexican-American elderly.

Also, part of the testimony will have to relate to Texas and New Mexico only. Although I do work a five-State region, region 6, and each of the rest of the States have some population, the population within the rest of the States of Mexican-American elderly is small.

The extended family exists, as it does with the Indian, to some extent. It is still a closely knit structure. Particularly if the elders either live within the same household or the same community. However, I feel that to some extent, this structure is deteriorating. The young Mexican-American individual is getting better educated, is moving out of his home environment and, therefore, the elderly person is left in the home to fend for himself.

Two Types of Assistance

Presently, we know for the most part that Mexican-Americans receive two types of assistance. There are many thousands of elderly even now in both New Mexico and Texas that do not receive Social Security, either because they did not participate while they were working or because they are not aware they are entitled to it.

There are many, because of the age barrier, that do not receive old-age assistance. In each of these two cases, the family does provide some assistance. However, this assistance is in direct proportion to the financial situation of the family itself.

Right now, at the present time, from the information that is available, there are 1,558,000 people age 55 and over in Texas. Of these, 992,000 are 65 and over.

In New Mexico, there are approximately 120,000 people who are 55 and over, and 71,000 of these are 65 and over. A further comparison of the figures shows that 328,000 of the 992,000 65 and older people in Texas are indigent; 24,700 of the 71,000 persons 65 and over in New Mexico are indigent. The above data refers only to the two States in region VI having the highest concentration of Spanish-speaking elderly.

Not even estimated figures are available to indicate what percentage of the elderly poor in Texas and New Mexico are Mexican-American. The 1970 census categorized Mexican-Americans as white. We cannot make even an educated guess.

During the 1970 community forums, which marked a prelude to the White House Conference on Aging, it was documented that in Texas and New Mexico income was the No. 1 priority followed by, though not necessarily in this order, health, transportation, employment, housing, nutrition, et cetera.

Due to conditions that exist among the Mexican-American elderly poor, all of these categorical needs are interwoven to the point that one need directly affects the others. The focus of this report will be on the problem of health in an attempt to explain the accessibility or inaccessibility of nursing homes and extended-care facilities to elderly poor Mexican Americans.

The questionnaire used to survey the elderly at the community forums during September 1970 included health questions not specifically related to nursing homes and extended-care facilities. Health was categorized as "Health and Related Services" when these questionnaires were compiled.

Questionnaires in both English and Spanish were answered in Texas and New Mexico. At this point, it should be noted that the questionnaire was weak in content, and its version in Spanish was confusing.

The following data is derived from the English and Spanish questionnaires that were compiled from Texas only. "Health and Related Services": (*a*) "Prefer to live where medical and nursing care available"—English questionnaire response showed 6,392 out of 13,199 indicating need, or 48.4 percent responding. Spanish questionnaire response showed 1,028 out of 1,398 indicating need, or 73.5 percent responding—65 percent greater need ratio than the English version.

(*b*) "Prefer to live where need not take care of repairs and maintenance." English questionnaire response showed 6,215 out of 15,548,

or 40 percent, indicating need. Spanish questionnaire, however, showed 910 out of 1,461, or 62.3 percent, indicating need. Again, we see an increase in need of 51 percent in the Spanish as opposed to the English versions.

It is clear from this data that the Mexican-American elderly would like to live where medical and nursing care are available, although the data may not mean that they would prefer a nursing home or extended-care facility.

Currently, there are some 65,000 nursing home beds in Texas, with 47,000 paid through vendor payments under Medicaid. In addition, there are 10,500 beds in extended-care facilities. In New Mexico, there are 2,450 beds in nursing and related care homes and only 1,253 beds in extended-care facilities.

No Ethnic Breakdown Available

An inquiry was made to both the Texas Health Department, Division of Nursing and Convalescent Homes, and the Texas Welfare Department Statistical Division in order to obtain resident ethnic breakdowns.

In each case, this information was not available. No such breakdown exists. Therefore, there is no "at hand" data of a reliable statistical nature available on ratios of Mexican-American elderly residents in nursing homes.

Whatever this percentage may be, be assured that the percentage is small when compared to the total number of elderly Mexican-American poor. For example, in a city of 195,000 residents recently visited, fewer than 14 Mexican-American elderly reside in the eight nursing homes.

In another city of 30,000, less than five Mexican-American elderly are in the two nursing homes. The first city in question has approximately 60,000 elderly persons 55 and over, of whom 13 percent are Mexican-American. The latter city has some 6,000 elderly 55 and over, of whom 40 percent are Mexican-American elderly.

We know that both Medicare and Medicaid provide direct assistance, particularly for the elderly indigent in nursing homes and extended-care facilities.

It is appropriate to note that there are literally thousands of Mexican-American elderly poor who do not receive Social Security benefits, either because they did not participate in the program during their working years or because they are not now aware that they are entitled to it.

In either case, Medicaid vendor payments alone are not enough to meet the cost of services provided in nursing homes or extended care facilities. There are many Mexican-American elderly poor who do not receive Old-Age Assistance, either, because they do not qualify due to age or they also are not aware of it.

In the latter case, adequate health services are just out of the question unless the family or other relatives can provide the assistance. In some instances, the county takes partial responsibility—especially in emergency cases.

Reluctant To Live in Nursing Homes

Regardless of whatever assistance is available to the Mexican-American elderly poor, these elderly seem afraid of or reluctant to being placed in a nursing home or extended care facility.

By and large, nursing homes are owned, operated, and administered by non-Spanish-speaking individuals. Additionally, the bulk of the professional and medical staff also is non-Spanish-speaking, which automatically establishes a barrier between the Mexican-American elderly and the facility.

This fear or reluctance of the Mexican-American elderly stems from the fact that Anglo resident and administered nursing homes and extended care facilities encounter a language and cultural barrier which is, in turn, demoralizing to the viejitos.

In addition, although difficult to document, prejudices exist in some facilities which deter many Mexican-American elderly from utilizing such services even though Medicare and Medicaid pay for them.

If admitted, the Mexican-American elderly may receive a level of care unlike that provided the non-Spanish-speaking residents. These situations may be relayed by the elderly residents to other potential residents, creating fears and reluctance in others who need the services or facilities.

Another factor contributing to the inaccessibility of nursing homes and extended care facilities is their absence in rural areas and rural communities. It is difficult enough for individuals with financial means to acquire adequate health care; it is far more difficult for people who are on either Medicare or Medicaid, or both.

Other factors related to inaccessibility may include the lack of knowledge and understanding that such facilities exist or that Medicare and Medicaid can provide direct assistance to the potential resident.

In summary, this report has attempted to depict the problems of the Mexican-American elderly poor with regard to the accessibility or inaccessibility of nursing homes and extended care facilities.

The limited available data show the problems of the Mexican-American elderly in Texas and New Mexico; next to California, these two States have the highest Mexican-American elderly population.

Some of this report's inadequacies result from minimal data that can be pinpointed on the Mexican-American elderly. But, in spite of the little information available, it can be seen that the percentage of Mexican-American elderly poor in nursing homes, based on their total population, is proportionally less.

This fact indicates that these facilities are not as accessible to Mexican Americans as they would be to the Anglo elderly in comparable conditions.

The factors attributable to this small percentage may be, and probably are, prejudices against the Mexican-American elderly, fear by the individual of the facilities, lack of resources, family structure and culture, and the availability or unavailability of such facilities.

Recommendations

(1) Complete lack of adequate statistical data prevented the preparation of a more concise report. Without any data, there is

hardly any basis for comparison and unless positive steps are initiated to correct this inadequacy, comparisons on future reports will not be possible.

Little is known of the Mexican-American elderly poor in this country other than the fact that they exist and their primary language is not English. Actual numbers, problems, needs and other data, are not available.

This is not so with the Anglo elderly, and, to some extent, with the black elderly. A program similar to Project FIND, aimed at seeking out the isolated, neglected elderly and linking them to appropriate resources, sponsored by the Federal Government or a national organization, is needed to identify the Mexican-American elderly, poor and nonpoor alike.

Every State in the Union has Mexican-American elderly in their populations, but no one knows where or how many. Such a project would discover how many are in nursing homes or extended care facilities, as well as some of the precise reasons for problems that exist in this area.

(2) Equally important, colleges, universities and other institutions of higher learning should develop, in cooperation with the State nursing homes associations, studies that encourage the participation of Spanish-speaking students in programs to develop high-caliber professionals in the field of aging and gerontology.

There now exist only a handful of Spanish-speaking professionals and paraprofessionals whose field is that of aging and/or gerontology.

(3) Medicaid now provides vendor payments for indigent residents in long-term care facilities under Old-Age Assistance. In keeping with family ties and culture still prevalent among Mexican-American families, it is recommended that an elderly person's immediate family be eligible for a subsidy or allowance payment to make it possible for the family to care for the person, probably at a much reduced rate than the current vendor payments to nursing homes. The precedent for such care already exists in foster home care programs.

(4) Comprehensive programs and services to provide health and related services, such as home health care and other programs to maintain the Mexican-American elderly in his own environment and prevent institutionalization, should be developed. Presently available programs and services need to be broadened to include the particular health needs of the Mexican-American elderly.

(5) There are instances in which the Mexican-American elderly could have received health and related services in a less-expensive facility but, due to the 3-day prior-hospitalization requirement by Medicare, they were placed in a hospital instead. It is recommended that this 3-day waiting period be eliminated.

(6) Many Mexican-American elderly poor face the burden of costs for medical appliances, drugs and other essential professional services not covered by Medicare. It is recommended that such costs be included under Medicare.

(7) Though personal prejudices and biases cannot be eliminated by training alone, training for nursing home and extended care facility administrators and other professional staff, including medical, should include developing an awareness and understanding on behalf of the Mexican-American elderly and their special needs.

Such training, or evidence of such training, should be mandatory for long-term-care licenses, at least in areas with high Mexican-American populations.

It is hoped that the above recommendations, as well as other recommendations applicable to Mexican-American elderly brought out at the White House Conference, will be closely and seriously reviewed by this subcommittee for appropriate action. Thank you very much.

Senator Moss. Thank you, Mr. Martinez. That is a good opening statement, and we will look forward to hearing more fully from the panel.

I take it from your testimony that there is some degree of discrimination to accepting the Mexican Americans, but also on the other side, there is a reluctance to go, partly because of the language barrier and partly because of cultural background that causes the Mexican Americans from presenting themselves at nursing homes.

Mr. MARTINEZ. Yes, sir.

Senator FONG. Mr. Martinez, are there any nursing homes run by Mexican Americans in Texas?

Mr. MARTINEZ. Of all the nursing homes—and I cannot give you an exact number, but certainly 65,000 beds are quite a number—I could find only one administrator that at least had a Spanish surname.

Senator FONG. If there is a need for it, why isn't it that we have more? You have quite a community there.

Mr. MARTINEZ. Yes, sir; I realize that. I have no idea other than perhaps individuals with Spanish surnames or even middle age have not realized the need as far as being involved in the field of aging, gerontology. There are only a handful of Mexican-American professionals or Spanish-speaking professionals in the field of aging.

Senator FONG. Thank you.

Senator Moss. Thank you very much. Now we will hear from Dr. Jacquelyne Jackson who will speak regarding our black American citizens.

STATEMENT OF JACQUELYNE J. JACKSON, PH. D., ASSOCIATE PROFESSOR OF MEDICAL SOCIOLOGY, DUKE UNIVERSITY; MEMBER, ADVISORY COUNCIL ON AGING AND AGED BLACKS

Dr. JACKSON. Thank you, Mr. Chairman. On behalf of The National Caucus on the Black Aged, which is effectively chaired by Mr. Hobart C. Jackson, I wish to express our appreciation for the opportunity provided us to share with you some of our concerns about long-term care facilities for aged blacks. My response to the two questions posed for this hearing, "Why minority groups are rarely found in nursing homes?" and "What specific measures should be undertaken to provide for the needs of members of minority groups who are both old and ill?" focuses specifically upon blacks since I am more knowledgable about blacks than any other minority group and since I believe that blacks as a racial, minority group in the United States—historically and presently distinctive from other minority groups—warrant separate consideration in highly, important ways.

This response is limited especially by the absence of sufficient data about aging and aged blacks, a gap which could be partially closed at least by a reanalysis of data already on hand by such

Federal agencies as the U.S. Bureau of Census, the Research and Statistics Division of the Social Security Administration, and the National Center for Health Statistics, and by sufficient problem formation, and data collection, analysis, and interpretation in the future.

In the absence of needed, relevant data, however, I shall rely on those few data already available and on impressionistic judgments culled from my observations and research extending over a period of some years of experience as a black and as a sociologist trained especially in social theory, the family, race relations, and social gerontology.

In so doing, I shall approach each question separately and provide a summary of what I regard as the probable, major factors explicating the scarcity of blacks in nursing homes and the most important measures needed to improve health and other conditions for those who are black and old and ill.

Black Scarcity in Nursing Homes

All available data suggest clearly that factors other than chance have affected what some regard as the gross underrepresentation of blacks in nursing homes. But those data do not and cannot provide any valuation of this underrepresentation. For example, they do not prove or disprove the preferability of a nursing home, a geriatric or chronic hospital, or a long-stay mental hospital as a site for those who are old and ill and no longer capable of satisfactory self-maintenance. Perhaps a prior question to that of the scarcity of blacks in nursing homes is that of the suitability of extant nursing homes for specific blacks who are old and ill.

It appears likely that the best, single answer to the question of the scarcity of blacks in nursing homes may lie within racially differential rates of admissions to (a) nursing homes, personal care with nursing homes, and personal care homes, (b) geriatric or chronic hospitals, and (c) long-stay mental hospitals.

Unfortunately, in this connection needed data were not available for blacks, but only for nonwhites. With that important caveat, table 1 [1]—which shows the number of residents in nursing and personal care homes, geriatric and chronic hospitals, and long-stay mental hospitals, per 1,000 population, 65-plus years of age, by color and sex, in the United States in 1963, and the 1969 rates for nursing and personal care homes—reveals higher rates of institutionalization in long-stay mental hospitals for nonwhites in 1963 than for their respective, white counterparts.

Nonwhite rates for those 65 to 74 years of age in geriatric and chronic hospitals were slightly higher than their white counterparts, a phenomenon true also for nonwhite males, 75 to 84 years of age, as compared with similar, white males, with the pattern reversing by race for those 85-plus years of age.

By 1969, while the rates had increased for all groups found in nursing and personal care homes, the rate for nonwhite males, 65 to 74 years of age, had overtaken the comparative white male rate during the intervening years between 1963 and 1969.

[1] See table 1, p. 2457

A merger of all three of the 1963 rates for each of the four color and sex groups, that is, nonwhite females, white females, nonwhite males, and white males, results in the highest rate of institutionalization for persons 65 to 74 years of age for nonwhite males (24.1/1,000), followed by white males (18.6/1,000), nonwhite females (18.2/1,000), and, finally, white females (17.8/1,000).

On the other hand, for persons 75-plus years of age, the combined rate was highest for white females, 266.1 to 1,000; followed by white males 139.3 to 1,000; nonwhite females, 82.4 to 1,000; and least of all, nonwhite males, 78.2 to 1,000.

Do such results suggest that we now ponder the question of the greater scarcity of whites, 65 to 74 years of age, in these combined facilities; or, conversely, the greater scarcity of nonwhites, 75-plus years of age, in these combined facilities?

A more feasible solution is for us to develop hypotheses about the most desirable facilities for meeting the needs of those who are black and old and ill, irrespective of usage patterns by majority aged, and to develop, as well, hypotheses about major factors affecting differential rates of admission by race and sex to nursing and personal care homes, geriatric and chronic hospitals, and long-stay mental hospitals.

As a step in that direction, it may be noted that, among the 65- to 74-year-old groups, nonwhite females and males differed from their white counterparts in that the former had highest rates of institutionalization in long-stay mental hospitals, followed by nursing and personal care homes, and by hospitals; whereas the latter pattern was nursing and personal care homes, long-stay mental hospitals, and hospitals.

But, for those 75-plus years of age, while no sex distinctions by race were apparent in the rankings of the rate of institutionalization, all four color and sex groups were most likely to be institutionalized in nursing and personal care homes, with nonwhites being next most likely and whites being least likely to be found in long-stay mental hospitals.

One important question is the extent to which disability statuses affect the admission rates to these three types of facilities. As apparent in table 2,[1] which contains a comparison of the extent of disability of residents of these facilities for both sexes of all ages in the United States in 1963,[2] residents of long-stay mental hospitals, where, by chance alone, nonwhites were overrepresented, were more likely to be out of

[1] See table 2, p. 2457

[2] That is, "all ages" equals 15-plus years of age for long-stay mental institutions, and 20-plus years of age for nursing and personal care homes and geriatric and chronic hospitals.

It may also be relevant to raise here the question of the need for more precise determinations of factors underlying the differences which appear in data about number of persons with one or more physician visits per year (which, in 1969, was 67.5 percent and 66.2 percent for whites and nonwhites, 45–64 years of age and 71.6 percent and 67.4 percent for nonwhites, 65-plus years of age, NCHS), bed-disability days per person in 1968 and 1969 (11.6 and 7.2 for 45–64 years of age, and 20.5 and 13.1 for persons 65-plus years of age, nonwhites and whites respectively, NCHS) restricted activity days in 1968–69 (29.1 and 19.5 for persons 45–64 years of age and 47.6 and 33.1 for persons 65-plus years of age, nonwhites and whites respectively), work loss days for currently employed (9 and 6 for 45–64 years old and 10.1 and 5.4 for those 65-plus years of age, nonwhite and white respectively, NCHS), and percent of persons limited by chronic conditions (7.7 percent and 4 percent for persons 45–64 years of age, and 25 percent and 15.1 percent for persons 65-plus years of age, nonwhite and white respectively, not able to carry on major activity; 13.9 percent and 11.3 percent for 45–64 years of age, and 23.1 and 22.3 percent for persons 65-plus years of age, nonwhite and white respectively, limited in amount or kind of major activity; and 2.4 percent and 3 percent for 45–64 years of age, and 3.4 and 4.2 percent for 65–plus years of age, nonwhite and white respectively, limited but not in major activity, NCHS), since these differential rates should feasibly be reported for race by socioeconomic status, and since such factors as provisions or eligibility requirements connected with acquisition of OAA, unemployment compensations, and other benefits may well affect these reported data. In addition, occupational differences allowing differential "days off" may also affect these rates. The question is the extent to which the differences may be due primarily to socioeconomic factors or primarily to racial factors.

bed, walking unassisted, continent, and free from serious hearing and visual problems than were residents of the remaining two facilities.

Significantly, there were not major differences by percentage "always aware" in the three types of facilities. Some of the differences explicated above may be explained partially by the average, younger age of the residents of the long-stay mental hospitals than the remaining two facilities.

But the question is still valid. Age appears to be one factor differentially affecting racial admissions to these three types of facilities. Other factors must certainly include differential ownership patterns. Old blacks are probably least likely to be found in proprietary nursing and personal care homes, due to a variety of factors. These factors clearly include greater racial discrimination on the part of both proprietary nursing and personal care homes especially, and the continued Federal support of such homes producing barely or less than minimal compliance with antidiscriminatory legislation.

They include significantly fewer black-owned-and-operated proprietary homes, due in no small measure to the great difficulties many black businessmen or would-be businessmen experience in obtaining sufficient capital assets.

They include higher average monthly costs in proprietary homes per patient, even though a substantial number of such homes benefit from Federal and/or State financial assistance. Coupled with the latter factor must be that of the significantly lower income, on the average, of black aged, as compared with white aged.

And I might add parenthetically that, in addition to the fact that most black aged live in poverty, the income gaps between black and white aged actually widened between 1959 and 1969. Thus, in general, differences must be sought in terms of such factors as availability of existing facilities of different types, their monthly costs, patient load, distance from family and relatives, primary source of payment, awareness of facilities, and the nature and type of commitment for the ailing, aged person, and his or her projected length of stay.[1]

Paucity of Training Programs for Blacks

Such factors open up considerations about the training and interest of black health professionals, including physicians, and the extent to which such training programs as those sponsored by the Administration on Aging and the National Institutes of Child Health and Development, have been made accessible to blacks.

In this respect, both agencies can be severely criticized for their paucity of such efforts. The Administration on Aging is particularly guilty on a number of counts, not the least of which is their attempt to whitewash the issue by opening six training programs at black institutions during 1971–72, with only one of those programs providing

[1] An additional factor may be sought in differential patterns not only by age but by sex. According to NCHS: "Characteristics of Patients in Mental Hospitals" (p. 5), in addition to nonwhite patients being younger than white patients, there were differences in their sex ratios. The sex ratio for nonwhites was 149 males per 100 females, as compared with 107 males per 100 females for whites. For nonwhites, males were in excess through age 74; whereas, for whites, males were in excess through age groups under 55, with the proportion of males and females between 55 and 74 being about equal, and females in excess for those 75-plus years of age. According to NCHS: "Characteristics of Residents in Institutions for the Aged and Chronically Ill" (p. 5), the nonwhite residentially based population was about equally divided by sex, but the ratio of females to males among whites was about 2 to 1. More specifically, 47.8 percent of the nonwhite residents in nursing and personal care homes were male, as compared with 33.7 percent of the whites. For geriatric and chronic "hospitals," nonwhite males comprised about 60 percent of that population, whereas males represented about 54 percent of the white population.

graduate training, with almost all of those programs providing dead-end occupational training generally in the absence of sufficient personnel trained in aging for the student participants, and with the selection of institutions, in the main, ignoring those which could well have had higher priorities, due to the higher academic standards and more relevant curriculums already existing in their institutions.

Specifically, given the funding of six black institutions in 1971–72, in addition to Fisk University, institutions which should have been granted higher priorities include Howard University, Maharry Medical College, Atlanta University, Tuskegee Institute, and either Southern University in New Orleans or Texas Southern University.

Finally, in considering differential factors affecting rates of admission and differences in admission facilities, consideration should be given to family factors, such as the presence or absence of spouse, age, and number of dependents upon the primary breadwinner, and attitudes of family members toward admission and speed of admission, advice patterns, and especially those proffered by physicians and social workers to ailing aged and their primary responsible agents, the possibility that a larger proportion of those between the ages of 65 and 74 years of age in long-stay mental hospitals in 1963 among nonwhites had an average greater length of stay in institutions than did whites located in other types of facilities (i.e., that nonwhites in such facilities may have entered at an earlier age and in pre-Medicare days), and, most important, the fact that those blacks who reach the age of 75 years are more healthy than whites reaching that age, and, therefore, less likely to be in need of institutionalization, as reflected, for example, in their significantly lower rates of institutionalization in the combined facilities.

As may be expected, data for home care for persons 55 or more years of age revealed that nonwhites were more likely to receive such care, exclusive of physician visits, than were whites. The most frequent caretakers were family members. In 1966–68, comparative rates were as follows: 4.0 and 1.9 percent respectively for persons 55–64 years of age; 6.6 and 4.2 percent respectively for persons 65–74 years of age; and 17.2 and 13.1 percent respectively for nonwhites and whites, 75+ years of age.

Socioeconomic Status

Failure to separate the data by socioeconomic status prevented any determination about the effects of that status upon receipt of home care, but, in general, for nonwhites and whites, an inverse relationship between income and home care persists.

That is, in all probability, the higher the socioeconomic status of an aged person's children, in the absence of spouse at least, the greater the likelihood that the aged person will be institutionalized.

Among blacks, I believe that greater institutionalization among those of middle socioeconomic status is also a function of fewer available children and grandchildren and other relatives in close proximity to assist in needed care for an ailing, old parent, as well as the greater likelihood that the old parent's child and that child's spouse will both be employed fulltime. Thus, we need data about the extent to which full-time employment of black couples with ailing, aged parents affects decisions to institutionalize such parents.

Many speculations are possible, but, in summary to the question of the scarcity of blacks in nursing homes, the answer probably lies within the realm of racially differential rates of admissions to various types of facilities, with such patterns being influenced by racism, as well as by socioeconomic statuses and other relevant family variables and cultural attitudes and traits.

In addition, we should note a recent finding reported by the late Donald P. Kent and Carl Hirsch, based upon their study of low-income black and white aged in Philadelphia. Essentially, aged blacks with extremely low incomes were also those most likely to reject institutionalization or at least not desire to be placed in nursing homes or similar facilities. I suspect that such attitudes are quite prevalent. They are also historically justified in that many blacks have actually witnessed old blacks dying in deplorable circumstances in various facilities through the years, and a number believe that one should increase the possibility of dying in a degree of dignity and that such a form of death may best come by remaining at home.

The most important question is the determination of the specific types of facilities needed by specific types of ailing, aged blacks, such as those of differential socioeconomic statuses and familial structures.

Needed Measures

Since sound data constitute a prerequisite to sound policy, it is extremely useful for one to exercise caution in suggesting needed measures to improve the conditions of or meet the needs of blacks who are old and ill.

With such caution, the most critical needs of most aged blacks are those of income, health, and housing, and in that order. All of these needs are interrelated.

For example, financial security may be of prime importance in aiding an old person to adjust satisfactorily to his illness or, indeed, in obtaining adequate treatment allowing recuperation.

Pleasant physical surroundings may be especially critical, and certainly standard housing equipped with modern conveniences and against accident-prone contraptions are needed. I believe most of all that aged blacks, ill or well, can benefit first by the receipt in their own hands of sufficient income and that they are, can, and will be effective consumers in the marketplace.

This is not to deny the need for developing services which can be purchased, but I deplore those programs which tend to treat the aged as children, and I detest those which continue to utilize ineffective and ill-trained social workers as "agents of God."

The history of welfare in the United States as it relates to blacks should have convinced us already of the folly of increased "welfare" and "handouts," no matter how disguised, for blacks. Must we really have social workers following blacks from the womb to the tomb?

Bearing my own cautions to myself and my cautions to others in mind, let me proceed to make some suggestions about needed measures.

Income

The income of all aged—65 or more years of age—blacks now living in poverty should be raised to approximate the median income for

primary individuals or for families equaling their family size, depending upon the category in which they fall.

Since blacks tend to define themselves as being older at an earlier, chronological point in time than do whites, since they may age in "body age" faster than whites, and since they are generally old earlier in the labor force, I reiterate my proposal about the need to reduce the minimum age-eligibility requirement for primary beneficiaries of OASDHI, so as to reflect extant differences, from age 0, in the life expectancy tables by race, and, thereby, reduce the racial discrepancies now apparent in social insurance coverage for employed workers and for retired workers covered under OASDHI.

While the need is especially acute for black males, I also wish to stress the significant need to improve immediately the educational, occupational, income, and employment levels of black females, who, in these respects, fare even worse than black males, so that those who are not yet old and ailing will be able to prepare better for their retirement days.

This latter proposal is particularly applicable to those who are without or likely to be without spouse.

Health

I support recommendations, such as those made, I believe, by the Honorable Frank E. Moss, who has urged the authorization of day care under Medicare in S. 3267, and other suggestions contained in S. 3268, S. 3269, S. 3270, S. 2935, S. 2934, S. 2933, S. 2932, and S. 2931, as well as those specified in S. 2924 through S. 2929.

I would hope that consideration will be given to the establishment of trained "parent sitters," available at graduated fees for day or evening sitting with old persons—with Federal supplements being provided, where needed to insure adequate wages for the sitters—home health and visiting nurse services to all ailing blacks in need of same without regard to age, and the obliteration of any distinction between Medicaid and Medicare, but a national health insurance program providing medical and dental care; insuring that the establishment of a National Institute of Geriatrics would mean sufficient consideration to needed research, demonstration, and training programs or participation for blacks, as well as the employment at all levels of blacks from the inception of such an Institute; a greater emphasis upon developing more black medical personnel in the professions, such as physicians, registered nurses, pharmacists, nurse educators, dentists, and hospital administrators, as well as blacks in such related areas as medical sociology, medical anthropology, medical psychology, clinical psychology, and medical economics, and less emphasis upon greater priorities being placed upon developing blacks as paraprofessionals; and, finally, some way of providing funds to an independent agency to evaluate the programs funded to improve long-term care and other facilities.

I also believe that health care should begin as quickly as possible, so I wish to stress the need to improve health care conditions for aging, as well as aged, blacks.

Housing

Perhaps the most obvious measures are those of increasing income so that standard housing requiring no more than one-fifth of an aged black's total income will be needed.

Every effort should be made to enforce federally established building codes, so as to improve the quality of much of the shoddy "new" construction surrounding us. Buildings should be constructed so as to meet the needs of aging and aged blacks, and a variety of alternatives should be available.

Such modern conveniences as telephones, dishwashers, air conditioners, washing and drying machines, and various safety features should be included automatically in public housing for the elderly. Such conveniences should increase the likelihood of being able to remain at home, except under unusual circumstances.

Research

At least 12 percent of all funds allocated for aging during each fiscal year in the next decade should be earmarked specifically for research about blacks. Research areas should cover physiological, sociological, psychological, and other processes of aging.

Especial concentration should be placed upon methods of reducing hypertension and cancer, accidents and homicides, and ways of increasing longevity for black males. All relevant Federal agencies should be requested to collect and provide needed data on aging and aged blacks and make such data available through the usual process of published reports.

Of especial importance is a carefully designed, systematic, national study undertaken to determine precisely why existing nursing homes contain a paucity of blacks and to determine the conditions under which nursing homes may be most useful and least useful to blacks.

In addition, some projections of the needs of nursing care for blacks in the next few decades should be made, so as to assist in the development of facilities and personnel.

Finally, and in closing, while your emphasis is upon those who are black and old and ill, we should not forget that, since most old blacks are relatively healthy, and not in need of institutionalized care, we should initiate every effort to optimize conditions for them so that they may remain relatively healthy for much longer periods of time, and we must now turn our attention away from mere quantification of racial differences, but to reductions of relevant racial differences which add diversity to life.

We must be more concerned about the quality of life and the quality of services, and less concerned about, for example, the number of physician visits by aged persons annually, but the quality of those visits in terms of physician-patient interaction and satisfaction.

Perhaps long-term care facilities can yet set a model for the medical world by working more quickly to phase out racism than the models we now have present.

We thank you.

(The tables follow:)

TABLE 1.—NUMBER OF RESIDENTS IN NURSING AND PERSONAL CARE HOMES, GERIATRIC AND CHRONIC HOSPITALS, AND LONG-STAY MENTAL HOSPITALS, PER 1,000 POPULATION, 65 PLUS YEARS OF AGE, BY COLOR AND SEX: UNITED STATES, 1963 AND 1969

Characteristic, year, and age group	Color and sex group			
	Nonwhite female	White female	Nonwhite male	White male
Nursing and personal care homes, 1963:				
65 to 74 years of age	5.6	9.1	6.2	6.9
75 to 84 years of age	15.0	49.9	12.4	30.5
85 plus years of age	42.9	185.8	40.4	111.9
Nursing and personal care homes, 1969:				
65 to 74 years of age	7.1	12.7	10.5	9.5
75 to 84 years of age	21.8	67.3	18.2	39.0
85 plus years of age	58.2	205.8	27.3	129.8
Geriatric and chronic hospitals, 1963:				
65 to 74 years of age	1.5	1.0	3.3	2.4
75 to 84 years of age	2.6	4.5	4.6	4.5
85 plus years of age	8.2	14.8	4.7	13.2
Long-stay mental hospitals, 1963:				
65 to 74 years of age	11.1	7.7	14.6	9.3
75 plus years of age	13.7	11.1	16.1	9.7
Composite of all facilities above, 1963:				
65 to 74 years of age	18.2	17.8	24.1	18.6
75 plus years of age	82.4	266.1	78.2	139.3

DATA SOURCES

National Center for Health Statistics: Characteristics of Patients in Mental Hospitals, United States," April-June 1963. "Vital and Health Statistics," Public Health Service publication No. 1000, series 12, No. 3. Washington, D.C., U.S. Government Printing Office, December 1965.

National Center for Health Statistics: "Characteristics of Residents in Institutions for the Aged and Chronically Ill, United States," April-June 1963. Public Health Serivce Publication No. 1000, series 12, No. 2. Washington, D.C., U.S. Government Printing Office, September 1965.

National Center for Health Statistics: "Health in the Later Years of Life. Public Health Service," stock No. 1722-0178. Washington, D.C., U.S. Government Printing Office, October 1971.

TABLE 2.—COMPARISON OF EXTENT OF DISABILITY OF RESIDENTS OF NURSING AND PERSONAL CARE HOMES, GERIATRIC AND CHRONIC HOSPITALS, AND LONG-STAY MENTAL HOSPITALS, BOTH SEXES, ALL AGES, UNITED STATES, 1963

Disability status	Nursing and personal care	Hospitals	Long-stay
Percent out of bed	57.1	57.3	90.0
Percent walking unassisted	58.0	52.0	91.4
Percent continent	73.2	73.9	88.7
Percent always aware	50.2	58.8	46.5
Percent with no serious hearing problems	84.1	86.9	95.5
Percent with no serious visual problems	80.6	85.0	95.5

Source: National Center for Health Statistics: "Characteristics of Patients in Mental Hospitals, United States, April-June 1963." Vital and Health Statistics, Public Health Service Publication No. 1000, series 12, No. 3. Washington, D.C., U.S. Government Printing Office, December 1965; National Center for Health Statistics: "Characteristics of Residents in Institutions for the Aged and Chronically Ill, United States, April-June 1963." Public Health Service Publication No. 1000, series 12, No. 2. Washington, D.C., U.S. Government Printing Office, September 1965.

Senator FONG (presiding). Thank you, Dr. Jackson, for this very detailed statement. The bell has rung and I have to proceed to the Senate floor to vote. I think we are going to have several votes in a row. Mr. Halamandaris will continue with the hearings.

Mr. HALAMANDARIS. Thank you, Senator Fong. We would like to go back and start from the beginning and hear our Asian panel in depth. Proceeding down alphabetically we want first to try to size up the problem and, second, to get your ideas for legislative solutions to include in our legislative package amending H.R. 1, the House-passed Social Security bill.

Will our Asian panel come up, please?

PANEL ON OLDER ASIAN-AMERICANS—MISS SHARON FUJII, CONSULTANT TO KAWABE MEMORIAL HOUSE, DOCTORAL CANDIDATE IN GERONTOLOGY, BRANDEIS UNIVERSITY; EDWIN C. HIROTO, ADMINISTRATOR/SECRETARY OF CITY VIEW HOSPITAL AND KEIRO NURSING HOME; SAM YUEN, MSW, DIRECTOR OF SELF-HELP FOR THE ELDERLY

Mr. HALAMANDARIS. Mr. Yamagata, of our staff, has done a great deal of work, in setting up this hearing. Would you introduce the panel, Mr. Yamagata.

Mr. YAMAGATA. Yes, Mr. Halamandaris. Seated to my right is Sharon Fujii. Next to Sharon is Mr. Edwin Hiroto, administrator of a nursing home in Los Angeles, and seated next to him is Mr. Sam Yuen, who is the director of the Self-Help for the Elderly program, a multiservice agency in Chinatown, in San Francisco.

Mr. HALAMANDARIS. Fine; the witnesses may proceed in any order that they wish.

Mr. YAMAGATA. I believe Mr. Yuen is first.

STATEMENT BY SAM YUEN

Mr. YUEN. The Asian-American elderly in long-term care facilities face all the fears, anxieties and problems of other elderly. While the half true notion the "Chinese take care of their own" lingers, we are constantly reminded that a large proportion of the elderly in San Francisco's Chinatown are completely without families, due in part to the immigration restrictions prior to 1965.

Many others have spouses or children who are themselves living at subsistence levels. Even middle-class Asian-Americans cannot provide the necessary health and support services for their elderly parents without bringing financial destruction upon themselves.

When illness and increasing physical limitations accompany old age, the problems of loneliness, poverty, and confusing bureaucratic red tape become so acute they are unmanageable.

We would like to remind you of several additional points about Asian-Americans that affect their relationship to nursing homes and extended care facilities.

One, the number of these elderly Asian-Americans is much greater than commonly assumed. Two, a large majority do not speak English and have a different cultural background. Three, many elderly are committed to more than one kind of health care. The elderly may go to a western medical doctor for one kind of ailment, to an herbalist or accupuncturist for other kinds.

Nursing homes should be located in or close to ethnic neighborhoods, easily reached by family and friends, and staffed by people who understand the language and culture, as well as the problems of the elderly patients they serve.

To remove the elderly to out of area homes creates deprivation and separation from people they were close to. Research has proved that the result is unhappiness as well as impairment in their physical and mental health.

Homes Viewed as "Death Houses"

Elderly Asian-Americans often associate going to these traditional nursing homes with going away to die because these homes make little or no attempt to overcome the language and cultural barriers or to truly rehabilitate them for return to their own homes and community.

Once brought there, they are forever left there and completely forgotten. The elderly have seen too many of their friends go away and never return Nursing homes, therefore, have to them become "death houses" or "collection stations" for the mortuary.

At Self-Help for the Elderly, we are involved in a demonstration project to develop alternatives to nursing homes. On Lok Senior Health Services will open the first day health center in San Francisco's Chinatown, providing innovative services at different levels to meet the changing needs of each client as a result of an ongoing evaluation program for each of them. We are hopeful that, because of its rehabilitation-oriented program, On Lok Home will reduce the number of elderly who have to leave the community for outside nursing home care.

Recommendations for Improving Care

We would like to make several recommendations toward improving nursing home care, making it more suitable to the needs of elderly Asian-Americans.

We recommend substantial financial increase for all services required for nursing home care and, with this, the enforcement of governmental standards for nursing home care.

We strongly recommend that additional consideration be given to groups such as Asian-Americans who have not received a voice commensurate with their problems. These additional considerations should include training for bilingual personnel, research and demonstration, translation of all languages, and so forth. Perhaps most important, there should be a willingness to support programs that recognize cultural differences and values among Asian-Americans.

We recommend that self-determination for the elderly be emphasized in providing options about nursing homes and involving them in the decisionmaking process. We recommend long-term funding guarantees so that well-planned and well-conducted programs can be supported and services provided without interruption and excessive politicking. We support sound evaluation of all programs, but do not believe this means spending half our time negotiating for funds.

A permanent structure to administer programs for the elderly is needed. Such a structure would help provide continuous and orderly planning. The simple logic for this recommendation is that the number of Asian-American elderly is increasing at the same rate as all elderly since 1900, from 4 to 10 percent of the population. In Chinatown the elderly represent 19 percent of the population.

Let me repeat. 19 percent of the population which is almost twice as many as the average.

We recommend that the committee look into the On Lok Senior Health Services project as a possible alternative to nursing homes by

establishing additional projects to demonstrate its feasibility and validity.

Finally I would like to comment that we have made similar statements on nursing home care and the specialized needs of Asian-American elderly to this and other governmental bodies. Each year we see nursing home conditions in northern California get worse instead of better. I hope that this group will be able to take more responsibility and follow through so we will see improvements at the local level, too.

Thank you very much.

Mr. HALAMANDARIS. Thank you, Mr. Yuen. We were in San Francisco in 1970 with Senator Frank Moss conducting hearings, and at that time we heard that there was a rather desperate situation, relating to members of minority groups who could not be placed in nursing homes in the San Francisco area and were sometimes taken 60 miles away.

Mr. YUEN. Yes, I remember that. And still these are the Anglo-operated places, and there are no bilingual staff persons or administrators to administer them, and it is strictly American food which the elderly Asian-American cannot try to get used to, and I think the government has to develop ethnic neighborhood-based nursing homes because of the distance involved between the home neighborhood and the institution where it happens to be located, creates a serious problem because the family cannot find time or the means to buy a car or to rent a car and go to see them.

Mr. HALAMANDARIS. Yes. We were told that there was only one Chinese or Oriental nursing home in the San Francisco area.

Mr. YUEN. Yes; this is the convalescent hospital, if you can include that as a nursing home. We do have only one but this place is always filled.

Mr. HALAMANDARIS. How does it function and which patients does it serve?

DAY HEALTH CENTER

Mr. YUEN. Well, it is better than none. I am not going to knock anybody now, but there is definitely room for improvement. We need continuous evaluation of each individual patient in the day health center so that we can allow some of them to live in their own homes, and by doing this, we will be able to cut down the rate of poor people who cannot afford the means of health care to be sent to nursing homes.

Mr. HALAMANDARIS. You said that it could be improved in some ways. How would you improve it if you could?

Mr. YUEN. Well, I will say that the administration part could be improved a good deal, because this is true to every kind of private enterprise.

What I had in mind is federally funded demonstration projects—more projects. Fortunately we already got funded, but it will take about a year for it to get started working somehow. We wish Congress would be able to appropriate money to start this on a larger scale.

Meanwhile, I do hope that this committee will look into the proposal presented to you in this area of nursing homes. It is composed of different services within one single package, the core of which is the establishment of a day health center providing health care, activities,

social work, et cetera, in order to alleviate individual problems. From time to time patients will be reevaluated. Those who need more care will be sent to a nursing care facility while those who have improved to the point of being able to manage their own affairs will eventually be returned to their own homes.

Mr. HALAMANDAIRS. Mr. Yuen, I think you are anticipating my next question. I understand that Dr. Lionel Cosins——

Mr. YUEN. Yes; we have been working with him. Somehow I think there is a parallel in our thinking. What we have in mind is a day hospital which operates in about the same way. Health care plays a very important role in preventing unnecessary deterioration on the part of the older person. I think the thing we have in common is to make an attempt to bring back from the hospital as many as possible as soon as possible. We have another component which deals with residential care in cooperation with the Salvation Army's new building.

We have 16 beds there for those in-between cases who are not well enough to be left alone to manage their own affairs and not sufficiently deteriorated to be sent to the nursing home. Here they may be helped to recover well enough to return to their own homes or, if not, be referred to an appropriate program. Since the health of the elderly tends to fluctuate more than that of most younger people, both types of care are necessary.

Mr. HALAMANDARIS. Mr. Yuen, we heard so many nice things about Self-Help for the Elderly when we were in San Francisco, I want to compliment you for that organization and I am sure that you are accomplishing many wonders for the elderly in the community.

I have a few more questions for you, then we will give Mr. Hiroto time for his statement. You indicated in response to my brief question that you believe the nursing home which serves the Chinese in the area could be improved.

Then, you mentioned that magic word "profit motive." My question is: who owns the nursing program and do you really believe that that nursing home, if it were run on a nonprofit basis, would somehow be better?

Mr. YUEN. Yes, provided the resources of such community agencies as Self-Held for the Elderly, its social work part and housing part and the meals on wheels part, and possibly other projects that happen to work out.

With this background, I think in terms of hiring staff and getting the residential care part ready for occupation.

Mr. HALAMANDARIS. Do you feel strongly about that point? I am going to ask Mr. Hiroto, who is administrator of the Keiro Nursing Home, to answer that same question.

Do you feel strongly about the question that I asked, and your answer?

Mr. YUEN. I am sure. And, we will make any sacrifice necessary to support it and to protect those who come to it for care.

Mr. HALAMANDARIS. Who runs that nursing home now?

Mr. YUEN. It is owned by a couple of Chinese people. One used to be the head nurse of Chinese hospital. There is no chance of getting everyone into these places. For the time being, there is no Chinese nursing home, so that when the Chinese older person goes into a Filipino-run home, there is some resemblance, at least on the outside, that he is part of an Asian nursing home. But again, the language

difficulty and other cultural amenities are different between the Filipino people and Chinese people.

People think the Chinese and Filipinos, they must have the same problems, they must have the same kind of needs, which is not the case.

Mr. HALAMANDARIS. Well, we have done the same kind of thing. We have you grouped under Asian-Americans. My colleague, Mr. Seto on my left, has a question.

Mr. SETO. Mr. Yuen, I have one primary question. Isn't it true that there is more than one Chinese dialect spoken in the San Francisco area, and that it would be useful for a viable gerontologist to have the knowledge of more than one?

Mr. YUEN. I think that is true of dialect.

Mr. SETO. Which would be the most useful?

Mr. YUEN. Well, it depends.

Mr. SETO. Cantonese?

Mr. YUEN. Yes; Cantonese and See-yup.

Mr. SETO. I think the Chinese-Americans have numerous dialects, whereas the Japanese-Americans do not have that particular problem; is that not true?

Mr. YUEN. I think they probably have the same problem too.

Mr. SETO. But Cantonese would be the most helpful dialect?

Mr. YUEN. Yes. I think that should be sufficient at this point, because more Chinese-Americans learn Cantonese, but as you know, Cantonese is dominant in San Francisco and in all California.

Mr. SETO. Thank you very much, Mr. Yuen.

(The prepared statement follows:)

PREPARED STATEMENT OF SAM YUEN, M.A., DIRECTOR, SELF-HELP FOR THE ELDERLY, CHINATOWN, SAN FRANCISCO, CALIF.

I. THE ELDERLY IN ASIAN-AMERICAN COMMUNITIES

Asian-American elderly in long-term care facilities face all the fears, anxieties, losses, and other problems faced by all elderly. Although we recognize some validity in the idea that "we take care of our own," we are constantly reminded that only a portion of elderly Asian-Americans have functioning families, nuclear or extended. The following are merely a sampling of the segments of our population that lack such support:

1. The elderly Filipino men in California's rural areas and, more recently, in urban poverty ghettos. These persons often have no families at all.

2. The elderly Chinese-Americans in San Francisco's Chinatown. A large proportion of these are without families; many others have only spouses or children themselves living at subsistence levels. We would estimate that a high percentage of these Chinese-Americans live below the median income level for their age group.

3. The elderly Japanese Americans in Los Angeles and San Francisco's J-Towns. These are like the elderly Chinese-American described above.

4. The elderly Asian-Americans in Hawaii especially rural areas and Honolulu slums.

5. Pockets of elderly Asian-Americans in such places as Pocatello, Chicago, Portland, Fresno, New York, and Greenville, Mississippi.

In actual numbers, all Asian Americans combined are a small proportion of the population of the United States. Many of the middle aged Japanese, Chinese, and Koreans have reasonable education and moderate incomes. They are justly proud of their accomplishments in this country, overcoming the sometimes intense prejudice and discrimination against them. They are, similarly, justly proud of their willingness—where possible—to care for their elderly parents.

But our present resources fall far short of doing the necessary job for the elderly and even for our parents. Often a modest standard of living is obtained only by all eligible members of the family working. The Asian Americans cannot provide the necessary health and support services for the Asian-American elderly without

bringing financial destruction upon themselves. Although many are working class and middle class, very few are well-to-do. Major financial and personal sacrifices are now being made to maintain our elderly, while simultaneously providing our children with the wherewithal to advance their educations.

Our problems, however, are not so much the parents of the middle class, but the large proportion of elderly whose children are not financially successful or who do not have children at all. These are invisible people to the non-Asian community, and they are to some degree invisible even within the Asian communities. They are poor; they are lonely; they are isolated; they are helpless in the face of bureaucracy; they are confused in filling out forms.

In short, there is not a single difficulty faced by an English-speaking, western-oriented elderly person that is not also faced by an Asian American elderly person. And most of these problems are more acute for the Asian American elderly.

In San Francisco's Chinatown we see the Chinese and Filipino elderly who are poor and isolated. Often their condition is based on years of discrimination: discrimination in immigration policies which prevented their families from joining them and made them as fearful of all government agencies as they were of the U.S. Immigration Service; discrimination in employment opportunities which kept them in low-paid jobs and without hope of adequate pensions; and discrimination in housing which helped keep them in tiny substandard hotel rooms. The effects of these factors are most severe when the elderly are sick and have no one to help them and their own homes are considered unhealthy.

II. PROBLEMS OF EXTENDED CARE FACILITIES

In answer to your question of why minority groups are rarely found in nursing homes, I would like to make a few comments about the Chinese Americans. All Asian Americans should not be lumped together as one group because they have different languages, cultures, customs, and food habits. Elderly Chinese Amercians associate going to nursing homes with going away to die. They have seen too many of their friends go and never return, so it is difficult to reduce this fear. Staying in your own home is closely linked with the will to live. There are no nursing homes in Chinatown, so people have to go far away. The elderly rarely see their friends return to the community and often cannot visit them in the nursing home. If the home were in the community perhaps it would be considered a "health" facility rather than a place to die.

With particular regard to convalescence care facilities, longterm care facilities, or nursing homes, we would like to make the additional following points.

First, the number of elderly Asian Americans who are improverished is much greater than commonly assumed. We base this upon observations and some statistics gathered informally, since we do not know of any relavant study.

Second, the number of elderly Asian Americans who are without accessible children or other close relatives is similarly much greater than commonly assumed.

Third, the numbers of elderly Asian Americans who do not speak English is substantial. For one study, conducted in 1970 a sample of 110 Japanese Americans in Los Angeles were selected to be interviewed; of these 43 preferred to be interviewed in Japanese. Of the 33 respondents over age 60, 30 preferred to be interviewed in Japanese.

Fourth, many elderly Asian Americans are committed to relationships with health professionals that differ from those relationships assumed by non-Asian Americans. Also, many Asian Americans are accustomed to the services of health professionals and to treatment processes that would be anathema to western practitioners. In addition, many Asian Americans use medications that are unfamiliar to western nutritionists and physicians. Although all these health-related elements may be perceived as ineffective folk medicine, we would like to mention that both tranquilizers and acupuncture were originally Asian treatments that western practitioners "knew" could never work.

Fifth, it is now generally agreed that nursing homes should be accessible to the community or neighborhood within which the person lived and where his family and friends have stayes. This is even more important for Asian Americans, since removal from the neighborhood also removes them from newspapers they can read, celebrations they can identify with, food they enjoy eating, fellow residents with whom they can converse, and staff members who understand their language and their customs.

Sixth, research on depreivation and on separation has established that reducing sensory input and separating persons from those close to them both have deleterious effects, not only upon the happiness of the individuals in question but also

upon their physical and mental health. When an elderly Asian American is required to live in an environment where he does not receive the normal input that others receive, because he cannot understand the language, and where he is separated from his neighborhood friends, his is being forced submit harmful mental and physical stresses.

At Self Help for the Elderly we are involved in a demonstration project to develop alternatives to nursing home care. After five years of frustration in working with nursing homes and seeing what happened to people there, we are trying to provide enough services in the community so that people will not have to go to nursing homes. For several years we have used the resources of attendant care, home health aides, and home delivered Chinese style meals to enable the elderly to come home sooner or not go to nursing homes. But we have found that more is needed such as appropriate physical and occupational therapy, day care, improved nutrition and better housing. On Lok Senior Health Services will be carrying out the first day health center in our area to provide some of these services. We estimate that a few people will still need nursing home care, and we have made arrangements with one facility with Chinese speaking staff and food to provide a few beds. There will be smooth continuity of care from the community to the hospital and nursing home and back to the community. If our demonstration project is successful, than we hope to reduce the number of elderly who have to go to nursing homes because there will be adequate services in the community for them.

III. RECOMMENDATIONS

What, then do we recommend?

First, we obviously recommend most strongly substantial financial increases for services for all elderly required to be in longterm care facilities. We would like to discourage closing existing facilities and sending people to their old neighborhoods to live in dreary hotels or to nursing homes until these communities are given the wherewithal to provide necessary services for the people. We would recommend governmental intervention in substandard nursing homes and some form of checking into those not substandard. We would recommend health education, training programs for nursing home personnel, research to gather statistics and to evaluate programs, and so forth. In general, we would recommend those actions that help all elderly and that raise the standards of all nursing homes, through both legal and educational means.

Second, we strongly recommend that additional consideration be given the elderly of those groups such as the Asian Americans, who have not received a voice commensurate with their problems in the past. We refer specifically to groups whose elderly often have severe limitations in speaking English, are often ignorant of how to deal with the bureaucratic processes, are accustomed to life styles not consistent with mainstream America, and adhere to custom and manners and values somewhat at variance with those normally found in this country.

These additional considerations should involve (a) training programs to provide bi-lingual health and social service personnel for these elderly; (b) in-service training for present personnel regarding customs and values of the Asian American elderly; (c) research programs to determine the extent of those in need of services and the kinds of services they require, but such research should normally be carried out in conjunction with an actual program under way or in planning, so that research does not occur in a vacuum; (d) translation of some documents into appropriate languages and provision of translators where the documents do not exist in these languages and perhaps most important of all; (e) a willingness to support programs that recognize the differences in taste, customs, manners, and values among Americans, so that these elderly may continue to enjoy familiar foods, read familiar newspapers, wear accustomed clothing, celebrate appropriate holidays and so forth.

Third, we recommend that self determination for the elderly be emphasized. Any form of institutionalization, no matter how "small group oriented," seems to create a pattern of dependency that becomes difficult to break. Even with some physical weaknesses there may be other physical and emotional strengths that need to be encouraged. Elderly should have options both in the selection of a nursing home and what occurs inside. There should be choices in food, locations, recreation, and where appropriate, the kinds of therapy. Nursing homes could certainly be made more suitable for the elderly, if the elderly were more involved in planning for them and in the decision-making process. While they may not know technical solutions they are certainly most aware of the needs and problems.

Fourth, we recommend longterm funding guarantees. The present style has been to provide a relatively brief grant (two to five years) based upon matching funds. The first six months of the grant are devoted to setting the program up in many instances; the last six months are devoted to anxiety, frantic job-seeking, trips and telephone calls to Washington, and finally either a renewed program or a phased out program. This decision often is unrelated to the merit of the program or the effectiveness of its administration. It has led to considerable bitterness among members of the ethnic communities who see it as a game played in Washington to obtain votes at propitious moments. While we are willing to submit to impartial evaluation of our programs, and we realize that certain programs might need changing or curtailment, we basically wish to know that a well-planned, well-conducted program will continue to be supported, so that we can attend to helping the elderly and to improving nursing homes, rather than to politicking with Washington.

Fifth, a permanent structure to administer programs for the elderly is needed. This would help resolve the problems of longterm funding. The simple logic for this recommendation is that the number of Asian American elderly is increasing in the same way the number of all elderly has increased since the turn of the century. The percentage of elderly in the total population has increased from 4% in 1900 to 10% in 1960 and is expected to go higher. It is time for the government to face up to the fact this responsibility will be increasing and diversifying, in kinds of programs needed and for special groups such as the Asian Americans.

Mr. HALAMANDARIS. We will now call upon Mr. Edwin Hiroto and I hope in due course you will respond to the questions I put to Mr. Yuen, but first of all, is your nursing home proprietary?

Mr. HIROTO. No; it is nonprofit.

Mr. HALAMANDARIS. Do you have any firm feelings about the question of whether a facility on a profit or nonprofit basis makes any difference?

Mr. HIROTO. I do. They are personal in nature, but I feel strongly there are not sufficient nonprofit nursing homes in the industry and that this lack of nonprofit nursing homes is one of the factors leading to the problems of that industry in not meeting the needs of the patients.

Mr. HALAMANDARIS. Would you say that this is a peculiarly Asian or Japanese problem?

Mr. HIROTO. No; that would be an overall assessment of the industry.

Mr. HALAMANDARIS. I had to ask that. Please continue with your statement.

STATEMENT BY EDWIN C. HIROTO

Mr. HIROTO. Thank you. I, too, want to express my appreciation for the invitation to be here. Before I give you my statement, I would like to declare that I was just 30 short hours ago in Hawaii and have had about 4 hours of sleep, so you will excuse me if I don't make too much sense.

Rather than discussing that which was included in the written statement, I would like to expand on it a little. Because I am the administrator of the Keiro Nursing Home as well as the City View Hospital, I look at the question of accessibility to nursing homes in a little different manner. That is, as access relates to other long-term care facilities as well, such as board and care or intermediate care or senior citizens' housing. I feel that the same problems that are faced by minorities, the Asian minorities, in gaining accessibility to the nursing homes can also be stated for the board and care and intermediate care and senior citizen housing areas as well.

Part of the problem of access, I believe, does relate to lack of nonprofit or community-based organizations in the nursing home field. With a nursing home which is held as a proprietary, for-profit organization, "quality of care" and the "level of care" suffer because no matter what the intent of the operators, there has to be at least a passive interest in profit.

So, perhaps one of the important things that might come out of this hearing would be an effort on the Federal level to create a requirement of quality or qualities of care within nursing homes.

The other thing I would like to suggest is that these Federal programs—grants, subsidies, and low-interest loans—should have clearer guidelines. These various programs should have administrative guidelines applied in its effort to meet the needs of underserved people. Just creating appropriations by Congress is not sufficient to meet these needs.

MINORITIES REMAIN UNDERSERVED

They continue to remain underserved and the minorities continue to remain underserved minorities. So it is necessary that within the administration of these programs that those responsible for the administration find methods or means whereby they can be more accessible to these people.

We have had, for example, application for an apartment project in the HUD office for 5½, almost 6 years now. We started out under the old 202 and now the 236 programs. I think we are probably being funded, but because we didn't know how to play the game of making applications, we were in deep trouble.

I believe all prospective applicants for programs of this nature end up in that same "bag" of not knowing which direction to turn, and so I would hope that in meeting these additional needs of the elderly, that somehow we can create the machinery within which the people who sincerely, honestly want to help have a way of getting those Federal funds and getting that Federal support.

I can only add one comment and that is I am most grateful that the Senate Committee on Aging has seen fit to understand and recognize the fact that minority groups do need their problems solved. Perhaps this hearing may make some difference in meeting that goal.

Mr. HALAMANDARIS. Thank you. We certainly share that hope. My first question relates to something that I heard in my childhood as I grew up, that among the Chinese community there was never any juvenile delinquency. The same was said to be true in the Japanese community, and both have the tradition of great veneration and respect for their elders.

I am wondering if that tradition continues or whether it has been eroded somewhat. I guess my question, if written by a journalist in Life magazine would be: Is the family dead? Is the extended family dying out? Grandmother and grandfather don't live with us any more. I think you have an idea what is on my mind. Would you like to respond to that?

Mr. HIROTO. Yes. I think that the Asian community's young are becoming more Americanized, so we are getting more juvenile delinquency and so are the families, so the extended family is disappearing. And the difficulties that are faced by all are faced by the Asian minority as well.

Mr. HALAMANDARIS. I see. Well, I count that as unfortunate.

Mr. YUEN. May I comment on your question?

Mr. HALAMANDARIS. Surely.

Mr. YUEN. I think your statements on juvenile delinquency among the Asian-American community is partly true. What I tried to say is, you will find some explanation as to the question of:

No. 1, I think, is most important; that is, the economic factor involved in this kind of family. As you all know, most of the young teenagers involved in street crimes or whatever are from poor immigrant families who have not established themselves at all. First of all, there are no job opportunities for their parents who speak no English and have little skill; adequate housing is not available; there are only a few training courses. These changes of environment have eroded the solidarity of traditional families, and parental control has diminished.

When we make the statement that the Chinese take care of their own, we are referring back to many centuries ago when our economy was still agrarian. The extended family is very much needed, and the mutual help and cooperation are important in order to make the family self-sufficient.

This is why the elderly person enjoys a very enviable position as the head of the family, and he controls all the financing and he has the vast knowledge stored in his head for the purpose of the agrarian family. The weather conditions or the success of crops all depends on the memory of the older person.

Now, this is why the extended family functioned perfectly back, let's say, 2,000 or 1,500 years ago. But when they moved into this new country, there was no more agrarian kind of economy waiting for them Instead, everyone has to go to the factory, punch cards in and out, and earn wages. There is no more need for the older person with his vast knowledge, and that if you lose your role or function within the group you also lose respect, and the care from the family.

Mr. HALAMANDARIS. Let me ask a couple of questions by way of summation of what we have heard.

Sharon, I will give you an opportunity.

Miss FUJII. I just wanted to respond to the question you just raised. I think to me this is a perpetuation of a myth which most people have of us as Asian Americans, and I think that that kind of thinking is inaccurate.

The fact that you do not hear of our problems does not mean that we don't have problems. I think we are learning more and more to articulate the difficulties that we do have, and young people in particular have problems with drugs, and pregnancies out of wedlock, et cetera. We have, because of the family structure in the past, tried to develop parallel structures to deal with them, but these are no longer adequate.

Mr. HALAMANDARIS. Let me ask you to write down the factors that I give you. First, are nursing homes necessary for some people? Do we have to have nursing homes?

Even though we could provide in-home services, there is a certain time when nursing homes are required. Is there anyone who will take exception to that? Would most people agree?

Mr. YUEN. Agreed.

Why the Scarcity of Asian-Americans in Nursing Homes?

Mr. Halamandaris. Now, asking the question why there are no Asian-Americans—using the term loosely—in nursing homes, would you help me rank the following factors. No. 1 would be the cost of care, the economic factor. No. 2 would be the issue of discrimination. No. 3 would be social and cultural factors. No. 4, I guess I would call personal choice—they don't want to go to nursing homes.

Is there any sort of consensus? Now, in my mind, the way I heard Sharon's testimony and from what I have heard from all of you, the most important, at least from the point of view of the Asian community, would be ranking in order of importance as follows: Number one would be social and cultural differences. Primarily the difference in foods and so on.

No. 2 would be this business of personal choice that they really don't want to go to nursing homes or it just hasn't been done.

No. 3 would be cost, and last, perhaps, would be discrimination.

Miss Fujii. Can I respond, because I guess I should clarify something. Your two and three I consider as being the same and that and discrimination I would have to rate probably equally as to why you don't find Asians in nursing homes. Maybe this wasn't made very clear in my statement, but just as important is the need for nursing homes to communicate, to reach out to minority elderly, that this kind of service is available. Thus far they have not done so by providing information in the various languages or hiring bilingual staff. So I would have to rate them equally and I apologize if I was unclear on that.

Mr. Halamandaris. I appreciate that.

Mr. Hiroto. Could I say something?

Mr. Halamandaris. Surely.

Mr. Hiroto. When we first undertook the creation of this Keiro Nursing Home we took a survey of some of our medical staff members at the hospital and 23 members responded to that survey.

One of the questions was "how many of your patients are now in nursing homes." Then the second part of that question was "how many of your patients should be in nursing homes but are not." Of the 100-plus patients included in the response, there were approximately 20 who were in nursing homes and 80 who were not that should have been. I would therefore place question No. 1 as "first."

Southern California is in a tremendously overbuilt situation so far as the number of nursing homes is concerned, so I would hesitate to try to measure what part discrimination plays in admission or nonadmission. I feel very strongly from our experience, say from 1962 or 1963 on, that probably within the range of your questions, one is very accurate and Nos. 2 and 3, somewhere near that range, and that last question—I wouldn't be able to answer.

Mr. Halamandaris. Could I interject? Has the confrontation been made? By that I mean have Asians tried to get into nursing homes and been refused? Have you really had a fair test on the issue of discrimination?

Mr. Hiroto. No; I don't think we have.

Mr. Halamandaris. So it is hard to evaluate that issue.

Miss. Fujii. But where there are concentrations of Asians we do not have Asians running these nursing homes, or Asian patients in

them. I think that is indicative of something. I don't know what you would want to call it, but it would seem strange, especially where there are nursing homes close to Chinatowns or Japanesetowns, and you don't find elderly people of these extractions in these facilities.

Mr. YUEN. I am from northern California. Maybe the climate there is a little better as far as discrimination is concerned. So far we have never run into any discrimination at all. They are just happy to accept as many as we can give them. I wouldn't put discrimination in my own list.

But I think there is a dearth of nursing homes. Not the traditional nursing home, but the new On Lok concept which has been funded by HEW. This is the new trend of nursing homes, and in addition to that the health care aspect, the continuous evaluation process for each and every one.

Cultural considerations and language proficiency are very important. There has to be a breakdown of cultural and language barriers before you can function successfully.

What is your second question. I didn't get it. You put cultural——

Mr. HALAMANDARIS. Oh, yes. Then we talked about cost and discrimination, and there was a fourth category that I had difficulty defining, relating to personal choice.

Mr. YUEN. Well, I think probably the most serious problem of the extended care facilities for disabled elderly is that they are operated for profit. Most people, if they have means, go to nursing homes. Even if they haven't, they can go through Medicare/Medicaid.

Mr. HALAMANDARIS. Did you say it would be a problem or would not?

Mr. YUEN. It would be a problem for some. Cost wouldn't be a problem, provided the people are eligible for Medicaid and are old enough for Medicare. It would be a problem for the in-betweens who either have too little money to go to private nursing homes or too much to be eligible for Medicaid.

LACK OF EXPERTISE

The reason there are no Chinese operators of nursing homes is that they do not have the training and information as to how to organize and operate, and so forth. Certain other qualifications, such as being an RN, would improve one's chances of getting into the business.

From our experience there are quite a few RN's who got tired of working for doctors and hospitals, and they run a nursing home business and they make it go, so I think the emphasis is to train, to inform people of procedure, getting set up.

Mr. HALAMANDARIS. I am going to ask my colleague, Mr. Yamagata, if he has questions, and if so, I will let him direct them to the panel. Mr. Seto and Mr. Affeldt have questions.

Mr. AFFELDT. I have just one. During hearings conducted by this committee, one of the most serious problems is retroactive denial payments. Now, Mr. Hiroto, as a nursing home administrator, I would like to ask you to what extent have you been victimized by this problem and also to what extent have your patients suffered the hardship of a retroactive denial payment.

Secondly, I would like to know what you think should be done to deal with this problem.

Mr. HIROTO. That second one is harder. Yes, retroactive denial created some hardships—definitely—no question about it. In our nursing home, we stood the gaff and we didn't pass it on to the patients, so they didn't suffer as a result of that.

I would like to allude to something that Mr. Yuen said, there is still a continuing problem insofar as Medicare is concerned for the patients' accessibility, because Medicare in effect no longer covers extended care facilities.

On inpatient stays, the rule has become so strict that it is impossible for a person to be eligible for long. So there is a problem for the middle American who has more than $1,500 (in the State of California), to get some kind of extended care without going completely broke and then getting on to Medicaid.

As far as how we resolve the problem of retroactive denials, we haven't had a problem for some time because the Medicare program has clarified its position on that, and the reason we don't have a problem is we don't have more than 4 percent of our patients at any time who are Medicare patients. In other words, they are ineligible, so the patient possibly is suffering the consequences.

ELIMINATE WAITING PERIOD

Mr. AFFELDT. As you know, there is a 3-day requirement to be eligible for nursing care and home health care. In a recent report to the Committee on home health care, it was recommended that this 3-day requirement be eliminated. I would like to have your reaction to that suggestion.

Mr. HIROTO. My reaction is, I think there could be some definite savings by getting rid of that requirement. What effectively happens is that the physician has to make certain that the patient is hospitalized prior to admission to a nursing home, so he finds a proper diagnosis to make sure that the patient is hospitalized for 3 days. I would think that a direct admission to a nursing home is just as reasonable as a recommendation for admission to an acute-care hospital.

Mr. AFFELDT. Do you have any comments on that recommendation, Mr. Yuen?

Mr. YUEN. I think there should be something done by this body in order to look into the real reason why the Social Security Administration is making this retroactive payment denial, even back to 2 years ago. How can we expect a small agency in any city, not just San Francisco, to be able to carry on. First, there is not that much reserve in the payroll to keep up the service. It almost seems that they are discouraging people from using home health services. This penalizes the innocent older person. Even if we give them the benefit of some extra money for which they are not eligible, it is better than making innocent people suffer, especially when they are 65 or 70 or 75 and need this kind of home health care so much.

SPECIAL DIETARY NEEDS

Mr. AFFELDT. I have one more question. I shall direct this to Mr. Yuen. The nutrition program for the elderly provided that special attention should be given to the needs of elderly minority groups and

the poor. Additionally, the proposed regulations provided that the agent is supposed to take into account special dietary needs of minority groups.

My question to you: Has the Administration on Aging contacted you about focusing on the special dietary requirements of older Asian Americans; or for that matter, anyone in the Asian community, to your knowledge?

Mr. YUEN. They have not contacted me. I contacted them. It seems to me that is the way Asians are usually treated. I contacted HEW's regional office (region X) after the Nutrition Act had been released at the request of elderly Asians and interested persons in order to explore an ethnic food program for Seattle's inner city.

Mr. SETO. I would like to direct this question specifically to Mr. Hiroto, but if Mr. Yuen wants to comment on it, that is fine. Would you please comment on the feasibility of ISSEI, NISEI, and SENSEI giving voluntary help to nursing homes to help bridge the social and cultural gap? In other words, specifically volunteering as a reader to the elderly, volunteering to cook ethnic food, and volunteering to organize recreational programs.

Mr. HIROTO. We have a voluntary program going on now at the Keiro Nursing Home, and it does in effect bridge that gap, and it is remarkable how, going back to nonprofit versus proprietary, the nonprofit organization allows us to create these programs; because it is nonprofit, we are able to use the energies of a whole lot of people—the talents of many professional, capable people—for free.

The Asian Social Workers of Southern California is a large, 60 to 70 member group of professionals, and they have for the last 2½ years provided all of our professional social welfare work for us. Through them we have been able to work with the UCLA School of Social Welfare, gaining students in a placement program to supplement and complement the work of the volunteer professionals and have thus been able to take advantage of all of these talents for the patients.

We have a large group of ancillary members who come in and assist in feeding of patients every noon and evening, and this, too, gives us the ability to increase quality of care. In every field, every paramedical area, is in one way or another covered by volunteers or by a partly professional staff and volunteers. And this makes a tremendous difference.

A nursing home is a nursing home is a nursing home, but what is received there is something that can't be easily defined.

Mr. SETO. Then you strongly support any type of Federal program which would encourage or help the youth or even the older retired Japanese-Americans or Chinese-Americans donating their spare time to help the elderly Asian-American?

Mr. HIROTO. Yes, definitely.

Mr. HALAMANDARIS. Thank you, Bob. We want to bring up our next panel, but before we go I want to address Mr. Hiroto, and would you respond to me privately on this question. It relates to one of the newest regulations which prohibits the use of accelerated depreciation by nursing homes. I wonder if you have been affected and have any comments?

Sharon, would you care to make a final comment? It seems to me you haven't talked since the beginning of the hearing.

Miss FUJII. No, I made my statement.

Mr. HALAMANDARIS. It will be included in the record in full at this point.

(The statement follows:)

PREPARED STATEMENT OF SHARON M. FUJII

I am pleased to have an opportunity to address the Subcommittee on Long-Term Care about the accessibility of nursing homes to minority groups. I further commend the Subcommittee and its staff for including elderly Asian Americans among the minority groups represented here today. Too often the practice has been to exclude Asians from any serious consideration because of adherence to a convenient mythology, which maintains that Asians have no identifiable problems. As noted in the report of the Special Concerns Session on elderly Asian Americans during the 1971 White House Conference on Aging, some 32 million dollars had been appropriated between 1969 and 1971 for community projects for the elderly. "Not one dollar was given to Asian American communities for their aged; the reason, according to government officials, was Asian Americans don't have problems." [1]

In subsequent statements, I will discuss the problems of elderly Asian Americans regarding the accessibility and availability of nursing homes. These problems must be viewed within a cultural context if the issues which relate to nursing home accessibility are to be adequately understood.

It should be noted that elderly Asian Americans represent a diverse category, consisting primarily of Filipinos, Koreans, Chinese, and Japanese. As used here, the designation Asian American refers to those who trace their national origins to East Asian countries. Similarly, the different Asian ethnic groups possess distinguishing characteristics among which are language, migration patterns, and family traditions. Each ethnic group is unique with distinct and separate experiences. Extreme care must be used to avoid misleading generalizations despite similarities. More extensive research studies and demonstration programs are needed to better understand the characteristics and conditions of elderly Asians in America. Nonetheless, it is generally accepted that they share certain problems, such as inability to communicate in English and cultural patterns which discourage utilization of existing services, thereby rendering many government programs and policies useless to elderly Asian Americans. These problems will be discussed later in greater detail.

ELDERLY ASIAN AMERICANS: A GENERAL DESCRIPTION

For decades Asian Americans have been considered part of the "other" category in all public information reports. Only until recently has there been growing awareness and sensitivity to our existence. 1970 Census figures indicated that there are 1,369,412 Japanese, Chinese and Filipinos in the United States.[2] This figure does not include Korean, Tibetans, Mongolians and other East Asian groups since they are not separately counted by the U.S. Census Bureau. Their numbers seem relatively few and sufficient substantive or speculative information does not seem to be available on them.[3] Recent estimates further suggest that there are an additional 103,000 Koreans in this country.[4] The majority of Asians are located along the West Coast and Hawaii, having a combined total of 990,461 (458,681 Japanese, 236,413 Chinese, 274,367 Filipinos and 48,000 Koreans).

From the 1960 Census, there were 12,415 Chinese over 65 years old, representing 6.88% of the total Chinese population; 29,235 Japanese over 65, representing 6.03% of the total Japanese population; and 6,456 Filipinos over 65, comprising 3.61% of the total Filipino population. More recent statistics are not available. Accurate information indicating the percentage of elderly Asians who are in nursing homes does not exist. One source has proposed that only 4% of the elderly in nursing homes are nonwhite.[5]

[1] White House Conference on Aging, *Special Concerns Session Reports—The Asian American Elderly* (Washington, D.C.: U.S. Government Printing Office, 1972), p. 2.

[2] 591,290 Japanese, 435,062 Chinese and 343,060 Filipinos were reported based on the 1970 Census.

[3] Richard A. Kalish and Sam Yuen, "Americans of East Asian Ancestry: Aging and the Aged," *The Gerontologist*, vol. 11, no. 1 (Spring, 1971), Part II, p. 36.

[4] This estimate was made by the Asian American Social Workers, Los Angeles in January, 1972.

[5] U.S. Department of Health, Education, and Welfare. *Health in the Later Years* (Washington, D.C.: U.S. Government Printing Office, 1971), p. 50.

The present generation of elderly Asians is almost entirely an immigrant population. They migrated from East Asian countries between the 1890's and mid 1920's, settling initially along the West Coast and Hawaii. Many are in their mid 70's. They immigrated to the United States in search of economic opportunities and often had no intention of becoming permanent residents. Our elderly men worked as laborers on the railroads, in logging camps and mills, in salmon canneries and as farmers. Their experiences in this country have been characterized by hardships and disappointments. "They suffered from racial discrimination; they have encountered major linguistic and cultural barriers to assimilation; and have low occupational status." [6] Racial attitudes led to a series of discriminatory acts: the Gentleman's Agreement of 1908, the Immigration Act of 1924, the evacuation of the Japanese to concentration camps during World War II, and restrictive quotas on Filipino immigrants between 1935 and 1945. They have suffered from discrimination in labor, housing and education. Their experiences are too numerous to relate. The degree of social and cultural exclusion is supported by the statistic that 96% of the elderly Japanese have not become American citizens even though three fourths of them have lived here for more than 40 years.[7] It is not surprising, therefore, that many elderly Asians live in self-imposed alienation from the majority culture, retaining traditions and languages of the Orient.

With the passage of the McCarran-Walters bill in 1952, more elderly Asians have come to this country. Some have migrated as quota immigrants; others came as relatives of American citizens; and still others emigrated under the Refugee Relief Act of 1956. Unlike the earlier immigrants who were relatively homogeneous in terms of age. education, and social class, the recent elderly immigrants are more heterogeneous. Between the late 1950's and early 1960's, 200 Chinese over 60 years of age immigrated to the U.S. each year.[8] With the Immigration and Nationality Act of 1965, the numbers of Chinese elderly entering each year has averaged around 500 while the numbers of elderly Japanese newcomers appears to be less.[9] Since 1965, only 561 Filipinos over 60 have entered the country.[10]

BARRIERS TO NURSING HOME UTILIZATION BY ELDERLY ASIAN AMERICANS

Why haven't nursing homes served elderly Asians? Is it because there is no demand for long-term institutional care since families and friends have traditionally "taken care of their own?" Is it because our numbers are small and therefore easily overlooked? Is it because there has been no attempt to develop institutional care which is acceptable to the life style of elderly Asians? Why do they prefer to remain with their children and relatives even when skilled nursing care becomes necessary? And of those who are in nursing homes, what factors and conditions influenced placement? Such questions can not be answered here, but will have to be explored in order to comprehend the nature of nursing home utilization by Asian Americans.

Major deterrents to nursing home use include the following:
the absence of ethnic foods which satisfy oriental dietary preferences;
the absence of bilingual and bicultural staff;
the absence of trained personnel who are sensitive to elderly Asians, and who are capable of relating to racial minorities;
the tradition of caring for the elderly within the extended family system; and
inadequate dissemination of information regarding nursing home availability.

Lack of bilingual staff and ethnic foods, family traditions, and the impersonal character of nursing homes appear to be the major obstacles to utilization. Most elderly Asians cannot communicate in the English language. Consequently, they are subjected to insensitivity and unnecessary harassment by workers having no understanding of the language or its peoples. In some nursing homes where elderly Asians are found, the absence of bilingual staff contributes to patient neglect and personal frustrations with individual ability to function in this kind of environment. Such a setting can become a virtual prison, having negative psychological and sociological impact upon the patient. When there is no common basis for communication, it becomes impossible to adequately assist elderly Asians.

[6] Kalish and Yuen, p. 36.
[7] Asian American Social Workers, Executive Task Force, *Final Evaluation: Demonstration Project for Asian Americans, July, 1971—February, 1972* (Los Angeles: Asian American Social Workers, 1972), p. 40.
[8] B. L. Sung, *Mountain of Gold: The Story of the Chinese in America* (New York: Macmillan, 1967).
[9] Kalish and Yuen, p. 39.
[10] *Ibid.*, p. 40.

Numerous situations where communication has been crucial can be described. Only two will be cited. In one nursing home, an elderly Japanese woman was strapped to a wheel chair presumably for her own protection. She was unable to speak any English, and there were no bilingual staff present. She was ignored most of the time. One day she was found dead from suffocation because the straps were too tight. Another tragic incident involved an elderly Chinese woman in her 80's who refused to eat her meals because the food was not familiar to her. She found the meals unappetizing. Unable to speak English, she could not explain why she would not eat her meals. The staff considered her behavior obstinate. This continued for several weeks until she had to be put into intensive care for malnutrition.

Within the Asian culture there is an emphasis on the extended family so it is common practice for relatives to care for the aged at home. Such help is highly individualized. The practice is also compatible with the desire of most elderly to remain in their own homes as long as possible. It remains to be seen whether the Asian family can continue to care for their elderly relatives at home.

Another obstacle or barrier is the lack of nursing homes, with the exception of several in California and Hawaii, which are operated by Asians for their elderly. In Seattle's inner city there was one such facility that served elderly Japanese and Chinese. Founded in 1945 by the late Mr. Hirabayashi, it had 25 beds, and provided class three nursing care. Most of the 25 patients were welfare recipients. Prior to closure, the average cost of patient care was $240 per month. The State welfare department's reimbursement rate was five dollars per day. Patients were in their mid 70's, and like numerous other nursing home residents, they desired activity programs to occupy their time. Over the years, there were always bilingual staff. The facility was closed in late 1969 for failing to meet State safety standards. The 25 patients were dispersed to several nearby nursing homes recommended by Asian doctors. Had attempts been made to assist the Hirabayashi Home to meet State regulations, and had funds been available to cover the costs, the closure would have been unnecessary.

Currently in Seattle three separate groups are planning to construct multi-ethnic nursing homes, which seems to suggest that existing long-term care facilities are inadequate. It is obvious from attending planning meetings that the concept of long-term care is relatively unfamiliar to Asian Americans. Those who are involved insist that there is a definite need to establish nursing homes planned and operated by Asians. When institutionalization does occur, the tendency has been to place the elderly in a few nursing homes which work closely with Asian doctors. It has also been observed by nursing home personnel that elderly Asians upon entry into a nursing home seem to exhibit greater physical disability than other patients, which suggests that institutionalization is delayed until there is no other alternative.

RECOMMENDED ACTION

Research studies must be initiated with Federal, State and local support to assess the needs and conditions of elderly Asian Americans. In this area, it would seem relatively simple for the U.S. Census Bureau to regularly produce information on the numbers of Asians by age categories. The Census Bureau is further urged to delineate the "other" category.

Asians like other minority groups are often caught in what seems to be an unending dilemma. To obtain financial support from public and private sources for service projects, we must be able to document our needs, which in turn requires research. However, funds for research studies have been difficult to secure resulting from the belief that Asians have no significant problems.

An indication of nursing home accessibility to minority elderly is the rate of utilization. Through general surveys, information could be collected to ascertain the extent to which existing nursing homes are being used by elderly Asians. We need to learn where they are placed and why, what is their average length of stay and average age, and what physical disabilities do they have.

Along with support for research studies, funds must be released for special demonstration programs to develop and test various long-term care service delivery methods that take into account the culture and language. Existing nursing homes, located near concentrations of Asians, could be expanded to serve minority elderly or perhaps residential facilities might be converted to intermediate or extended care facilities. With reference to the latter, a rather unusual situation has developed in Seattle over the past few years. There is an over abundance of Federally subsidized senior citizen housing in Seattle's Model City neighborhood. One recently completed facility, the Kawabe Memorial House, is attracting elderly

Asians. The building began as a 202 project, but was converted during construction to HUD's 236 and 221(d)3 programs. It has 162 units of which 135 are studio apartments. Because of the abundant housing supply in the area and because of interest among the Asian community for an ICF or ECF, a request was made to HUD's regional office to temporarily convert one or two floors to such use until a permanent long-term care facility could be provided. The request was denied even though the building could meet State requirements.

Assistance cannot be restricted to nursing homes, but should be made available for developing alternatives to institutional care—home care programs that offer a range of supportive services from home-health and homemaking services to group homes, foster homes for adults, and home delivered meals. These alternatives will enable elderly persons to remain in the community.

Added attention should be directed to training nursing home personnel about minority elderly, and recruiting bilingual staff. At the same time, community education programs could be launched to inform minority elderly and their families of what is available and how they go about receiving aid.

In planning health care services for elderly Asians, there must be increased cooperation and technical assistance from state offices on aging, local units on aging, and Federal departments through their regional offices.

HR 1 now pending before the Senate Finance Committee contains a serious limitation in Section 207, which would cut back Federal matching funds by one third to states for skilled nursing care after 60 days. Passage of this section would disastrously affect elderly Asians who may have to enter nursing homes in the future. This provision, if approved, would contribute to the further reduction of skilled nursing care by curtailing matching funds to the states. It is, to me, a regressive measure, especially when it has been amply documented that there is a desperate need to increase the quality of care in nursing homes. That cannot be realized with financial reductions. Instead, additional allocations are recommended to finance coverage of restorative services and activity programs for patients, and to provide incentives for construction, rehabilitation or upgrading nursing home facilities.

All long-term care institutions receiving Federal assistance should be regularly reviewed for compliance with licensing standards and the Civil Rights Act.

The aforementioned suggestions obviously require financial resources and a redirection of national priorities so that greater attention can be given to the problems of minority elderly. If there is to be a sincere commitment to change and to making old age a period of dignity and personal satisfaction for all of the nation's elderly, then the resources must be granted for research and demonstration programs benefitting minority elderly, for upgrading existing nursing home services, and for developing alternatives to institutional care. If the United States can spend billions of dollars fighting a war in Southeast Asia, then it surely can do more than it has in the past to assist its aged Asian Americans at home.

Mr. HALAMANDARIS. Will the panel on Aging and Aged Blacks come up, please?

PANEL ON AGING AND AGED BLACKS: HUBERT L. HEMSLEY, M.D., COMPTON, CALIF., CHARLES R. DREW MEDICAL SOCIETY, MEMBER, ADVISORY COUNCIL ON AGING AND AGED BLACKS; HOBART C. JACKSON, PHILADELPHIA, PA., CHAIRMAN, ADVISORY COUNCIL ON AGING AND AGED BLACKS, PRESIDENT, NATIONAL CAUCUS ON THE BLACK AGED; JACQUELYNE J. JACKSON, PH. D., DURHAM, N.C., ASSOCIATE PROFESSOR OF MEDICAL SOCIOLOGY, MEMBER, ADVISORY COUNCIL ON AGING AND AGED BLACKS

Mr. JACKSON. Thank you for this opportunity to appear.

I am Hobart C. Jackson, chairman of the National Caucus on the Black Aged and chairman of the Advisory Council on Aging and Aged Blacks to the U.S. Senate Special Committee on Aging. I have also been the administrator of the Stephen Smith Geriatric Center in

Philadelphia for 23½ years. This facility has as one of its components, the Stephen Smith Home for the Aged, the oldest home for the aged or nursing home in this country to our knowledge, administered by blacks and providing care and services to the black elderly. We were organized in 1864.

The difficulties that blacks and other minorities have in getting needed nursing home care is well known in the field despite the lack of definitive documentation of the problem.

Minority groups are not found in nursing homes, in my opinion, primarily for two reasons: (1) because of racially discriminatory practices and (2) because of extreme poverty. We might also add the failure of those with the power and the resources to do anything of a substantive nature about the problem.

The difficulty that we increasingly find in our work with the black aged across the country, as it relates to the nursing home situation, is that the problem is almost the reverse of that of the white aged. The problem, in other words, is not one of how to keep the older black person out of a nursing home or similar institution, it is, rather, how to get him or her in a good one.

As the new thrust for the development of alternatives to institutional care takes place, we are becoming disenchanted with the construction of nursing homes, with bricks and mortar, at a time when there are no nursing homes of significant proportions in minority communities.

The existing predominantly white church related homes for the aged are not admitting their black members. They do not have outreach programs to attract minorities. The good proprietary nursing homes are too expensive for minorities to afford. Most of the minority elderly receive old-age assistance and many proprietary facilities limit the number of such recipients and some will not admit any.

Unable to Give Expeditious Service

Despite our growth at Stephen Smith from a facility accommodating 45 residents in 1949 to one that now provides care and services for some 350 residents and tenants, one of our greatest frustrations comes from not being able to give expeditious service to the many persons on our waiting list who need nursing home care. The proportion of those on that list who need nursing home care has steadily increased over the years until currently about 90 percent of our applicants need skilled nursing attention. This is just the reverse of the situation that existed 23 years ago. Applicants today are older, sicker, more handicapped, and more disabled. This, of course, has resulted in an accompanying transition in our service function whereby most of our residents require skilled nursing care.

Many elderly black persons need and want nursing home care provided by black persons in their own communities but such care is, in general, just not available.

And while the President has escalated the situation among nursing homes to a position of prominence because of his expressed concern, I fail to see emerging at this time a positive viable system of nursing home care that would include blacks and other minorities.

I see instead a punitive approach which may result in the closing of some nursing homes that are attempting to serve minorities and

the poor on the grounds that they are not meeting standards. Other facilities, that perhaps should be closed, will also be terminated in the process.

The Sarah Allen Nursing Home in Philadelphia is a good example of the kind of nursing home that, in my opinion, should be worked with and enabled to meet standards through the provision of special resources. Here we have a situation that is true of most minorities in the field—impoverished agencies attempting to provide care and services to impoverished people with an obvious lack of financial resources.

The board of directors of the Stephen Smith Geriatric Center and our National Caucus on the Black Aged developed a position statement on the Sarah Allen Nursing Home* in January of this year which we'd like to file with this statement. While there has been some action by State officials to keep this home operating, the question of needed additional and special financial resources has not been faced as yet.

What specific measures should be undertaken to provide for the needs of members of minority groups who are both old and ill?

Since we are in position to almost start from scratch in minority communities in providing services for those who are both old and ill and since the number who will need this service is increasing at a significant degree as pointed out by the Special Concerns Session on Aging and Aged Blacks at the 1971 White House Congerence on Aging, I propose that we profit by the mistakes of the past and not just construct isolated nursing homes in minority communities, but instead develop multipurpose, multiservice, community-related geriatric centers. These centers would provide both residential and nonresidential services and varying levels of care and services.

The needs of any older person could be directly or indirectly met at the center: Out-reach services into the homes of older persons in the neighborhood would also be available as well as effective referral services when necessary.

Preferably they would have about 50 beds for in-resident service and they would be strategically located throughout minority communities.

HEW Financing Needed

In this connection as I pointed out at a conference at Duke University in June of this year, the U.S. Department of Health, Education, and Welfare should make available 100 percent financing for the development of black sponsors of nursing homes; 100 percent grant money for construction; and operating reimbursements for these residents and patients at a level consistent with the costs of care and services provided; and 100 percent funding for the development of alternatives on nonresidential programs. Blacks and other minority sponsors are not able to take advantage of Hill-Burton provisions and other matching formula plans because of inability to produce the matching funds and are not usually in position to amortize loans because of escalating operating costs. The same approach for housing the elderly in black and minority communities should be made by the Department of Housing and Urban Development.

*Statement attached, see p. 2479

The likelihood of the greater prevalence of infirmities among the black aged has been referred to by the Special Concerns Session of the 1971 White House Conference on Aging and Aged Blacks. These increasing infirmities suggest a perceptible rise in the need for institutionalization. Present planning is needed for those currently requiring institutionalization and unable to get it and for those needing institutionalization in the future. The Federal Government has not provided seed money, construction money, or operating money consistent to meet these needs.

We must guard against the perpetuation of inequities by seeing to it that our existing programs and any new programs serve all the minority elderly at least to a degree proportionate to their representation in the population, preferably, however, much more than this because of the multidimensional aspects of the problem.

We must also keep in mind insofar as minorities are concerned that the new programs developing for the aging are no substitute for money, their greatest need. The black aged especially need the opportunity to exercise options and choices—for until this time they've had practically no choice—but to be at the complete mercy of the providers of services.

The old tendency to plan for the black elderly imposing standards upon them is a hardy perennial that we should shed immediately—although it's obvious that it will persist in plaguing us. We've got to learn how to plan with people instead of for them. We must recognize the strength of elderly minorities in developing and helping to carry plans that are going to be in their best interests.

What continually surfaces from them, and I refer back at this time to the National Conference on the Black Elderly put on by our caucus 2 weeks prior to the White House Conference where some 800 elderly blacks from 20 States articulated their views and made resolutions for resolving them—what continually surfaces is the need of any open society.

As Whitney Young once said "our goal must be to move beyond racism to a truly open society. A society in which each human being can flourish and develop to the maximum of his God-given potential—a society in which ethnic and cultural differences are not stifled for monotonous conformity—a pluralistic society, alive, creative, open to the marvel of self-discovery."

An Open Society

An open society is not merely an integrated society—one that grudgingly allows blacks and other minorities some of the privileges of that society. It is rather one that offers some options and choices. There are a few black elderly who may want to enter existing nursing homes in predominantly white situations. They should have that opportunity. But there are also those who, for whatever reasons, want to remain in their own communities. Such a choice should not be penalized by inadequate services, discriminatory practices, and open hostility. It should be simply one choice that they should be free to make.

Access to viable multipurpose, multiservice geriatric centers in their neighborhoods with residential and nonresidential services is a choice that ought to be open to them.

It is certainly time that the Federal Government and other interests began to work with the development of viable systems of health and social care and services in black and minority communities with and through black and minority institutions and people: rather than continue to pursue a punitive approach of establishing standards criteria for them, without providing the accompanying resources with which to meet the criteria. This process usually results in closing those institutions that do exist and keeps others from even getting underway and thereby results in the systematic erosion and deterioration of services to blacks and other minorities.

We call for positive approaches rather than regressive measures in black communities—ones that, instead of being abhorent and repugnant to black people, as most of the current approaches are, would permit them to use their talents and skills in the injection of some much needed humanity in our work with older people.

ATTACHMENT

POSITION STATEMENT ON SARAH ALLEN NURSING HOME, BY BOARD OF DIRECTORS, STEPHEN SMITH GERIATRIC CENTER

INTRODUCTION

In view of the recent problems facing the Sarah Allen Nursing Home in West Philadelphia we feel that it is important and appropriate that we speak out on this matter because of the implications for the poor and Black elderly of our community.

SARAH ALLEN NURSING HOME

The Sarah Allen Nursing Home is a voluntary non-profit nursing home located in West Philadelphia in a predominantly Black community. It was started by the A.M.E. Church some five or so years ago with considerable assistance in the planning provided by the State Department of Public Welfare. The church has since relinquished its role and the Home is now governed by a self-perpetuating Board from the community. There are still some A.M.E. ministers on the Board.

From many points of view, the Home has never had a real opportunity to make it. Saddled with a huge debt at its inception, its financial problems have been compounded by the esclating nursing home care costs. There have also been many internal problems. Practically all of its residents receive an inadeqate State payment with which to purchase their care under the assistance program.

The State Department of Public Welfare has recently issued a "cease and desist" order which will result in the Home's closing despite the great need of this community for nursing home beds.

AN HISTORICAL PERSPECTIVE

According to Dr. Jacquelyne Jackson, secretary of the National Caucus on the Black Aged, prior to 1847 Black physicians tended to be self-trained or apprentice-trained, or, much rarer, to have received some training outside of the United States. In 1847, Dr. David Peck graduated from the Rush Medical College in Chicago, becoming the first Black medical school graduate from an institution in the United States. Subsequently, although a mere handful, other Black physicians were trained at white institutions. The first Black medical school was opened on 9 November 1868 at Howard University. At that time it was not restricted exclusively to Blacks. The first medical school restricted solely to Blacks was opened in 1876 when what is now the Meharry Medical College was a part of the Central Tennessee College.

In 1882, the Leonard Medical School of Shaw University, Raleigh, North Carolina, was established and it was closed in 1915. The Medical Department of the University of West Tennessee, opened in 1900, closed in 1923. The Louisville National Medical College, founded in 1888, closed in 1911. Flint Medical College in New Orleans operated from 1889 until 1911. The Knoxville Medical College

founded in 1895 had a brief existence of about six years, and the Chattanooga National Medical College also had a very brief existence around the turn of the century.

With the exception of the last two institutions (i.e., the Knoxville Medical College and the Chattanooga National Medical College), only Howard and Maharry were able to survive the devastating impact of the "Flexner Committee."*

That report established medical standards which should be met by existing medical schools (or by new ones) and had the net effect of forcing Leonard, the Medical Department of the University of West Tennessee, the Louisville National Medical College, and Flint Medical College to close due principally to their financial inability to meet the standards. Thereby, Blacks were deprived of significant sources of medical education and, to this day, have been handicapped by an insufficient supply of medical physicans.

The practice of closing Black institutions because they do not meet standards instead of developing an approach that enables them to excel in their performance has resulted in the systematic erosion and deterioration of services to Black and poor people.

We should learn well from these lessons of history rather than have them go for naught. It is certainly time for the Federal government and other interests to develop viable systems of health care in Black communities through Black institutions rather than resort to the punitive approach of closing them because they do not meet standards.

If other facilities were truly "open" to Blacks the situation would be different but they are not! The effect then of closing the Black institutions is regressive and is abhorrent and repugnant to Black communities.

We are also unhappily reminded of the premature demise of the Bureau for Child Care in Philadelphia in recent years when this much-needed agency should have been "saved" and moved to a level of providing a viable service.

Additional information developed by the National Caucus on the Black Aged and the United States Senate Special Committee on Aging reveals that the same attitudes and practices that have always led and still lead to the premature death of many Black children and adults in the United States linger on to plague those who happen to survive into old age.

Blacks have been forced to attempt to provide services and facilities for their own older persons, relatives, and friends, because the larger society has completely failed to do anything of a substantial nature about this problem. Research findings and personal experiences lead to the inescapable conclusion that health, welfare, and other life sustaining services for the Black aged are grossly neglected. This neglect is found at all levels of social and political organization—local, state, and national. Delivery of these services is grossly inadequate.

The Black aged in general, and especially those who are also poor (which includes the majority), are denied the medical and social support services that they so desperately need and which, in many situations, are, at least in principle, available to them.

Less than 3% of the residents and patients of homes for the aged and nursing homes in the United States are Black. The Protestant non-profit homes have practically no Black residents and are especially guilty of racially exclusive practices. The lack of the use of the proprietary home is more related to the inability to pay the rates charged. And yet the high incidence of poor health among Blacks of all ages inevitably leads to a higher death rate than their white counterparts have—shockingly high in this sophisticated and enlightened age of medical breakthroughs against the killing diseases. There is an especially serious problem in some hospitals where many Black elderly patients receiving Medicare have been treated as ward service patients.

THE SITUATION AT SARAH ALLEN

It seems to us that the situation at Sarah Allen must be assessed and evaluated in the light of this information. Here is an institution attempting no matter how ineffectively, to provide some equity for those persons subjected to greatest inequities in our society. Here is an organization attempting to introduce some humanity into an inhumane system.

Admittedly Sarah Allen needs help in the worst kind of way and in many different areas, but it has a nucleus from which there should be efforts to develop a viable organization to serve the elderly of the West Philadelphia community.

*Flexner, Abraham. *Medical Education in the United States and Canada.* To the Carnegie Foundation for the Advancement of Teaching, Carnegie Foundation, New York City, 1910.

The problems at Sarah Allen are simply a microcosm of the total problems of our society and reflect the lack of attention being given to our human problems. Instead of closing Sarah Allen every possible effort should be made to save it, improve and broaden its service until it becomes a facility in which all Philadelphians could take justifiable pride.

ACTION THAT SHOULD BE TAKEN

Because of the "common cause" concern that officials at Sarah Allen and those at Stephen Smith Geriatric Center have, we respectfully propose that the following action be initiated by the State Department of Public Welfare.

That a meeting be called of representatives from Sarah Allen, Stephen Smith, the Health and Welfare Council, the U.S. Department of Housing and Urban Development, the United Fund, the State Department of Public Welfare, the City of Philadelphia, and the community at large with the objective of considering in depth the problems of Sarah Allen and developing plans and procedures for not only preserving this facility but projecting substantive plans toward the development of viable programs and services to meet the needs of the elderly of the West Philadelphia community. It is felt that through joint, cooperative, and coordinated efforts an answer to Sarah Allen's problems can be found which in turn will greatly benefit the aged in West Philadelphia and the City of Philadelphia.

Mr. HALAMANDARIS. Thank you, Mr. Jackson. I will ask Dr. Hemsley to present his statement at this point and then we will ask questions.

STATEMENT BY DR. HUBERT L. HEMSLEY

Dr. HEMSLEY. Senator Moss, members of the Subcommittee on Long-Term Care, ladies and gentlemen, I want to thank you for your kind invitation to speak concerning the complex problem of aged blacks and nursing homes.

We are charged with the responsibility of answering the question of why elderly blacks are rarely found in nursing homes and what can be done to improve long-term care for this most deprived segment of our senior citizens.

Long-term nursing care is a small part of the health industry and the obstacles that continue to impede blacks from securing adequate health services in other areas are also operational here.

There are vast differences between the culture of the majority population and that of elderly blacks so that goals, priorities, healthy concepts, et cetera, are viewed in entirely different perspectives.

This gap is certainly in existence in Los Angeles today where the aged poor are crying out for needed medical facilities which are humanistic, comprehensive, and accessible but have thus far received only the traditional crisis-oriented ameliorative programs which failed so abysmally in the past.

There are 1,400,000 blacks 65 years and older and thousands aged 45 to 64 have spent their prime years contributing to the growth and greatness of America. However, just as their forefathers were kept in physical slavery they have been economically and psychologically enslaved all their lives.

Their health indices reflect a lifetime of substandard housing, limited educational opportunities, and lack of adequate medical and social resources which are the natural legacy of a society in which white supremacy and social Darwinism have been the philosophical basis for pathological decisions concerning blacks.

Regarding the status gap, in any social system there are gradations of classes and social statuses. In America, this gap exists between

physicians and patients. When you consider the fact that minority physicians have been restricted in medical school opportunities, residency training, and hospital staffing, and thus far from meaningful participation in emerging health programs, the dilemma grows.

Older Negroes are more than twice as likely to be poor as elderly Whites: 50 percent in poverty as compared to 23 percent for the Whites. In rural areas the ratio is 66 percent for blacks and 31 percent for Whites.

Fifty percent of the black men and four-fifths of the black women between ages 55 to 64 had a total 1969 income of less than $4,000. This comparatively low wage during employment years certainly would reduce Social Security in retirement years. For the 55-to-64 age group and the 65-and-over group, white males are receiving about twice as much as black males.

The migration of minority groups into urban areas breed conditions of crowding, poor health and sanitation, maladjustment, unemployment, social revolution, violence toward society, and against themselves—alcoholism, drug addiction, and so forth.

Over half of the total black population still resides in the South, but this increases to three-fifths for the elderly of both sexes. Above age 55, whites are three times as likely as blacks to be living in the suburbs or in the ring surrounding the central cities of metropolitan areas; 56 percent of all negroes are in central city areas.

Poverty, racism, and institutional rigidity have created a physical environment where blacks have been systematically deprived of adequate jobs, income, and housing and have produced a psychological and cultural milieu where frustrations and repressed aggressions become manifest in greater incidence of stroke, heart disease, mental disability, and hypertension than is found in the white population.

Higher Mortality Rate for Blacks

In jeopardy from the cradle to the grave, the black American finds himself with a higher morbidity and mortality at every stage of life, except in the very advanced age groups—75 years and over. From age 45 to 64 black women have twice the mortality rate of white women.

From age 55 to 64 mortality for black men is 10 percent higher than for white men. Between the years 1960 and 1968 life expectancy for black males declined a full year from 61.1 to 60.1 years. Relatively, fewer blacks live to benefit from Medicare and to collect Social Security benefits.

Despite the higher incidence of acute and chronic diseases the black elderly see physicians at an annual rate of 4.9 visits as compared to a rate of 6.1 visits for whites. The copayment and deductible features of Medicare act as effective deterrents to utilization of this program by the black elderly.

Furthermore, a large percentage of black elderly are excluded from the benefits of Social Security and Medicare by virtue of their previous employment or occupations (that is, domestic and agricultural workers, and so forth).

It is quite apparent that the black aged are suffering from no temporary aberration but are experiencing the continuing effects of

poverty and racism. Now, in their golden years, they are relinquishing whatever hopes they may have had—resigned to ignominious death in a subtle form of euthanasia.

The casualties of technology, automation, and cybernation are not accidents. Advanced mechanization, while adding to the gross national product, is substituting machines for men with increasing frequency. The result is movement out of skilled occupations and semiskilled positions, underemployment, unemployment, and early retirement.

These trends strike directly at the most vulnerable segment of the labor force—the black elderly. They have become obsolete, awaiting the inevitable in hopeless isolation. Thus, we find ourselves shackled with the legacies of the past, inspired by the rhetoric of yesterday, yet facing the realities of today.

How are we to step forward into the future? What specific measures should be undertaken to provide for the needs of members of minority groups who are both old and ill? We recommend the following: Medicare coverage should be expanded and improved to provide coverage for home care, long-term care, and extended care without prior admission to an acute-care hospital; expanded coverage for home care; coverage for out-of-hospital drugs; removal of the 100-day time limit on skilled nursing home care for those patients who continue to need such care; and, parts A and B of Medicare be merged and all deductibles and copayments be eliminated.

Costs for these services should be financed through taxes on rising payrolls and general revenues rather than from premiums paid by aged persons living on low fixed incomes. Services previously excluded such as foot care, eyeglasses, eye refractions and examinations for eyeglasses, examinations for hearing aids, false teeth and dental care, other prosthesis and outpatient psychiatric care should be provided. Medicare coverage should be expanded to include disabled Social Security beneficiaries. Front-end financing from the Medicaid trust fund should be utilized to develop senior citizen day care centers and a full range of geriatric health service centers, including community health outreach workers, transportation, information referral and advocacy services.

These centers should be owned and operated by nonprofit indigenous community corporations. The Administration on Aging should identify and design and support opportunities for older persons to render services to their communities.

Joint Effort Needed

The Administration on Aging and any or all public and private agencies should join together in a cooperative effort to develop programs of technical and financial assistance for local community groups in order to provide daily meals to ambulatory older persons in group settings and to shutins at home.

The $2 billion spent yearly by the Federal Government for private nursing home services should be diverted to non-profit social utilities and homes for the aged sponsored by religious organizations, benevolent organizations, community corporations, et cetera, where there is joint consumer control and equity by a representative number of the elderly receiving services.

Existing nursing homes and long-term care facilities owned by black nonprofit sponsors should be given grants and low interest bearing loans for rennovation and construction to meet minimum State and Federal standards.

The archaic practice of static custodial care in institutions where the elderly go to "lie and die" is self-defeating, inhuman and economically unsound. We recommend the development of a sociomedical approach utilizing progressive patient care techniques, phased intensive, intermediate, minimum care, rehabilitation, resettlement and joint effort of the health team integrated with community support to maintain the elderly in their chosen environment.

These services should include but not be limited to home health services, occupational and physical therapy, recuperative holidays, meals on wheels, day centers, recreational clubs and ambulance and transportation services.

The following new trends in long-term care should be researched and implemented wherever feasible:

1. Holiday admissions, the voluntary admission to nursing homes, extended care or appropriate facilities during the family's planned vacation;
2. Short-term admissions, a program providing for intermittent 2-week admissions of the aged patient every 4 months; and
3. Day hospital, the utilization of a unit combining medical and nursing care, physical and occupational therapy together with a noon meal for the aged.

Uniform Health Care Legislation

The implementation of health care legislation should be uniform and mandatory and not dependent upon matching State funds or voluntary participation of individual States.

Wherever feasible within the black community, comprehensive health services should be delivered through a community health corporation composed of indigenous consumers and providers rather than the traditional approach (medical schools, public health departments and medical health associations, etc.)

This health corporation should secure significant input from informed and relevant consultants within or without their community. The above will insure that equity, cultural relevance as well as self-sufficiency and self-respect become the end product.

Research in experimental health delivery system should be conducted to determine the best method of financing comprehensive geriatric services. Arrangements might include front-end financing from Medicare trust fund, Medicaid appropriation for neighborhood health centers or a combination of social insurance and general tax revenues for HMO's, etc.

We are opposed to restrictive provisions of H.R. 1, the House-passed Social Security and welfare reform bill scheduled to reach the Senate in 1972, and consider this a shortsighted attempt at achieving cost control at the expense of the poor and elderly with the resultant effect of transmitting cost to the State.

Regarding Medicare cutbacks, the increase in the deductible of part B supplemental medical insurance from the present $50 to

$60 beginning January 1, 1972, the provision would make it mandatory that the elderly pay a daily copayment of $7.50 for each day in the hospital from the 31st to the 60th day. At present they pay $60 deductible only for the first 60 days' hospitalization.

Also included, concerning Medicaid cutbacks, are the provision that would repeal the existing provision requiring States to have comprehensive Medicaid programs by 1977; the provision that permits States to maintain only basic Medicaid services and permits them to reduce or eliminate other services without prior HEW approval or utilization control; the provision imposing upon the Medicaid recipient cost sharing in the form of enrollment fees, deductibles and copayments; and the provision cutting back Federal matching funds for Medicaid by one-third after 60-days hospitalization in a general or tuberculosis hospital, 60 days of care in a skilled nursing home or 90 days of care in a mental hospital.

On May 10, 1971 in our address in Los Angeles we predicted that there would be many blacks, whites and many poor, elderly people who would die as a result of the inhuman treatment Sacramento had decreed.

I show you a full-paged editorial on page 32 of aged people who have died as a result of Medi-Cal cutbacks in the State of California.* I call upon this subcommittee to investigate this and to see whether or not steps could be taken to remedy this program.

Thank you for the opportunity to present my statement.

Mr. HALAMANDARIS. Thank you, Dr. Hemsley. That is an eloquent statement and to try to follow that with questions is going to be difficult indeed. I am wondering if you would comment briefly on this situation in Los Angeles and surrounding areas specifically about utilization.

We have heard one of our previous witnesses say that southern California is overbuilt and there is an excess of nursing home beds. Secondly, you made a point in your statement earlier relating to whether or not nursing homes should be proprietary or not. If you could comment on those two aspects, I would appreciate it.

Dr. HEMSLEY. I have thought long about profit versus nonprofit and I am convinced that poor people and minority people are being sold a bag of worms over this whole thing about profit versus nonprofit.

On our side of the tracks, on the other side of the cotton curtain, everything has been nonprofit for the last 400 years. It has been nonprofit ever since we have had 100 percent full employment on the plantation and it is nonprofit now.

BLACK-OWNED ENTERPRISES DECLINING

The number of black-owned and profitmaking enterprises has steadily declined, despite the fact that our GNP is over the $3 trillion mark. Also, when you look at it you find that the only business in the United States which can be nonprofit and exist is the Government. They are the only people who don't have to make money. Unfortunately, we do.

The other trick bag is that most nonprofit setups when you look at them from an accountant's view—and I am not an accountant—show you the tricks whereby nonprofit enterprises do make money and

*See appendix 1, item 1, p. 2523.

in a significant fashion so that anyone who likes to speak in depth about profit versus nonprofit and not conduct proper research, can be led down the bridle path.

What I would like to see are institutions in minority communities which are viable, which have a broad base are not subject to White House political expediency.

I think this type of thing has been a steady diet for minority people in the history of this country. We have got to recognize that the health care industry is the second largest industry in the United States, over $85 billion a year.

I feel that there should be institutions in the black community who make a profit in the health care industry, but there is a vast difference between exploitation and providing adequate services with justifiable return. What I would like to see is the type of efficiency which exists in the General Motors Corp., and other big corporations in this country and begin to establish these types of situations in our own community; for example, co-ops.

I think we are going to have to look closely about whether or not we can deal with nonprofit institutions in poor areas. About the overbedding situation in Los Angeles, I happen to be privileged to serve on the Los Angeles Health Planning Committee this past year and I am aware that there are a great number of nursing beds in the Los Angeles area, a great number of hospital beds.

Unfortunately, in the curfew area where I chose to practice this does not exist and there are many reasons why people do not put up institutions in minority areas. When the question was asked of our Asian counterparts why there are no Asian-owned nursing homes, or only one, it was because poor people cannot find the means to finance or to put up an institution in the nursing home taking care of people who cannot pay their bills.

As a result of this, nothing flourishes there. It is an economic wasteland. That is why if you apply the other principle you always come up with the same problem. What we need and what poor minority people need in this country is the same type of internal Marshall plan which allowed Japan to flourish and to grow following the second World War.

Those of us that have visited areas of Japan which were wasted by the atom bomb, now find them flourishing. What they did was to give the people the technological know-how and economic resources and let them do their thing. I feel that there are not adequate nursing homes in the Los Angeles area.

Black-Owned Nursing Homes Face Bankruptcy

Fifty percent of the black-owned nursing homes in the Los Angeles, Calif., area at this time are bordering on bankruptcy because the State has placed them in an untenable economic position.

We find the Nixon administration saying to us that the nursing homes must come up certain standards. Yet, they are not supplied with the resources. We feel that this is a calculated move to again put out of business those institutions which have been the lifeline for the black community.

Mr. ORIOL. Based upon the newspaper article which you submitted for the record,* you point out that this is part of the Medi-Cal program or the California Medi-Cal program. It says in this article by David Shaw—and I know nothing more than what is said here—32 elderly patients have already died, most of them within a short period, of even just days or hours after the State said they were not sick enough to warrant treatment in facilities which had scheduled nursing care available 24 hours a day.

Nineteen of the 32 patients died after they were transferred, all of them against their family's wishes and a great many of them against their own doctor's advice to facilities with either a lower level of medical care or no medical care at all at a savings to the State of $4 to $7 per patient per day.

Can you tell me if these patients were in a skilled nursing home to begin with?

Dr. HEMSLEY. That is correct.

Mr. ORIOL. Can you tell me what category of facility they were then transferred to? What is this facility without medical care?

Dr. HEMSLEY. What we have in California is intermediate care facilities. This is a facility in which there is a vocational nurse there. Usually, they provide services from 8 o'clock until 5 o'clock and after that there may be one person there throughout the rest of the evening.

They do have physicians that they relate to for medical problems, but it is felt that these patients do not require the skilled, intensive care of a nursing home——

Mr. ORIOL. And yet several died within hours after the transfer. They were not sick enough.

Dr. HEMSLEY. According to the Bureau of Health statistics in Sacramento, they weren't. This is the sort of thing we pointed to in our testimony on May 10, 1971, when we predicted it would occur. We think there are more lives being wasted and we bring it to the attention of this committee because it needs investigation.

Mr. ORIOL. May I just get a little into the procedure here?

Dr. HEMSLEY. I would appreciate it if you would.

Mr. ORIOL. Who decided that these transfers shall be made. What power does the physician have for these patients?

CANNOT EVALUATE CONDITION OVER TELEPHONE

Dr. HEMSLEY. As a physician and privileged to practice in Compton, which is the largest city west of the Mississippi with black population approaching 92 percent, we found ourselves as medically impotent that what we can say over the telephone regarding the patient's condition is one thing and what the people they have to evaluate the records—who have never seen the patients themselves physically—decide is another thing.

This goes from whether or not they are removed from a skilled nursing home, or whether or not they need surgery. Frequently people placed in those positions make untenable judgments—most persons with training could tell you you cannot decide whether a person needs

*See appendix 1, item 1, p. 2523

certain procedures without adequate physical examination which you yourself have to perform.

Because of the welfare status and the fact that the administration in California views all people on any State welfare program as being parasites, criminals, ne'er-do-wells, they are treated accordingly and their wishes and health status are treated accordingly. As a result, they make those types of decisions arbitrarily.

Mr. ORIOL. The people with the paper in front of them, you say they are in Sacramento?

Dr. HEMSLEY. Yes.

Mr. ORIOL. So they are not as up-to-date about a condition that had existed weeks before?

Dr. HEMSLEY. That is correct. Anyone taking care of elderly people knows this, that the situation can change from moment to moment.

Mr. ORIOL. And they have no right to object?

Dr. HEMSLEY. Many of the administrators have. Many of them have undergone the cost of keeping them there without getting payments and retroactive denials that Mr. Affeldt was speaking about. My practice is composed of 75 to 80 percent people who are Medicare or Medicaid recipients.

Mr. ORIOL. Do you as a physician have any reason to doubt the accuracy of this story?

Dr. HEMSLEY. Not at all. In fact, Mr. Shaw's article has been researched and I think again his records and resources could be for the benefit of this committee.

Mr. ORIOL. Do you as a physician believe that the transfer itself may have worsened the patient's condition bringing on the death?

Dr. HEMSLEY. There is no question in my mind that their transfer—moving these patients from one facility to another—is directly the cause of the death. I believe that one of five deaths of elderly and minority people, are directly related to economic differentials and racist institutions in this country.

Mr. ORIOL. Thank you. If I may turn to Mr. Jackson for a moment, and perhaps you have already covered this, as you know there is a new office within the Department of HEW designated by the President to deal with nursing homes and nursing programs to approve nursing homes.

I wonder whether you could, either as chairman of our Advisory Council or chairman of the caucus on black aged or administrator of a home for the aged, develop—unless you already have done so—and to be submitted by you or by this committee a description of what you would like to see that office do in terms of—I hate to say "demonstrations," but perhaps we do need some—demonstrations or other types of action that can be taken to deal with some of the problems we are dealing with.

Dr. Jackson, if you could, you have indicated in your statement the lack of hard data and I wonder whether that office could be called upon to supply this data, too.

BLACKS SHOULD HAVE A HAND IN PLANNING

Dr. JACKSON. While such a department as that designated by the President to deal with nursing homes and nursing programs to im-

prove nursing homes could be called upon to supply us with much of the needed data, it may also be necessary to consider several alternatives. One alternative may be the development of a program whereby the National Center for Health Statistics could be designated as the agency responsible for obtaining the desired data. Whatever system is developed, it is crucial that blacks themselves have a hand in every stage, including decisions about what types of data need to be collected, how such data shall be presented, analyzed, and interpreted, and what usage will be made of the data. At the very least, the national caucus on the black aged would be critically concerned about data relative to black access to nursing homes, conditions under which they reside in those nursing homes, and the statuses of black employees (including medical personnel) in such homes.

Mr. JACKSON. I think I did include in my statement a recommendation that we would certainly like to pass on. That has to do with the development of geriatric centers, multipurpose multiservice centers, providing both residential and nonresidential programs and services in black neighborhoods.

Mr. ORIOL. Have you brought this to Dr. Callendar's attention?

Mr. JACKSON. Perhaps not directly. She did attend a conference at Duke University at which I spoke on the same subject. It would appear that the thing that is mostly needed here is some kind of center that would take care of the mistakes of the past by not developing residential services in isolation but rather develop one that is going to be related to the community.

We are recommending that the centers be 100-percent financed federally. There should be 100-percent financing of development of black sponsors; 100-percent financing of construction costs of these facilities; and operating costs should be taken care of on a cost-reimbursement basis; that is, complete operating costs. We feel this is the only equitable way to approach this problem.

For example, going back to the question that was posed to Dr. Hemsley, I think that one of the real problems is that there has been a reluctance to face up to the cost of nursing home care across the country. This is not true just in California.

Mr. ORIOL. We are getting cutbacks rather than——

Mr. JACKSON. Right, we are not really facing up to the problem.

Mr. HALAMANDARIS. Mr. Jackson, let's continue along these same lines. In your opening statement to us you commented that we are continually faced with nursing homes being closed and the Nixon administration has been closing nursing homes instead of helping them upgrade. Is that the sense of your statement?

Mr. JACKSON. Yes.

Mr. HALAMANDARIS. And your remedy is that we need to help nursing homes upgrade. Specifically, what would you recommend? How can we help them? What kind of programs should we offer? Are you talking about new wings or more construction? Are you talking about training personnel? What are you talking about in terms of the type of support you would like to see if you had a nursing home that was on the borderline?

Mr. JACKSON. I have one that is on the borderline.

Mr. HALAMANDARIS. All right.

National Cost Reimbursement System

Mr. Jackson. I am talking about a combination of many of the things that you are referring to. Primarily, however, the great need is for a national cost reimbursement system in the minority communities. I am proposing as a prototype—in view of the fact that it might take legislative action to do some of the things that we are talking about, on a comprehensive basis—I am proposing the development of the multipurpose geriatric centers with 100 percent Federal financing in order to get some of these underway. The new concept here has to do with the nonresidential services including an outreach to the surrounding community.

With reference to the existing nursing homes, I think the biggest problem has to do with their funding. Operating costs for those who cannot afford to pay are not being reimbursed on the basis of the costs of their care. Many of these homes also have capital loans that they cannot amortize because of escalating costs. In most cases they have either adequate management or potentially adequate management with some assistance.

It is primarily a question of getting the resources in order to do the job. You have a situation, especially among nonprofit facilities in black communities where impoverished institutions are attempting to provide services to impoverished people, so you have a compounding of the financial difficulty. It is primarily, in my opinion, a matter of money.

Mr. Halamandaris. That was made very clear to me midway in Dr. Hemsley's statement. I would like to ask Dr. Jackson if she has a comment on this as to what is needed to help?

Dr. Jackson. The question of what is needed to help nursing homes upgrade themselves I think has been answered very aptly by Mr. Jackson, and I would add that one has to consider, as he emphasized, the need for developing new nursing homes in a number of areas where they do not now exist.

I would also like to reemphasize Dr. Hemsley's concern about profitmaking enterprises for blacks.

Mr. Halamandaris. Again, what about this assertion blacks take care of their own? Is it truth or a myth?

Blacks Care for Their Own

Dr. Jackson. No, it is not a myth. The question is whether or not the kind of care which is provided is sufficient and so what we find is that to the extent possible blacks provide for themselves and their families and others in need, that the extent to which they fail can be laid principally and almost solely to the fact that this society does not provide the needed supports to enable those blacks who cannot receive effective and efficient care to get that care.

Mr. Halamandaris. That is very well put.

Dr. Hemsley, maybe you can respond to this. Do you see the kind of erosion in respect for the head of the household that we see in other communities among the blacks? Do you see the erosion of this tradition which required them to take care and assume responsibility for

parents and grandparents? Is the extended family among blacks on its way out?

Dr. Jackson provided me with a very eloquent answer. How would you respond?

Dr. HEMSLEY. It is a very difficult point, there is no question about that. The black male—you talk about head of the family, you have to understand that in this society the black male has always been placed in the position where he was subordinate to his woman because he could never get a job while she always could in someone else's kitchen.

That is still the case today. Unemployment is 27 to 28 percent, according to the new Urban League statistics which just came out 2 weeks ago. As a consequence, it is a little difficult for my sons and daughters to look up to me if I myself cannot provide for them.

When you talk about erosion and who should be in a certain area in terms of field of responsibility, it is a little difficult for me as a male and being a chauvinist, which I am. The problem is even more complex because in the St. Louis area the Urban League was only able to place one black male in a job over the age of 41, which simply means when you get to my age in life and you don't have it made, you go steadily downhill.

Mr. HALAMANDARIS. Thank you. I just want to enter into the record a letter received from David Norman, Assistant Attorney General, Civil Rights Division, and also a letter from J. Stanley Pottinger, Director, Office of Civil Rights.

(The letters follow:)

DEPARTMENT OF JUSTICE,
Washington, June 1, 1972.

DEAR SENATOR MOSS: I wish to acknowledge and thank you for your letter postmarked April 26, 1972, requesting information with respect to nursing home complaints and actions by this Department.

The Civil Rights Division has jurisdiction to bring action against segregated or discriminatorily operated nursing homes under three civil rights statutes: (1) if the home is a public facility within the meaning of Title III of the Civil Rights Act of 1964, 42 U.S.C. 2000b, the Attorney General may bring an action, provided he has received a signed complaint from a directly aggrieved individual; (2) if the home in question is a recipient of federal financial assistance and the agency extending the assistance (e.g., HEW) is unable to bring about voluntary compliance with Title VI of the 1964 Civil Rights Act, the agency may refer the matter to us for suit under 42 U.S.C. 2000d–1; (3) inasmuch as nursing homes may be "dwellings" within the meaning of Title VIII of the 1968 Civil Rights Act, 42 U.S.C. 3602(b), the Attorney General may bring a civil action under the provisions of 42 U.S.C. 3613. In fact, the one lawsuit brought by this Division against a nursing home was brought pursuant to Title VIII, the fair housing law.

An examination of our records concerning Title III complaints (received since October 1969) indicated no such complaints with respect to nursing homes. Similarly, available records regarding Title VI matters do not indicate any complaints with respect to nursing homes. Our Housing Section investigated a rest home in Charlotte, North Carolina, in the summer of 1969; ultimately, that matter was resolved by informal negotiation.

As mentioned earlier, this Division brought one action against a nursing home, i.e., *United States* v. *Anderson County* (S. Carolina) *Home*, C.A. No. 69–324, D.S.C., filed in April 1969. The Department of Agriculture, which had Title VI jurisdiction by virtue of the home's receipt of commodities, had investigated the home and found racial segregation. When efforts to obtain voluntary compliance failed, the Agriculture Department referred the matter to this Division. Meanwhile, the home withdrew from the commodities program. Thus, the suit was brought under the fair housing law. It was resolved by consent order on March 2, 1970.

Primary responsibility for implementing Title VI with respect to nursing homes belongs to the Department of Health, Education, and Welfare. Since that department should be in the best position to respond to your inquiries, we have sent a copy of your letter to Mr. J. Stanley Pottinger, Director of the HEW Office for Civil Rights, and asked him to respond directly to you.

I hope that this information will be of assistance.

Sincerely,

DAVID L. NORMAN,
Assistant Attorney General,
Civil Rights Division.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., August 7, 1972.

DEAR SENATOR MOSS: Your letter to Mr. Jerris Leonard, Assistant Attorney General, Civil Rights Division, Department of Justice, regarding the kind and number of complaints received against nursing homes has been referred to this Office. I apologize for the delay in replying.

Under Title VI of the Civil Rights Act of 1964, the Office for Civil Rights, Department of Health, Education, and Welfare, has direct responsibility for the civil rights compliance determination for approximately 4500 extended care facilities participating in the Medicare program under Title XVIII of the Social Security Act. We also have responsibility for monitoring the civil rights compliance status of continuing grant agencies receiving Federal financial assistance from this Department. These State agencies, in the administration of their programs, use approximately 15,000 nursing homes for which they are responsible for the enforcement of Title VI. In carrying out their civil rights responsibility, State agencies are required to make civil rights investigations and to have reports on file to support their civil rights compliance determination for each nursing home. These reports are reviewed by our staff, and a random sample of nursing homes selected for on-site investigation as a method of evaluating the civil rights efforts of the continuing grant agencies.

Our records show for the year April 1, 1971, through March 31, 1972, Office for Civil Rights' personnel reviewed 710 nursing homes. In nearly all instances the nursing homes were found in compliance; but, in some instances, questions were raised because of low utilization by minority patients. The relatively small number of minority patients in these nursing homes appears to be due to questionable referral practices. In an effort to correct these practices, State agencies have been asked to review the referral practices of their local agencies and to eliminate all elements of discrimination.

During this same period, complaints were received against 19 nursing homes. These complaints involved discrimination in the assignment of rooms, failure to provide services on a nondiscriminatory basis, access and acceptance for service, and discrimination in employment. As of March 31, 1972, twelve of these complaints had been investigated and successfully resolved in compliance with Title VI. The remaining seven were still pending at the end of the last reporting period.

In July of 1969, all hospitals and extended care facilities participating in the Medicare program or receiving other types of Federal financial assistance were requested to submit reports reflecting their current compliance status with the requirements of Title VI of the Civil Rights Act of 1964. This information from extended care facilities was compared with similar information secured from these facilities in the spring of 1967. While, in general, these comparative statistics from 4400 extended care facilities reflected gratifying improvements in services to minority groups, the area of utilization by minority groups was still a cause of concern. Although there was an increase of 82 percent in the number of extended care facilities serving minority patients and an increase of 75 percent in the actual number of minority patients served, minority patients still constituted only 5.2 percent of the total patient load in these facilities. This study revealed that a substantial number of such facilities located in racially mixed areas were continuing to serve patients exclusively of one race. This was true despite the fact that these facilities had adopted and published open admission policies. A study is currently under way to determine the causes of the above situation and the actions necessary to correct this problem.

At this time, the review of one city has been completed. This review covered the three hospitals and two extended care facilities participating in the Medicare program in the Selma, Alabama, area. For the purpose of this study, we asked the three hospitals in Selma to supply a list of all Medicare patients discharged from the hospitals during the month of June 1971. We asked that they indicate the race of the patient and the type of post-hospitalization care ordered by the physician. In those cases where the doctor ordered additional care in extended care facilities, we asked that the name of the extended care facility be given. During the 30-day period studied, 67 black and 105 white Medicare patients were discharged from the three hospitals. Of these, four black and four white patients were referred to extended care facilities. Four of the black and three of the white patients were admitted to the two extended care facilities and one white patient was admitted to a nursing home outside the immediate area. While there appears to be no racial discrimination in the referral and admission process in this case, we believe that the area selected for the pilot study was too small to provide for an evaluation of the problems.

Another such study is under way in the Richmond, Virginia, area which includes thirteen hospitals and nine extended care facilities. Preliminary information indicates that the size of the study is sufficient to yield some insight to the problem.

Sincerely yours,

J. STANLEY POTTINGER,
Director, Office for Civil Rights.

Mr. HALAMANDARIS. I am reading the last line. "In fact, the one lawsuit brought by this division against a nursing home was brought under title VIII of the fair housing law."

The import is that since the 1964 Civil Rights Act was enacted, the Civil Rights Division of the Justice Department has brought one action, and only one action, against nursing homes because of discrimination. Let me ask you to go through this little exercise that I put our Asians through.

Among the four factors that I related, discrimination, cost, social, and cultural factors and extraneous miscellaneous categories whatever they are—it is hard to separate them, I realize that—would you agree that this is the proper order, Mr. Jackson?

Mr. JACKSON. Discrimination and cost I would rank almost together at the top. I think that racial discrimination and poverty are really the prime factors that are involved. I find great difficulty in separating them out. I think they are equally important.

Mr. HALAMANDARIS. Do the social and cultural differences play a role?

Mr. JACKSON. They certainly are a factor, but in my opinion they do not rank either with the racial discrimination or the costs involved.

Mr. HALAMANDARIS. Thank you.

CHIEF PROBLEM IS RACISM

Dr. HEMSLEY. I will have to agree with the Kerner Commission that the chief problem in this country is racism and it reflects itself in many areas. Why aren't there proportionate numbers of blacks and minority people in nursing homes? The question is answered when you find out there aren't any nursing homes which they can own and operate with their own life style. If the banking institutions, Government enforcement agencies, could give them the type of help they give the oil industry, Lockheed, or Amtrak, if they could

do just that, give that type of "welfare" to poor people, but what we have in this country is welfare for the rich and free enterprise for the poor.

We need to understand and most poor people don't understand, the aged are the most fearful conservatives that every existed. They don't understand these things; what they call subsidies are really welfare checks for people who have got it made. We need to change that around.

Most of the minority groups are forced to assimilate. They lose their own integrity as a result of it and begin to hate themselves. Once they hate themselves, we have to hate the greater society, so it is a very complicated thing.

Mr. JACKSON. Racism and poverty are certainly the primary problems that Americans face and I feel that in this situation they both are tremendously important deterrents in denying services to blacks in nursing homes.

I interrupted to say that Dr. Jacquelyne Jackson does have to leave at this time but Dr. Hemsley and I will stay.

Mr. HALAMANDARIS. I would like to puruse this at great length, but unfortunately we have other panels to be heard. I am going to dismiss you at this moment.

Mr. JACKSON. I would like to make a further comment that goes back to the question of whether the system should be primarily nonprofit or profit. I believe that question was addressed to Dr. Hemsley earlier.

SYSTEMIC CHANGE NEEDED

The way I see it the kind of change that we are calling for here is systemic change, that neither the nonprofit system nor the proprietary system as they currently exist are facing up to the problem of the black and other minority elderly in nursing homes.

The kind of change that we are concerned with would have to do with the systemic change that would see to it that the program and policies of these homes would involve consumers, families, and friends of patients, that these homes would truly be representative public accommodation and that they would be community related. They should consider health care a "right" not a "privilege" and should embrace the social and environmental concepts of care, not just provide sophisticated medical and nursing services.

It seems to me that a secondary issue is whether or not it is profit or nonprofit. As I envision this system, I think it would be primarily best implemented through a nonprofit system, but this would not mean that it would have to be limited to nonprofit.

I think there is something substantailly immoral about trying to make a profit on public assistance recipients, but in a public and affluent market I can see nothing wrong with the proprietary interest.

Mr. HALAMANDARIS. I have one final question to both of you relating to Senator Moss' opening statement. It impressed him and I want to direct it to you. In your experience, about how many black nursing home administrators are there in the United States?

Senator Moss' statement contains the rough figure of about two dozen. Do you think that would be about accurate? Second, would you comment on the fact that while there are very few nursing home

administrators that are black and very few nursing home patients that are black, there are a disproportionately large number of nursing home employees that are black?

The number of black nursing home employees should be no surprise to anyone when you consider that nursing home employees are usually untrained orderlies and receive the minimum wage. Would you comment on that, please?

Mr. JACKSON. I will comment on the latter part of that question first because I have taken public positions on this. One of the things wrong in the nursing home field is that we expect our greatest philanthropy to come from those who can least afford it. Most of the nursing home patients are white, but most of the workers are black who work in direct service.

I am talking about the work at the aide level. We often hear of the philanthropy of the rich but seldom of the philanthropy of the poor. To me this is real philanthropy, when you are working at the current minimum wage of $1.60 an hour and under very difficult working conditions. The thing that comes out of it is that if we are ever going to really communicate in any way the concept of "wholeness" to patients in nursing homes it seems to me with those who are working in the direct services must also embrace that wholeness concept.

The only way they are ever going to be able to do it is to have a minimum wage about twice the current level and much better working conditions.

With reference to the number of black nursing home administrators, I cannot say definitively how many there are. I think a lot depends on your definition of an "administrator."

I know that there are quite a few black proprietary homes across the country, not nearly as many good ones as needed, but perhaps the Senator's estimate of 24 I would not quarrel with based on the qualifications a good administrator should have. I know that there are not nearly as many qualified nursing home administrators as we need in the field.

Mr. HALAMANDARIS. That pretty well covered it. I was talking specifically about the paradoxical number of nursing home employees that are black or members of minorities and how this compares with the scarcity of administrators of nursing home owners that are black. Dr. Hemsley, do you have a comment?

Dr. HEMSLEY. California being the second State in the Union in terms of numbers of people over the age of 65, second only to the State of New York, and I think the highest number of elderly people over 75, also, and it is one of the areas most people come to live, whether they be old or young.

I do know in the L.A. area there are very few—I couldn't give you a number—why is it that you find at the lower economic level a predominance of minority people? It has a historical continuum.

It is the same type of philosophical thinking that allowed us to go from slavery to share cropping, all the way along the line, to the present day, so that you see a great many blacks working in the nursing home field, but no administrators.

Blacks and minority groups have helped to build this country. Then they were doubly penalized by the Social Security Administra-

tion when it refused to admit that they had given anything all those years.

We hear people talking about volunteerism. How a person with a family of four making less than $4,000 a year can volunteer to do anything but to get out there and fight their own personal war on poverty is beyond me. These are the people we call on. It is really paradoxical.

I see this time and time again, asking poor people to attend meetings and conferences and testify and give up their time and they can't even make that house note. I think this is terribly unjust.

It is OK for those of us who have it made.

Mr. HALAMANDARIS. Thank you. That concludes my question. Do you have any questions, Bob?

Mr. SETO. No.

Mr. HALAMANDARIS. I will then ask our next panel on Older American Indians to present their testimony.

PANEL ON OLDER AMERICAN INDIANS—IRENE CUCH, TRIBAL BUSINESS COMMITTEE, UTE INDIAN TRIBE, MEMBER, ADVISORY COUNCIL ON ELDERLY AMERICAN INDIANS; RONALD MOORE, CHAIRMAN, ADVISORY COUNCIL ON ELDERLY AMERICAN INDIANS; AND ROGER H. SANDOVAL, VICE CHAIRMAN, ADVISORY COUNCIL ON ELDERLY AMERICAN INDIANS, PROJECT DIRECTOR, OFFICE OF NAVAJO ECONOMIC OPPORTUNITY

Mr. MOORE. Mr. Halamandaris, I would like to say that the Indian people are being civilized, Americanized, and the old Indian way was that the men would take over first, but in this case I am going to ask Mrs. Irene Cuch to begin.

STATEMENT BY MRS. IRENE CUCH

Mrs. CUCH. Mr. Halamandaris, and other distinguished members of the Subcommittee on Long-Term Care on Aging, I appreciate the opportunity to testify today in support of my statement regarding the accessibility of minority groups to nursing homes and other extended care facilities, submitted to you earlier this week. I ask that my testimony here today become a part of this hearing record, and following my testimony, I solicit any questions you may desire to ask of me.

In the time alloted to me today, I want to relate to you some of the efforts Indians have put forth to obtain nursing home and extended care facilities; why the facilities are out of reach of the reservation Indian; some facts to substantiate the need for such facilities; and finally, present the statement I feel expresses the American Indian's views on the subject.

I can speak from a reservation Indian's standpoint having lived on the reservation all my life and associated primarily with other Indians

of like circumstances and surroundings. I have seen improvements in the living environment on reservations accelerated over the past 6 to 7 years due to federally financed programs and the devotedness of Federal, State and tribal employees to see the Indian's surroundings improved.

However, the availability of nursing homes has remained static or nonexistant during these otherwise progressive years.

As I stated in a letter to Senator Moss dated April 13, for submission into the record, this year in response to his inquiry concerning this same subject, the Indian hesitates to live in a nursing home because they are located off the reservation and away from his people and common surroundings.

The Indian would much prefer to live at home in a grossly substandard dwelling than to go off the reservation and live in a nursing home. I am sure greater utilization of nursing homes would result if nursing homes were located on reservations and if they reflected the Indian's culture and customs.

The magnitude of the inadequacy of nursing homes on reservations might be reflected by comparison. The enrollment of my tribe is 1,658 members with 183 of these being 50-plus years of age.

Thirty-four of that 183 would require special housing or nursing home residences if they were available. Seventeen of that 34 are definite nursing home candidates. That 17 represents 1 percent of my tribe.

Then if we look at the 460,000 Indians and Alaskan Natives living on reservations, that 1-percent comparison represents 4,600 potential nursing home patients.

Shortage of Facilities on Reservations

Today, there are less than 200 nursing home beds all total on all reservations, I am told—a shortage of some 4,400 beds. In fact, I only know of three reservation nursing homes to date. The first at Chinle, and a smaller American Indian nursing home operated by a church on the Gila River Reservation near Phoenix, Ariz. Then why the inadequacy of nursing homes, let us ask.

The problem is compounded by: one, the stay-at-home custom of the Indian has led to an oversight of the need. Two, due to this custom, if nursing homes were available on reservations, the mental and social well-being of the patient would be greatly enhanced by being close to his family.

Two, Hill-Burton Funds are primarily made available to States for nursing home projects. The States in turn establish advisory groups which dictate the use of such funds. Most advisory groups are composed of urban non-Indians with little sympathy for Indian projects, thereby making nursing homes or sheltered care facilities almost impossible to obtain by Indian people.

Three, some States refuse to license nursing homes on reservations due to a question of reservation jurisdiction and at the same time Federal funds are not authorized unless the facility is licensed by the State.

Four, tribes are too poor to build their own.

I think in recognizing the need for nursing homes on reservations, during the past 2 to 3 years most tribes have explored the possibility of obtaining such facilities. Meetings have been held and firms have been contacted to discuss the matter. One such meeting was held in Phoenix, Ariz. last fall to discuss the nursing home situation among other reservation problems.

Over 100 Indians from the States of Nevada, Utah, California, Arizona, and New Mexico were present. My own tribe has been pondering the nursing home question for the past year or so.

We went so far as to secure the services of a nursing home building firm of Broken Bow, Nebr. (N.H.B.I.) to do a study of not only our reservation need, but that of the entire Uintah Basin, Indian and non-Indian alike.

It was concluded after a week's study that another 31 nursing home beds are needed in the basin in addition to the 84 beds now available in two facilities. The cost of building and furnishing a 50-patient nursing home ready for occupancy approximates $500,000. The cost is much to great for a private loan venture if such loan could be obtained, and operating a facility of less than 50 beds is not feasible.

All I have said should support the five-point statement I want to make which I would like to become a part of this hearing record.

Nursing home or sheltered care facilities are urgently needed by Indian people while other special care facilities such as hospitals, sanitariums, etc., are being provided. However, due to present funding systems for nursing homes, Indian people have very little chance to obtain such facility. Should funds be made available to tribes for nursing homes, this should permit more appropriations to the Indian Health Service to do much needed upgrading of some IHS hospitals.

Federal funds should be made available directly to Indian tribes or organizations for the design, construction and operation of these facilities on reservations rather than such funds being administered through states. Indian tribes contemplating building and managing nursing homes should rely on the professional expertise of the Indian Health Service and the Bureau of Indian Affairs to avoid failure of the operation.

Indian nursing homes or sheltered care facilities on reservations should be governed by Federal regulations such as the Indian Health Service Hospitals, as opposed to State licensing regulations.

Nursing homes built on reservations would not be competitive with—but supportive of—other health care programs such as the Home Care, Home Nursing Services, Meals on Wheels, Community Health Representatives and other programs.

I believe it can be generally concluded that the Indian Health Service does endorse nursing homes on reservations provided certain IHS design and operational criteria are met.

Thank you very much.

Mr. HALAMANDARIS. Mr. Sandoval, would you like to give your statement at this point and then we can ask some questions of the panel in general.

STATEMENT BY ROGER H. SANDOVAL

Mr. SANDOVAL. Thank you for giving me this opportunity to speak to you about a problem which many of us know exists, yet which too few of us are willing to correct: the plight of all elderly native Americans, and more specifically in my case, the plight of the Navajo Nation's elderly.

First, a few facts about the Navajo Reservation. Navajo land occupies 25,000 square miles in the northeastern corner of Arizona,

northwestern corner of New Mexico, and the southeastern tip of Utah. That 25,000 square miles breaks down into 16 million acres—nearly equal in size to the State of West Virginia.

Of our 16 million acres, 1,500,000 are rough, desolate, and rocky canyons and mesas classified as wildlands. Little, if any, economic benefit is derived from this land.

Good roads are scarce. Whereas West Virginia has nearly 26,000 miles of paved roads, we have a meager 1,500. The rest of our travel is done over rugged dirt roads, which when it rains or snows, become virtually impassable.

The population of the reservation is estimated at close to 140,000 people. Of these, 13,000 are age 55 or older. The unemployment rate of our people is a staggering 65 percent. Average per capita income is an unbelievable $500 per year. Average annual precipitation for 90 percent of the reservation is from 5 to 8 inches a year.

As you might well guess, the problem affecting our aged is multifold. Our elderly are suffering from poor and unsanitary housing conditions, limited education, inadequate nutrition and medical treatment, lack of transportation and communication systems, just to name a few.

Isolated From Medical Care

Adding to th. misery of our older people is their literal isolation from society. I do not mean to say that people wish to live in, and closer to, urban areas near the reservation. Most of our elderly don't want to do so; they love their homes, they love their land. I do mean to say our people are suffering because of their isolation from bare necessities like medical and dental care.

As I stated earlier, good quality roads are few and far between on the reservation. This situation makes it extremely difficult for those fortunate enough to own a car or truck. But what about the thousands who do not drive, and who do not own any mode of transportation?

If they lived in Albuquerque or Phoenix, they could at least take the bus. But where they do live, public transportation is nonexistent. They cannot go to the nearest store when they want, which might be 40 miles away; they cannot visit relatives and friends when they want; nor can they go to the doctor or dentist when they want. They travel when a vehicle-owning acquaintance travels.

However, if an emergency arises, help is not just a key turn or a bus ride away. And for most of our elderly, help is not a phone call away either, because there are no phones.

The picture is clear. Because of this isolation caused by communications, transportation, and geographical barriers, our Indian aged, unlike many other elderly citizens in this country, are more vulnerable to the dangers and uncertainty of old age, because they are least likely to receive assistance when an emergency occurs.

We need new roads. We need road improvement. We need some system of public transportation. If providing a means of public transportation is not economically possible, let us provide mobile medical and dental units to go out and reach and treat these people in their homes.

Many of our elderly have expressed a desire for such a setup, and I agree with them when they say this would be the best way to meet their day-to-day needs as well as their emergency needs.

Those operating the units would know the local people and their problems. And the care would be much more personal, just as professional, and much more expedient than any form of institutional care.

From past experience, one thing is certain. The answer to meeting the health and personal needs of our elderly is not in sending them far away from their homes to institutionalize them. This practice has proved to be unsuccessful as well as extremely unpopular with our people. Our people prefer community-type living with community-type care.

If we are going to build nursing homes and extended-care facilities for our elderly, they must be built in their homeland; they must be constructed in a way that matches as closely as possible the type of living and home environment the people are used to; and they must offer adequate recreational and therapy programs for the patients.

One Extended-Care Facility

Right now, we have only one extended-care facility in operation on the reservation. In fact, I believe it is the only one of its kind on any Indian reservation in the entire country, located in Chinle, Ariz., in the heart of the reservation. It has a 79-bed capacity, 40 of which are reserved for elderly patients.[1]

Although the Chinle extended care facility is lacking in its recreational and therapy programs, and is architecturally constructed in much the same way as any other institution, the facility is a good thing. The care is good, the staff is nearly all Navajo, the patients are fairly close to their friends and relatives, native foods are served, and medicinemen—deeply respected and trusted by our people—are allowed to visit with and treat the patients. In other words, the facility is making a sincere effort to truly operate of, by, and for the Navajo people.

Still, 40 beds for an elderly Navajo population of close to 13,000 is not even remotely close to an acceptable ratio by our people. When you consider the hundreds of others who need to fill these beds, but can't, you wonder what becomes of them.

Their choice is a bleak one. There are no other extended care facilities on the reservation. The rest are located in reservation fringe towns; or as far away as Phoenix, 350 miles from Chinle.

So an elderly person who is ill, must ask himself the painful question, "Should I leave my home, my relatives, my friends, my land, and go to some faraway Anglo-run institution for help? Or do I stay here at home, though I am sick, and isolated from help at a time when I need it most."

Naturally, most of our people usually make the latter choice. The sad fact is, a decision like this should never have to be made.

A sample taken nearly 2 years ago indicated the major wants and desires of our Navajo aged;[2] 294 people, age 65 and over were interviewed, and though this sample is 2 years old, I am certain that the same sample taken today would elicit essentially the same answers.

[1] See app. 1, item 2, p. 2529.
[2] See app. 1 item 3, p. 2531.

Two hundred and seventy people made specific requests for improved transportation; 268 asked specifically for an adequate income; 145 for improved water supply; 104 for better housing; 76 for improved health care.

"CUSTODIAL CARE"

However, what was not asked for is the important thing. Of those interviewed, few mentioned "custodial care" as one of their main needs. Most not only prefer to remain in the community, but it is essential that they do so because of the important and meaningful roles they play in their family and community structures.

What we need are governmental programs which will assist our elderly people, not inconvenience them; and programs which will work with our elderly, not simply for them. When it comes to helping our elderly, we must not ignore their ideas, wisdom, and feelings.

Their input should be the No. 1 ingredient which goes into the planning and operation of these progams. The mobile medical and dental units is a good example. Our people want them and the reservation's geographical, transportation, and communications problems demand them. Why not have them?

Traditionally, our elderly have shunned institutionalized care. Yet if institutions must be built, build them on our people's homeland, and build them and operate them in a manner most conducive to the traditional and cultural values of the Navajo.

Above all, we must not abandon these people. We must totally involve our elderly in the midst of the decisionmaking and money-spending processes which will affect their daily lives. We must listen to them and see what they have to say—not merely hear their words for the sheer courtesy of it. They know what they want; let's give it to them. They have been neglected much too long already.

In behalf of all the American Indian tribes [1] in the United States I recommend the establishment of an Indian desk in the Office of the Administration on Aging here in Washington, D.C.

Thank you very much for giving me the opportunity to give this testimony.

Mr. HALAMANDARIS. Thank you, Mr. Sandoval. We appreciate that excellent statement. I would like to direct a question to the panel collectively, the same question I have raised with our previous panels, the question essentially is this, if I can phrase it.

I know that Indians, like Asians and perhaps like blacks, have a closely knit family structure and the oldest member of the family is regarded with great respect and veneration. The first panel of Asians indicated that this tradition of the Asians taking care of their own was a myth.

I posed the same question to our blacks and I asked, Do blacks take care of their own or is this a myth with regard to the black community? And Dr. Jacquelyne Jackson responded quite eloquently: "We have to take care of our own because nobody else is going to do it."

[1] Resolution, National Indian Caucus on Aging, app. 1, item 4, p. 2533.

My questions to you are: What is happening in the Indian community? Are the old still venerated, and as a separate part of that question; what happens in an Indian family when confronted with the dilemma of what to do with an older family member who becomes both old and ill? How does that affect the family structure?

Mr. Moore, do you want to address yourself to that?

Family-Care Is Not a Myth

Mr. Moore. The idea of people taking care of their own is not a myth. Years ago this was the lifestyle of the Indian people and it was done out of sheer necessity because nobody else would take care of the elderly. The second part of the question, in today's Indian society we are, I think, most of the Indian tribes, are now finding it necessary to compete economically, socially, and so forth with the other societies that are on reservations, near reservations, and other parts of the general community, and when a person gets ill, several things happen, I imagine.

No. 1, if a family head is incapable of supporting that family financially there probably is no real big problem. The wife would probably take care of the older person as best she could, but in the cases where the family is forced out of economic necessity to have both spouses working, then it becomes a problem, and what happens then is that usually the Bureau of Indian Affairs or the Public Health Service, whoever has jurisdiction over these people, then says that they should go to an institution, and realizing that there are no institutions on that reservation, they are forced to leave their communities and go to either Phoenix, Tucson, or some other large city where there are PHS with a nursing facility.

Also this causes a hardship on the family. One case of my wife's parents—not her parents but her family—we have one person in a nursing home in Phoenix about 300 miles from his home reservation. The family members of this person almost refused to visit him any more because he has gotten to the point where he wants to get out of the nursing home and every time somebody goes to see him he wants to go home, and he just has a very bad experience, so the family members are forced to not visit him any more and this is a tragic situation.

Mr. Halamandaris. Mr. Sandoval, do you have a comment to make?

Mr. Sandoval. Mr. Halamandaris, in as far as the question relates to the Navajo I will go along with Mr. Moore here and say this is not myth. This is a fact where the family ties are close, very close to the extent that our elderly are still being cared for by the immediate family members. It is not as close as it used to be a number of years ago due to the fact that the younger generation is kind of getting off into the outside society, drifting into the urban areas, and they are getting away from their older folks to quite an extent, but still the family ties, as far as the family care for the older people are concerned, this is still true to a great extent.

Mr. Halamandaris. I was interested in your reference, Mr. Sandoval, to the fact that medicine men are allowed into see patients in the Chinle Nursing Home. My question relates to what extent are they

allowed into Anglo nursing homes to visit patients? Do you have any comment on that?

Mr. SANDOVAL. I believe as far as the medicine man being in Chinle, this is totally true and to quite an extent in the Public Health Service hospitals on the reservation, but to have these medicine men go into the Anglo institution such as Albuquerque, Phoenix, and so forth, I do not have the information on that.

I suppose they do allow them to go there, but I have no real knowledge of the locations that far away from the reservation.

Mr. HALAMANDARIS. Can you clarify for me the meaning of the term "medicine man"? Now, presumably that means a leader, a well-respected leader of a tribe whose visit provides psychological uplifting. My question relates to his practice or lack of practice of medicine or the medical arts as we know them. Does he practice medicine in the Western sense?

Mr. SANDOVAL. I guess you might call him a practitioner of some sort, either psychological or whatever terms you want to use. He might be a similar thing such as the witch doctor who practices these things through his own way of doing things, and they are quite effective.

Medicine men not only are known in the Navajo Nation but as well in these other tribes. They have their own medicine men but basically it is a type of care which relates to a great extent to the use of herbs and to some extent—to a little witchcraft maybe. But they are practicing to quite a success out there and they are, like you said, well-respected, very well respected citizens.

Mr. HALAMANDARIS. Dave Affeldt, chief counsel of the committee, has a question.

Mr. AFFELDT. I shall direct my question to Mr. Moore. In your judgment, is direct funding of Indian tribes, rather than through the State, necessary for adequate health care?

FUNDS NOT DIRECTED TO INDIANS

Mr. MOORE. Yes, because of several reasons that were pointed out by, I believe, Irene. One of the things that we find is that when Federal funds are funded through the States for general use throughout the State, the States usually take the notion that the Federal Government or the Bureau of Indian Affairs or Public Health Service is responsible for the total care of Indian people. Therefore, these moneys are allotted to the centers of population and they are rarely directed to Indian reservation programs, and also the mere fact that Indian reservations have a tough responsibility between the Federal Government and Indian people, I feel that Federal funds for this type of use should be funded directly to tribal counsels for their use.

Mr. AFFELDT. A similar question directed to Mr. Sandoval. Is the Chinle Nursing Home on the Navajo Reservation?

Mr. SANDOVAL. Geographically it is just about the center of the whole reservation.

Mr. HALAMANDARIS. The question then, Is it licensed by the State of Arizona?

Mr. SANDOVAL. Not at this point it isn't.

Mr. HALAMANDARIS. But then do you qualify for Federal funds in any way or do the patients, I mean qualify through Medicaid or Medicare funds? It is the same situation where Irene described it, not being licensed by the State because you are a Federal enclave and therefore you can't qualify for Medicare and Medicaid; isn't that true?

Mr. SANDOVAL. That is essentially true.

Mr. HALAMANDARIS. That seems to me to be grossly unfair. I believe that we can do something about that. There ought to be a way that Federal certification of nursing homes on Federal enclaves and Indian reservations can be made so that the patients could qualify for Medicare and Medicaid. I don't see any problem in duplication there with what the Bureau of Indian Affairs provides; do you, Bob?

Mr. MOORE. No; I don't see any problem.

Mr. HALAMANDARIS. Let me ask you one final question and then we will hear from our Mexican-American panel. I have asked previous witnesses to give me some sort of ranking of several factors which I believe are reasons why Indians or Mexican-Americans are not found in nursing homes, and those reasons were cost, discrimination, social and cultural factors or just another miscellaneous category that I described by saying they simply don't want to go to nursing homes. I am wondering how you would rank these. To what degree is discrimination a factor? To what degree is cost responsible? To what degree is the absence of Indian nursing homes explained by social and cultural differences, or is it that they just don't want to go? I have no idea how to rank those.

Mr. MOORE. I would rank social and cultural factors as No. 1, and then discrimination, cost, and not wanting to go. I think there is discrimination just by the mere fact that we do not have very many nursing homes and the redtape that tribes have to go through to get one is a discrimination, itself, but as far as discrimination—thought of as racism—I guess I don't really feel in that way we are suffering discrimination. But all of these other matters do point to a certain amount of discrimination.

Mr. HALAMANDARIS. Mrs. Cuch, do you have a comment on that?

Mrs. CUCH. Well, we have looked at this problem of nursing homes through a study, and we brought out whether there is discrimination in nursing homes or not. Some people in the nursing homes now feel there is some slight discrimination, but as far as placing the Indians in nursing homes, they are accepted. However, they do not have a comfortable feeling because they are not with their own kind.

So, therefore, I think they kind of hold back on a lot of things they would like to do rather than ask for some assistance. They are a little reluctant. I think here, too, might be a language barrier and I wanted to bring this out. Earlier you asked Mr. Sandoval about the medicineman. I think this is something that maybe non-Indians don't understand, the role of the medicineman.

MEDICINEMAN'S SERVICES

We always have had a medicineman in our tribe and I think here, as far as the medicineman coming into the nursing home, our people have never been asked whether they would like him to or not. I think

there is some reluctance whether or not to accept this kind of thing. My people are really afraid that maybe nursing home people might not approve of it. So there is a hesitancy to ask.

Also, I think the Indian people have often wanted a medicineman's services, especially our elderly. They still ask for the medicineman's blessing. This is an important thing that they have. They believe in God, but they also like the assistance of the medicineman all through the performing of the blessing, and I think this still holds true today. I, too, would like to endorse Mr. Moore's categorization a moment ago.

Mr. HALAMANDARIS. I want to ask Mr. Sandoval to respond to that same question. One brief question to all of you. Do you know of any advisory councils with Indian members who consult with HEW or HUD—both of whom provide great amounts of Federal money to build nursing homes? Do you know of any Indians advising these agencies on their need for nursing homes?

Mr. MOORE. I am not sure of any advisory groups specifically for nursing homes. I found out about 2 months ago that there was an advisory group composed of Indians, but I was not able to find out which specific agency they assist—HEW and the Administration on Aging I believe.

But I don't think there are any Indian advisory groups.

Mr. HALAMANDARIS. Thank you. Mr. Sandoval, do you want to respond to the previous question in the ranking of those factors? What is the most important to you? We have talked about cost and discrimination and social and cultural factors.

Mr. SANDOVAL. My order of arranging these four points is much similar to Mr. Moore's and this is social and cultural value, and I would differ with him on the cost and discrimination. I would rank cost as No. 2, or rather no desire to go as No. 3, and discrimination at the tail end due to the fact that discrimination as we understand it now, or the generally accepted explanation of discrimination as related to racism, there is no problem there, I don't believe. So I rank that No. 4.

Mr. HALAMANDARIS. Thank you very much.

RECOMMENDATIONS

Mr. SANDOVAL. I would like to give you or like to have entered into the record here, our recommendations that came as a result of a National American Indian Caucus resolution that was adopted in San Francisco in April 1972, if I may.

Mr. HALAMANDARIS. Sure.

Mr. SANDOVAL. These recommendations will be as follows:

No. 1, projects for aging services and facilities for American Indians and Alaskan natives be funded directly by the Federal Government to local tribes or duly organized tribal or intertribal bodies.

No. 2, Federal funding of projects for American Indians and Alaskan Natives not to be time limited, but be continual funding for these projects which have proven successful and demonstrated the value of their services to the Elderly American Indians and Alaskan Natives. Level of funding to be contingent upon the ability of the tribal group to provide their own financial support.

No. 3, the matching fund requirements for aging projects for American Indians and Alaskan Natives be adjusted or waived dependent upon the financial ability of the tribal group involved. When applicable, the in-kind matching contribution the tribal group could provide would be accepted as having met the requirement for local matching of Federal funds.

No 4, that an Indian desk be established in Washington, D.C., to head the Indian Administration on Aging. I thank you again.

Mr. HALAMANDARIS. I have one last question. Maybe Mrs. Cuch could answer this. The question of whether or not nursing homes are proprietary; that is, run for profit. Do you believe that this hampers the kind of care that can be offered, or does it matter? How is this viewed in the Indian community?

Mrs. CUCH. As far as the cost jeopardizing care once the facility is in operation, I don't think it does. However, cost is a great obstacle in obtaining the facility to begin with. For example, our tribe had one individual applying for loans to obtain $500,000 for the facility, but no one can obtain that kind of loan. Obviously though, an individual would have to operate at a profit to pay off the loan.

The only way I can see a nursing home of adequate size being built on our reservation is to obtain the money by grants and operating the facility as a nonprofit establishment. This, too, should not restrict any services needed by the patients since a loan repayment is not in question.

So I think this is the attitude taken and, Mr. Halamandaris, I have a letter here from Senator Moss when he wrote the advisory council members regarding this question in his investigation relative to this same subject we are talking about.

I have a copy of my letter to Senator Moss which I would like to present as part of the hearing record.

Mr. HALAMANDARIS. Thank you. The letter will be inserted at this point in the Record.

(The letter follows:)

APRIL 13, 1972.

HON. FRANK MOSS: I appreciate the opportunity to express my observation about nursing homes or shelter care provisions for members of reservations. I will try to reply fully to your recent inquiry.

I do not know much about the Black's but for the Indian's use of nursing homes, I do not think discrimination as to use of the facility is much of a problem. First, we should recognize the Indian's hesitancy to use nursing homes due to his long standing preference to spend his "last days" at home, irregardless of his substandard dwelling.

Secondly, practically all the nursing homes available to Indians are off reservations. Whereas, if nursing homes primarily for Indian occupancy were constructed on reservations where they could reside with their own people, I am sure more of my people would be inclined to utilize the facility.

On the Uintah and Ouray Reservation, we have 183 tribal members 50 years and older. Although we are making great housing progress, we have determined 34 of our Senior Citizens as needing special housing they don't have. Seventeen of the 34 would qualify as nursing home patients, while the other 17 just needs shelter care wherein someone does the household chores for them. The latter are able to bathe and care for their own personal hygiene.

Roosevelt and Vernal each have nursing homes totaling 75 beds together, but less than 10 Indians reside in both combined at anytime, again off the reservation and their reluctance to live there.

The Uintah and Ouray tribe has contemplated building our own nursing home facility and have consulted Nursing Home Builders, Incorporated, Broken Bow,

Nebraska, to determine our real need. Following one week's preliminary study, the firm determined an additional 45 bed facility is needed to satisfy the Uintah Basin's nursing home need. Too, they recommended no nursing home less than 50 beds is feasible, but that size facility costs $400–$800,000 ready for occupancy.

To date, to provide housing for our Senior Citizens, the Ute Tribal Housing Authority is making application for HUD Low Rent Housing. We are still pondering the nursing home facility due to the expense involved. The latter would become more real if more funds were available for reservation nursing homes.

In summary, I would say that if Long-Term Care for our older Americans is to materialize with regard to housing, that not only should nursing homes or institutional care be looked at, but shelter care and low rent housing for the aged as well. Then, to reach rural reservation segment of the populace to provide these facilities, funding must be direct from Washington to Indian Tribes rather than funds be administered through states. Such funds administered by states seem to get channeled to municipalities rather than to reservations.

If I can be of further assistance to you, please advise.

Respectfully yours,

IRENE C. CUCH,
Ute Tribe Business Committee,
National Advisory Council Member.

Mr. MOORE. I would also like to have entered into the hearing record a response from the Salt River community in reference to this hearing, a letter from Mr. Frell M. Owl, from the Cherokee Band in North Carolina, and a report that was turned in to me by the area office in Phoenix.

Mr. HALAMANDARIS. They will be inserted in the appendix to the hearing record.[1]

Thank you very much. Thank all of the panel for an excellent presentation and for enlightening me on the duties of a medicineman among other things.

I would now like to call up our next panel, the Mexican-Americans.

PANEL ON OLDER MEXICAN-AMERICANS—CORINE M. GARCIA, SENIOR OPPORTUNITIES AND SERVICES FOR BENT, CROWLEY, AND OTERO COUNTIES, MEMBER, ADVISORY COUNCIL ON ELDERLY MEXICAN-AMERICANS, COLORADO MIGRANT COUNCIL; HOMER T. MARTINEZ, REGIONAL REPRESENTATIVE, NATIONAL COUNCIL ON THE AGING, MEMBER, ADVISORY COUNCIL ON ELDERLY MEXICAN-AMERICANS; AND SISTER RAMIREZ (REPRESENTING DR. JORGE PRIETO, MEMBER, ADVISORY COUNCIL ON ELDERLY MEXICAN-AMERICANS), CORDI-MARIAN SISTERS FOR THE MIDDLE WEST

Mr. Halamandaris. We would like to welcome all of you here. We previously heard from Homer Martinez. We would like to welcome Sister Ramirez and our friend, Corine Garcia, from Rocky Ford, Colo. You may participate in any manner you wish.

STATEMENT BY MRS. CORINE M. GARCIA

Mrs. GARCIA. Mr. Halamandaris, I am very glad to be here today and very proud to be able to represent my people. We speak

[1] See app. 1, items 5, 6, and 7, pp. 2534-2536.

about the elderly, the Mexican Americans or the Spanish Americans. We have them in the urban areas, and we have them in the rural areas.

I feel that my expertise is in the rural areas. That is where I come from. The people that I work with live in small communities so that just about everyone knows everybody, and that has many handicaps.

There is a lot of prejudice and discrimination toward the people that I work with, and therefore the group of people that I serve is really the minority which no one wants to assimilate or be directly involved with, so therefore I am speaking for minorities. There are many reasons why our people do not go into nursing homes, and there are many words that we use for old people, but the one word that we use with endearment, respect, and love is "viejito."

This first generation people do not speak English, and come from many different backgrounds. Even though they are Spanish their environments are different, but they do speak the same language. The sterilized atmosphere of the nursing home institution scares many of these persons and when they are committed into a nursing home, their life span seems to be cut short and death is imminent.

Interpreters Needed

The language barrier seems to be the main problem. When you go into a home the bare necessities have to be requested through an interpreter or otherwise it becomes a very embarrassing situation where the elderly person has very much respect for his human body. To be exploited by the Anglo when he goes in there, to really have to do things that are completely against his morals and what he stands for, what he believes in himself, can cause a great problem and therefore creates a deeper trauma of adjustment.

When you are old, you are cast into the world of old people regardless of where you are or where you come from or what your vocation in life has been, you are cast into the world of old. Where there has been discrimination, once more you are being jeopardized in the type of environment that you are sent to.

I would definitely say that the nursing homes, as they are now, are not for the poor, whether they are Mexicans, blacks, whites, or otherwise. The ones that are for profit have no room for us in any way, and those that are nonprofit are similar and therefore money becomes necessary survival for a lot of these people.

Medicare patients or residents do not receive adequate care, and the stigma of welfare or some other identification on these types of persons adds to their indignity, and therefore they suffer additional emotional stress.

"The extended family cares for their own." This is ridiculous. First generation Spanish-speaking elderly have little or no education whatsoever, and are not aware of nursing homes or what they are intended for. Their children also do not have an education and they also will not admit their shortcomings in not knowing the procedure of getting their parents or grandparents into a nursing home. Therefore, we are creating a false front.

Nursing homes will declare that there is no prejudice or discrimination in their homes, but the accountability of their staff and the reaction of the type of services

extended can and do discriminate against our people. A look at nursing homes where there is a large percentage of Mexican Americans in the community will find only a handful in the institutions. In my hometown alone, 43 percent of the population are Mexican Americans, 57 percent Anglo or otherwise, the Spanish percentage of the elderly is 13 percent. Yet, in the nursing home, there are only two Spanish-surnamed persons in the whole nursing home, and it has beds for 85 people.

I have visited a large number of nursing homes throughout the Nation, and I noticed time and again that these institutions will care for the elderly so long as they are able to take care of their own personal needs; but as they become less and less mobile and are no longer able to take care of their personal needs, they are no longer wanted.

What about solutions to this problem? I think I will go back to my recommendations in my notes. The first priority for me would be a two-way educational service because education is a very much-needed thing. The nursing home needs to be educated about our needs, and we need to be educated about what the nursing home is supposed to do and how they are supposed to do it.

We would like to see that nursing homes include special programs for the viejitos, and this means a trained bilingual, preferrable bicultural staff and administration, to make the environmental adjustment of the viejitos more comfortable, to introduce a culturally familiar atmosphere to their care setting; this could take the form of recognizable Mexican menus, decorations, entertainment, and available religious services. We tend to forget that religion plays an important role. You know we brought the faith into the Southwestern part of the United States. We are the faith there, but now even the church has cast us aside and forgotten this tremendous need of the elderly. So, therefore, the old people suffer there again because it is their faith and they brought it with them and is very much a part of them, and we intend to forget that this is part of them as a human being.

There is a need to include special programs for viejitos who refuse to leave and those who are reluctant to leave their homes. Give them supportive services, giving them dignity they have earned and seeing that their needs are met. For example, meals on wheels programs. I must state that my meals on wheels program, the meals part was started 3 months ago, but the whole visitation program was started over a 2-year period, and over 40 people have been on the home visitation program and not one has died.

Persons who can relate, and bring awareness in a concerned effort to bridge the gap are needed. I consider myself a professional in the field of aging, and yet my own State has no room for me because I do not have the educational qualifications in my background. I don't have a college background, so therefore I am not qualified to serve them.

Yet it is under my proddings that I have been able to acquire some type of tokenism for my people, and this is what I call it. I was given $600 to start a meals on wheels program. I can't think of anything else I can call it.

The people I serve have no running water, lights; even the toilet facilities are very limited. Who wants to be identified with them? So whenever you give me a dime or nickel, I have to squeeze it to make sure that it goes as far as possible.

Nursing homes are again a thing that is a service to the community, to people who are able to ask for these things. But the people that I serve will not ask for them, so therefore I ask for them. Even some small token for the present time I will accept it. I will nudge you for something more later on, but for the time being we need services for these people who are so quiet for so long and have given so much to their Nation.

One senior citizen in the area, at one time was a very well-to-do gentleman, and is now very close to being a pauper because of the health problems in his home. His wife suffered a stroke 5 years and 2 months ago, leaving her a vegetable. She does not recognize anyone; once in a while she tries to smile, but all that is alive is her eyes.

Mr. Wilson is a retired Santa Fe man, and his retirement pension is adequate for them. But because of Mrs. Wilson being ill and the high cost of the nursing home, trying to keep his home and its upkeep, he has had to go into his savings and is now close to not having much left. Is there any way that such a person can obtain Medicare before he loses all? They are so old and they have worked so hard for what they have, and now it must be sacrificed so that the lady can continue in the home. His expenses on his wife not including his own home and personal expenses are running close to $500 per month, and his income is much less than this figure. Income, $350 per month. Mr. Wilson requested that this statement be made.

Mr. HALAMANDARIS. Thank you. Your prepared statement will be inserted in the record.

PREPARED STATEMENT OF CORINE GARCIA

In quiet desperation some of our senior citizens are promoting legal permission for euthanasia to be carried out in terminal care situations at their own request. This fact speaks out for the long history of neglect which as a nation we have allowed to happen, and within this grouping even more desperate neglect is evident among our Spanish-surnamed elderly.

Let us consider some of these apparent realities:

A. The conscience of the nation does not permit speaking of our elderly as old people, but uses such euphemisms or terms such as "the aging, the senior citizen, pensioners, etc. However, the Spanish-speaking employ no such deception and use word "viejito" openly with honest admiration, dignity and love.

B. There is a popular misconception that few Spanish surnamed age beyond early or mid 60's. The misconception is so widespread, that once an aging person reaches his sixties, he is ready to be absorbed into obscurity.

C. "Viejitos" deprive themselves of food and other necessities for their children and grandchildren to have more than they had. Extended family care is a stereotype and many rural families are simply unable to support their parents.

D. It is fact that first generation Spanish-surnamed do not speak English or are uncomfortable being forced to do so. They are out of their element in an English-speaking situation.

There is a lack of information made available to the "viejitos" and their families about nursing homes and their use. The non-use of nursing homes or such care facilities in large number is not so much a point of distrust as a fact of just not knowing why it is there and what the home is supposed to do.

From this, several points can be drawn in reference to care for the Spanish-surnamed aging.

A different environment prevails in nursing homes in contrast to the familiar surroundings of the Spanish-surnamed aging.

Traditionally "viejitos" prefer the comforts in the home where they have lived most of their lives and raised children and even grandchildren. The home is a secure, even if improverished place, filled with warm memories and memorabilia.

In sharp contrast to such a memory-enriched setting, where the "viejito" has his bearings, is the sterile, institutional atmosphere of many of our contemporary nursing homes. In such a place, the aging person is not only deprived of many psychological supports, but the Spanish-speaking person is further isolated for lack of personnel and other residents to talk to him in his first language. This can become a cruelly embarrasing situation, when one must be dependent on translators to communicate one's basic needs.

Many "viejitos" would prefer not to suffer these indignities and remain in their own homes or cause hardship to their offspring by being dependent on them. They resign themselves to the "will of God". To be old and poor is to be without identity, for oldness and poverty are catch-all terms with which no one wants to identify. Many of this country's nursing homes in rural areas, while caring for the aging, are not set up to care for the poor, which represents a double handicap. Further still, applicants for nursing homes are screened on their mobility and those who would be most dependent on others for physical care are not encouraged to apply, or if permitted to enter, often times receive less than good care, or are simply neglected.

Sometimes it may seem that the surroundings of the "viejito" in his own home are unsafe, but to remove him from those emotional supports and transfer him physically to the cultural barrenness of an institution could well prove fatal from the sense of loss.

Among the recommendations being made to the Senate Sub-committee are:

The first priority is on a two-way education: informing the Spanish surnamed community about the presence of reputable nursing homes, and these must be a corresponding awareness developed on the part of care facilities to meet the special needs of the Spanish-speaking.

1. To see that nursing homes include special programs for the "viejitos"; and this means trained bilingual, preferably bicultural staff and administration to make the "viejito's" environmental adjustment more comfortable;

2. To introduce a culturally familiar atmosphere to their care setting. This could take the form of recognizable Mexicano minus, decoration, entertainment, and available religious services;

3. There is need to include special programs for the "viejitos" who are reluctant, or even refuse, to leave their homes of fifty or more years. We must have support services to bring care and recognition to these home-bound persons, giving them the dignity they have earned and seeing that their needs are met. For example, meals-on-wheels programs which include some frequent social functions and the necessary transportation to arrange the same;

4. A concerned effort to bridge the gap, educational as well as cultural, between Spanish-surnamed families who would be willing to use nursing homes to care for their "viejitos" and the public agencies and personnel who make the contracts and provide the follow-up. It is essential that these intermediaries be well acquainted with the culture and background of their clients;

5. Every possible resource available for promoting care for the aging which hopes to serve Spanish-speaking elderly must be sensitized to these special human needs;

6. Effort on the part of the mass media to highlight the conditions of the "viejitos" in a respectable, positive light and aid in mobilizing public and private endeavors to advocate for meaningful solutions to the needs of the "viejitos";

7. Promoting awards to study problems of the aging under federal grants (such as the Institute of Gerontology at the University of Michigan) to members of the Spanish-surnamed community for in-depth reporting on their own people's needs and available program monies to implement these findings and recommendations.

Mr. HALAMANDARIS. Sister Ramirez, we would like to have your statement. You are speaking today on behalf of Dr. Jorge Prieto?

STATEMENT BY SISTER RAMIREZ

Sister RAMIREZ. Yes, and I feel quite humble trying to represent that big man. Since we share his ideals I think we have parallels, or we parallel some philosophy. I am going to, I think, step on some of the same points that Mrs. Garcia has without ever having met her or known her, but I think that the greatest factor for the low participation of the Spanish minority group in nursing homes is a culture situation.

Our Mexican-Americans have been the slowest to aculturate. In particular our viejitos have not been able to learn the English language, and we cannot expect them to do it now. Could you manage yourselves in a hospital situation asking for much needed services in a language other than your own? Just put yourself in their place and you can see how very badly you will feel. Then our viejitos are very dubious. For decades they have been exploited, so all institutions to them are staffed by Anglos, by people that have taken advantage of them.

They just see themselves going into the nursing homes. Also, they have been segregated in jobs and education and housing, particularly. One very important thing is that their culture is unique. There is a

mixture of Indian and Spanish blood in all our Mexican-Americans and now so many have American blood, Texan blood. This makes the thinking of the viejitos completely reversed to our thinking.

What is logical to us seems illogical to them or vice versa. Besides that, they were never allowed to participate in the democratic process at any level. It was not until the 1960's in Crystal City that they were given any recognition to the Mexican-American vote.

Dr. Prieto himself told me that he was severely punished and was forbidden to speak the language that brought the gospel to Americans when he was in Texas in 1924. My two brothers were corporally punished for speaking Spanish in school, their mother tongue in school.

At the present time I can say that there isn't any discrimination de jure, but there is de facto discrimination, discrimination in the nursing home. The reason is because of the cost. Most of our viejitos are not able to pay any kind of fee. They don't have Medicare. They are not knowledgeable about that and they feel that it is sort of humiliating to go and ask for anything. They are a proud race and they feel that it would be humiliating.

Rich Get Favored Treatment

Also the hospitals have been patronizing to the rich, and they have been humiliating to the poor, so this has created a mistrust to any institution in our old people. In Illinois we have known of cases, Dr. Prieto has documented cases of people that we have sent him, and they have waited for hours because they cannot, if it is a private hospital, they cannot raise the money that is $100 or $150 that they have to pay on entering the hospital. They have waited for hours there before they are given any medical attention. So can you believe those people would trust any kind of an institution when they take their bodies to a nursing home?

Just a few weeks ago, Senator Edmund Muskie at Dade County Fla., speaking to a senior citizens council said the disaster we call medical service makes millions of Americans forgotten Americans. I have seen as you have seen overcrowded hospital corridors and overworked doctors and nurses. They stand as weak testimony to the failure of a medical care system.

If this is true of the English retired that have incomes, can you imagine what it is for our Spanish viejitos who have always been treated as second class citizens? These viejitos helped to build our land, built the railroad, tilled our soil, always without the minimal protection of other workers, that have never been included in workmens' compensation, in unemployment benefits, they are not in Social Security benefits because they work in agricultural work.

Now in old age and infirmities they have been discarded without any measure of Social Security benefits or any other. We do not think the answer for our viejitos is to be locked up in the traditional nursing homes which are not better than jails. The answer must be in decent housing which they can afford and in services they can trust and understand. For this generation of old people who have understanding untold hardships and deprivations it is unrealistic to think that they will accept the present concept of nursing homes. Our suggestions

would be an efficient bilingual visiting nurse for them who still have quite an extended family care service.

The infirmities of the elderly are not inevitable. We could have avoided a lot of their infirmities if they had had preventive medical care. This could be double incentive for our Mexican-American students who are not able to attend the universities because of lack of funds if we could have the work study groups extended to the Mexican-American and visit out, reach out, not just be looked up in the university doing minor indoor jobs, if they would reach out and learn first hand. They probably know the needs of their own families but reach out and come up with the answers to the needed services of the old people.

Spanish-Speaking Students Could Aid Elderly

The Spanish-speaking students could go out and teach these people of the services that they can avail themselves of such as, food stamps, legal aid, Medicare and Medicaid. Since part of the culture of the Spanish people is not to reach outside the family for help, as a preventative approach, it is felt that adequate housing would be a remedial measure, eliminating such inadequacies as outdoor plumbing which so many of our people out in the San Antonio area and the rural Texas area, and in Arizona have.

Mexican-Americans suffer from arthritis, from heart disease, from different ailments, so we could really help their miseries because we would not think it conceivable that if you have a toothache, you would not go to a dentist.

Well, our Mexican-Americans do not. They do not have the money. First, they try rinsing with salt water, putting on patches of some kind of herbs to see if that will alleviate the toothache, and they go on for days and days and days with that toothache.

We could alleviate those pains and aches for them. In conclusion, I would say that this society has a moral obligation to the elderly of Spanish-speaking origin. Have you ever thought that almost every grape, every tomato, every asparagus, peach, apple, orange, or the other fruits and vegetables we eat have been touched by Mexican-Americans?

Senator Paul Douglas of Illinois appropriately said during Kennedy's term of office that the only difference from slavery today is that now the slaves are brown and they are only rented for a few cents.

It is now your turn and duty to redress the grievances of this generation. The quality of its compassion is a measure of a Nation's greatness, so if we help our elderly, especially minority groups who have already suffered so much, so much greater will God make this Nation that we love so much. Thank you very much.

Mr. Halamandaris. Thank you for an excellent statement. That provides us with insight into the problems, and I must say before this hearing concludes, that I pledge to you and give you my guarantee that this hearing will result in a package of legislation, that it will help not only Mexican-Americans, but all Americans to cope with the problems that we have been hearing about today described as eloquently as you have.

You know that Senator Church is presently working on a package of home health services which would bring health services into the homes, and this is a package that has been in the works for a long time. I believe that when the Senator finally introduces it, we will have a welcome solution to these problems. I wanted to ask a question, Mrs. Garcia, the same question that I asked the other panels: Do Mexican-American families take care of their own?

What has happened to the extended family among Mexican-Americans in this country? Is family unit still strong? Is the family under attack in the Mexican community or not?

Mr. MARTINEZ. Well, I said earlier this morning that to some extent the family structure is present, but it is deteriorating. For example, by the time that I get to be an elderly person, I imagine that my children will look upon me not as my parents looked upon their parents, and this is because of changes that have taken place.

Equally so, the fact that the young individual is being better educated because of the opportunities that exist. I am not saying this is happening across the board. There are a lot of marriages taking place today that the culture of the close family structure is to some extent deteriorating to the point where it no longer is as strong as it was 15 or 20 years ago, for example, it is deteriorating. There is some semblance of it.

Mr. HALAMANDARIS. Sister Ramirez would you agree with that assessment?

Sister RAMIREZ. Yes; I believe it is still present now, but I am sure that it has to deteriorate. One of the reasons is the economic reason. The young married couples today may have four or five children, and they both have to work to make ends meet, so they are not able to take care of grandpa or grandma, but they still have the family present now, but I imagine the next generation, like I say, the intermarriages are becoming more and more.

Mr. HALAMANDARIS. They are becoming Americanized?

Sister RAMIREZ. Yes. Like a Mexican boy will marry an American girl, they do not want grandma and grandpa around to interfere.

Mr. HALAMANDARIS. What about my other question that I have asked previous panels, and that is how do you rank these various factors that we have been talking about today, cost and discrimination, social and cultural differences, or they simply just don't want to go to a nursing home?

Sister RAMIREZ. I think with our previous generation, we would have to say that cultural would be the first. As far as I can see, culture is the first reason. Then, cost is the second.

Mr. HALAMANDARIS. And discrimination?

Sister RAMIREZ. Discrimination, yes.

Mr. HALAMANDARIS. And lastly, they do not like the nursing home?

Sister RAMIERZ. No; they do not.

NURSING HOMES VIEWED AS JAILS

Mr. HALAMANDARIS. How are nursing homes viewed in the Mexican-American community?

Sister RAMIREZ. They are viewed like jails.

Mr. HALAMANDARIS. Do they have a bad reputation? Is that true?

Mrs. GARCIA. The way I would grade it, No. 1, discrimination. No. 2, not wanting to go in. No. 3, social and economic, and maybe No. 4, the cost.

Mr. MARTINEZ. Well, you are asking how they view the nursing home. To some extent, they view the nursing home as a means to an end, as a place of inactivity and loneliness, more so than what they face in their own homes.

In other words, we are very active people. We like to keep active, active in the neighborhood, active in the church, active in the home surroundings. It is amazing to see the number of elderly, for example, when the church sponsors a Saturday night bingo. It is mobbed because they like to socialize, and nursing homes do not provide them this type of activity.

Mr. HALAMANDARIS. So, as far as your ranking is concerned, would you say it is a toss-up?

Mr. MARTINEZ. Well, again, of course, like any other ethnic group that was here before, there are some elderly that do need and do require institutionalization, so it is a two-way street.

The needy ought to have adequate nursing care facilities, but those that do not need it, do not need to be institutionalized. Then, adequate programs such as one I mentioned this morning, home health care, home delivered meals, for example, or maybe broadening the scope of the foster grandparent program to include involvement with other elderly groups within the home.

These types of services need to be broadened. Also, to focus on the particular need of the Mexican-Americans in the home. So again, it is a two-way street.

Mr. HALAMANDARIS. Well, what about the question of whether or not nursing homes should be for profit. Is there any view of this in the Mexican-American community? Are proprietary facilities looked at suspiciously?

Mr. MARTINEZ. Well, personally speaking, I do not care whether they are profit or nonprofit or profitmaking institutions. The thing is that those institutions that are available should make as much of an allowance to provide adequate services to the loneliness in America, whether they are profitmaking or not. There are a lot of them available.

Of course, not as much as there are in the Nation, but in this one instance of a community visited, there was one nursing home that does not let any Mexican-Americans come in. I think the needs of the elderly Mexican-Americans should include them.

Mr. HALAMANDARIS. Have you been in many nursing homes in the Texas area in Houston, Dallas, throughout the Southwest? Have you been in many nursing homes?

Mr. MARTINEZ. Not many, because really the nursing home field is, I guess, I want to say, not "my bag," but I have been in some.

Mr. HALAMANDARIS. My question is, in your experience, do nursing homes in the area cater in any fashion to Mexican-Americans? We have a large Mexican-American community in the Southwest, and I would think it would be logical that nursing homes would cater specifically to older Mexican Americans.

Mr. MARTINEZ. Not necessarily.

Mr. HALAMANDARIS. Do they provide decent——

Mr. MARTINEZ. There is no statistical data anywhere that you can pinpoint and say there are this many Mexican-Americans in nursing homes and compare it to the overall population. There is none whatsoever.

Mr. HALAMANDARIS. I was wondering specifically whether you had heard of any nursing homes—I address this to the panel—any nursing homes in your respective areas which cater to Mexican-Americans by providing Mexican food, say, tortillas and tacos.

Mrs. GARCIA. No, there are 82 nursing homes in Denver, and that is quite a few. Not one has an administrator with a Spanish surname. As I said before, you can almost ask, and I did call. I wanted to put my mother in, and I was wondering if there were some other people there that can speak Spanish. I was not encouraged at all.

I did that just before coming up here, we are not invited or encouraged to place our people in homes like that.

QUESTIONABLE REFERRAL PRACTICES

Mr. HALAMANDARIS. I will tell you what response we received from Stanley Pottinger, who is the Director of the Office of Civil Rights in the Department of Health, Education, and Welfare,* and their explanation for the absence of minorities in nursing homes. You might find this humorous.

They blame it all on referral practices. To get into a nursing home, you have to be referred by somebody or someone. You have to have been in a hospital for 3 days. Some social worker has to refer you to a nursing home.

Mrs. GARCIA. Let me tell you one case that happened to me. One little lady was very ill and needed to go from the hospital to the nursing home which you can go to underground from the hospital to the nursing home, and they said that there is no room at the nursing home. So, we are going to have to send her somewhere else.

They called a little community about 37 miles away, and they said yes, we have room here. The name was Trujillo. Well, on second thought, we are going to have to be sure that we do have a place for you, so then the case worker said, why don't you go to Pueblo?

There is a beautiful nursing home, so they stressed, and it was filthy. The front part was beautiful, but the rest was not fit for human beings to be in. So, they came back, and they said, take her to Trinidad, 83 miles away, and that is where they took the little old lady.

The man came back to Rocky Ford and said, "How come we can't put my mother in here?" So, we filed a civil rights suit against the Welfare Department, and 2 days later, his mother was in the nursing home in Rocky Ford. But, all that just to get her back into a nursing home where she could be taken care of by her family.

Mr. HALAMANDARIS. That is an incredible story. What about in Illinois, Sister Ramirez?

Sister RAMIREZ. In Illinois, I do not know of one that has an administrator Spanish-speaking, and there may be some not even professionals. I think there are paraprofessionals working there, practical nurses or aides, or mostly they are in the maintenance portion of it.

*See letter, p. 2492.

There are very, very few in the nursing home who they communicate with. The cleaning ladies and dusting ladies.

Mr. HALAMANDARIS. Let me ask again, have you heard of nursing homes that in someway cater to Mexican-Americans? Maybe cater is the wrong word. Do you know of any that provide Mexican food?

Mr. MARTINEZ. No.

Mr. HALAMANDARIS. In your opening statement, you made reference to—what was the reference that you made to one Spanish surname?

Mr. MARTINEZ. One Spanish-surnamed administrator in Texas.

Mr. HALAMANDARIS. Out of the whole list of nursing home administrators?

Mr. MARTINEZ. Right.

Mr. HALAMANDARIS. How many nursing homes?

Mr. MARTINEZ. I have no knowledge at this time. I could not get any information. I stated that I had checked with the Texas Department of Nursing and Convalescent Homes, and Texas Welfare Statistical Division in order to obtain some kind of ethnic breakdown on the number of residents who were Mexican-Americans. They denied having this information. They did not keep it.

Mr. HALAMANDARIS. So, we can guess that there are a large number of nursing homes in Texas, somewhere around 1,000.

Mr. MARTINEZ. Well, there were 64,000 beds.

Mr. HALAMANDARIS. Well, my guess would be that it would be in the neighborhood of a thousand or so, and out of all those, you found only one Mexican surname?

Mr. MARTINEZ. One.

Mr. HALAMANDARIS. Now, you have indicated that as far as you know—and you do cover Texas and Southwest, and the people you have talked to—and there are very, very few in anyway, shape, or form, that make provisions for Spanish-speaking or Mexican-Americans. Is that your statement?

Mr. MARTINEZ. That is right.

Mr. HALAMANDARIS. That is incredible. I find that just very hard to believe. I do not know what we can do about that. The thought occurs, with all due respect to my friend, Mr. Hiroto, who is sitting in the back row once again, that the profession of being a nursing home administrator is not that difficult to get into educationwise.

There seems to be a tremendous demand. Why can't more minority members be trained to be nursing home administrators? It is not that complicated. What is involved is a high school education and then passing the license examination.

Mrs. GARCIA. I took the course of gerontology for nursing home administrator, but I have never really tried to take the State examination. I doubt if I would be hired anywhere in Colorado. I know I would not be.

ADMINISTRATORS LACK FORMAL TRAINING

Mr. MARTINEZ. Based on your comments it would not be difficult to be a nursing home administrator, but I think it goes a little further than that.

In reading some past testimony that has been given on long-term care—and I don't remember the gentleman's name, but he was a doctor—he said by and large most nursing home administrators had

received no formal training of any kind dealing specifically with the elderly as far as having compassion for the type of problems that the elderly have as people and as human beings and not as merely residents in the nursing home but as individuals.

Mr. HALAMANDARIS. Yes. You know, there is a nursing home situation which is brewing down in Houston. Mutual complaints, recriminations, back and forth between advocates on behalf of consumers, the patients that are in nursing homes, and on the other hand the Texas Nursing Home Association denying all the charges.

I wonder if you had heard anything about the developments. In your judgment are any of the accusations being thrown at the Texas Nursing Home Association valid? They are the standard accusations—poorly run operation, poor food, poor conditions. In fact, the State seems to have done very little in enforcing State standards. Do you have any comments about that?

Mr. MARTINEZ. No, I don't. All the facilities are really elaborate to some extent, the ones I have seen, in terms of types of recreation for the elderly. By and large, the things I have seen have been restricted.

They are not open to the elderly to take advantage of, but rather it is a type of structured program to where certain hours of the day they can't do this and certain hours of the day they can do it, and this type of activity.

Mr. HALAMANDARIS. Like Sister Ramirez said, they are viewed as prisons.

Mr. MARTINEZ. Right.

Mr. HALAMANDARIS. If they are viewed as prisons the question comes up: should we try to encourage the development of more prisons? I guess the answer is we want more nursing homes but they should be developed in such a way that they provide the quality services that we want.

I guess that is the answer and we should also try to provide in-home services which almost everyone agrees is what we ought to have today. That pretty well summarizes the questions that I had. Do any of you have any questions?

Mr. AFFELDT. I have just a few questions. As you may already know, the OEO legislation provides for an increase in the funding level for senior opportunities and services from $8.8 million to $30 million. Assuming that we could obtain adequate funding for this authorization, how many individuals do you think you could serve if you did have the sufficient amount of money that you needed?

Mrs. GARCIA. The area that I serve has a total of about 13 small communities which totals about 39,000 people, and of that, 28.8 percent are elderly. I know from previous experience that out of this I would very well be able to serve at least 5,000. I know I could if I was to be given the proper staff.

Mr. AFFELDT. If you were to serve 5,000, how much would this cost on an annual basis?

Mrs. GARCIA. You are looking at someone that is pinching every penny she gets hold of, so I would probably give a very conservative figure—I know if I were to be given between $75,000 and $85,000, I know that it could be done because there are a lot of miles to be covered.

I am sure what we need to do is to talk to people and really let them know what the situation is and how it is going to be corrected. This is the way it is. You are not getting any younger, so let's do something so that when we are old someone will do something for us.

Mr. AFFELDT, I would like to ask a question. Time and time again this is the notion of grantsmanship, Homer, because of the language problems, the fact that many minority groups are unaware of programs.

They are not being served to the extent that they should be. What can be done to overcome this very serious obstacle to assure that the elderly get their fare share of the Federal funding?

COMMUNITY ACTION AGENCIES

Mr. MARTINEZ. No. 1, again speaking on the region that I work in, for the most part community action agencies. I use that name as an example. Community action agencies have just now begun to look at the elderly's problems as a definite high priority.

It is partly as a result of the White House Conference, partly as a result of the legislation that has taken place pending on the OEO bill and through the Administration on Aging, the question being not so much as far as grantsmanship, because there are a lot of agencies very capable as far as grantsmanship is concerned.

Fifty-two in Texas, possibly as many as 65 percent, have some type of clientele that are Mexican-American elderly. It is not so much grantsmanship on the part of agencies, but rather the availability of funds for programs for the elderly at the local level that CAA's can take advantage of.

If these agencies received the funds, including those from the Administration on Aging for example, this would enable CAA's to develop programs and services for the elderly poor. Part of my responsibility now is to work with these CAA's and gear them toward possibly getting both title VII and title III that are coming down the pike in the near future.

It is a hard battle and one that is not going to be easy by any means.

Mr. AFFELDT. To what would you attribute those problems? Is it because of insufficient funding available or is it a hostility with regard to the community action agencies or is there some other reason?

Mr. MARTINEZ. It is basically hostility toward community action agencies because it is not apparent in every case, for instance. For example, there are five States in region 6, and out of those five only in one State do you see any participation of community action agencies in title III funding through the State. To some extent, this is due to some degree of hostility.

Mr. AFFELDT. My final question shall be directed at Sister Ramirez. With regard to nursing home care I believe an elderly patient must pay $8.50 per day now after the 20th day to 100 days. In addition, Medicare patients also have other requirements that they must meet.

For example, under part B a patient must pay the first $50 of his physician's services. Thereafter, he pays 20 percent coinsurance. Moreover, all Medicare patients enrolled under part B must pay $5.80 for their supplementary medical insurance.

To what extent do these copayments deter elderly minority groups from participation in Medicare or in terms of not receiving the care which they need?

Co-Payments Deter Elderly Participation

Sister Ramirez. I think it almost totally deters them. They don't have the first $50 to start out with and they don't have the $8.50 a day. It is impossible. Some of these people are getting $60 a month pension. The highest I researched was getting $112 and she was living in a suburb that was paying high rent, so she had bare means and this one woman has very great needs.

She is a cancer patient, a chronic illness, and she has high blood pressure and she just had cataracts removed. All she can get is extended care from her family.

Mr. Affeldt. In terms of meeting this problem, do you think it would be better to place primary emphasis with regard to developing a guaranteed annual income that would provide for a livable income for the elderly or should we be pushing toward broadening the scope of care under Medicare or, ideally speaking, should we be doing both?

Sister Ramirez. I say income would help them all around. It would be a preventive measure in the first place because they could get better nutrition and a little better housing than they have now.

All around, it goes to a higher income for these people, higher welfare, income, guaranteed income, guaranteed early income.

Mr. Halamandaris. Counsel Affeldt left out one program; that is the Medicaid program. I am going to ask you, about the degree and accessibility of the Medicaid program.

We often hear that the Medicaid program is taking care of the medical needs of so many of our poor. Of course, Mexican-Americans make up a large share of those who are below the poverty line. How accessible is Medicaid? How many Mexican-Americans are on Medicaid? Over 60 percent of nursing home patients have their care paid by Medicaid.

Sister Ramirez. I think a great many don't know about Medicaid. They have their Medicare and that is all, whenever we talk to them, but there are almost 500,000 Mexican-Americans in the Chicago area and we are the only Spanish-speaking Sisters in the area.

Mr. Halamandaris. They don't know about it?

Sister Ramirez. Well, like you said, they are afraid of institutions. They are wary and they are suspicious.

Mr. Martinez. I might add, too, as Sister Ramirez said, it is not Medicaid equally as they don't understand Medicare. I myself am ignorant about part B Medicare coinsurance so consequently would a less educated individual such as an elderly Mexican-American be able to understand all the ramifications involved in Medicare and Medicaid?

Presently, for example, they may not participate in nursing homes because they might not be aware that one exists or may not be aware that Medicaid provides some type of compensation. Then there is the Social Security increase, a 20-percent increase. This will automatically cut a lot of elderly out of receiving Medicaid payments because at the same level when Social Security is increased the old-age assistance is decreased. Therefore, a lot of elderly are going to be left out.

Mr. HALAMANDARIS. You are nodding your head, Mrs. Garcia.

Mrs. GARCIA. Colorado is one of the few States I think that is really good on Medicare and Medicaid because the State absorbs the basic fee that must be paid by the individual. We are a good State.

Mr. HALAMANDARIS. Poor whites, poor blacks, and other groups, don't know about the existence of the Medicaid program and they don't understand it any better than you or I understand it.

The point is that poor whites are the ones that are found in nursing homes. Somehow they get to take advantage of the Medicaid program and Mexican-Americans don't.

Mr. MARTINEZ. Someone who speaks the same language is more apt to understand what the person is talking about.

MEDICAID—A WELL-KEPT SECRET

Mr. HALAMANDARIS. You are telling me that Medicaid is a well-kept secret among the Anglos?

Sister RAMIREZ. Yes.

Mrs. GARCIA. I think when you read the newspaper—and Anglos do read the newspaper more than we do—usually you find out the new legislation. Sometimes it is put down so that people can understand it and then it does go by word of mouth, one to another.

I have been questioned about different stages of legislation which doesn't mean that I am that knowledgeable about it but when something does come out in the paper many of my people come and ask me what it is all about. I think Anglos do tell one another more than Spanish people do.

Mr. HALAMANDARIS. Again, it is incredible to me that Medicaid is providing almost $2 billion worth of care in nursing homes, that it is a well-kept secret, that none of our Mexican-Americans seem to know about or can take advantage of.

The point becomes even bigger when you talk about Medicaid in terms of who it services and the care that is provided. That is why I think educational services are needed so that we make these things known to the people so they might share and participate.

The Nixon administration is constantly telling us that Medicaid and Medicare are overutilized and they are seeking to cut them back. It doesn't appear to be overutilized, at least from the point of view of Mexican-Americans or other minorities of this country.

Mrs. GARCIA. I think our people would take more advantage if we could break through the language barrier.

Mr. HALAMANDARIS. I would like to thank the panel. We will close this series of hearings.

(Whereupon, at 2:05 p.m., the hearing was adjourned subject to call of the Chair.)

APPENDIX

Appendix 1

ITEM 1. MEDI-CAL CUT MAY IMPERIL THOUSANDS OF LIVES*

[From the Los Angeles Times, July 5, 1972]

THIRTY-TWO AGED DIE AFTER BEING ORDERED TO FACILITIES OFFERING LESS CARE

(By David Shaw)

The lives of thousands of sick old people throughout California may be endangered by a massive cutback in state Medi-Cal payments to nursing homes, a Times investigation has disclosed.

At least 32 elderly patients have already died, most of them within a short period—often just days, even hours—after the state said they were not sick enough to warrant treatment in facilities with skilled nursing care available 24 hours a day.

Nineteen of the 32 patients died after they were transferred—all of them against their families' wishes, and a great many of them against their own doctors' advice—to facilities with either a lower level of medical care or no medical care at all . . . at a savings to the state of $4 to $7 per patient per day.

The 13 other patients died even before the transfers could be made.

In many of these cases, the patients' doctors, nurses or families say, physical and emotional stress resulting from the transfer was a significant factor in the patients' deaths.

State officials deny this, and accuse their critics of masking their own vested interests behind a disingenuous concern for their patients.

It is virtually impossible, of course, to prove a causal relationship between transfers and the death of any individual patient. But critics of the transfer program say the mere fact that these particular patients died at least indicates poor judgment by the state in evaluating their medical condition.

Most of the patients were suffering from such illnesses as stroke, heart disease, cancer or various kinds of circulatory deficiences or mental deterioration. Doctors and nursing home officials interviewed by The Times say there will be many more such deaths if the state's austerity policies are not modified.

Under * * * conditions any patient the state wants transferred out of a nursing home is entitled to a "fair hearing." But until a court suit was brought on behalf of one patient, the state was not telling the patients of that right.

Even now, when the state formally notifies the patient of his fair hearing right, he is not notified that he also is entitled to have an outside doctor testify for him at state expense during the hearing.

The plight of the ailing elderly in California appears to stem, in large measure, from the creation last year of a new "intermediate" level of institutional care.

3. LEVELS PREVIOUSLY RECOGNIZED

Previously, the state Medi-Cal program recognized only three levels of institutional care for these people:

Acute care (hospitals) for patients sick enough to require the availability of doctors, emergency equipment and specialized treatment 24 hours a day.

Extended care (nursing homes, also called convalescent hospitals) for patients recuperating after acute hospitalization or otherwise in need of around-the-clock nursing availability for such treatment as catheterization, intravenous feeding, special medication or post-operative changes of dressing.

Residential care (essentially boarding homes) for people who were not medically ill but just had no other place to go.

*See statement by Dr. Hemsley, p. 2485.

62-264—72—pt. 20——7

All three kinds of facilities were—and are—open to private patients, paying their own way, as well as to those who require Medi-Cal assistance.

But three or four years ago, in the wake of the creation of Medicare, federal officials decided a new "intermediate" level of care was needed.

DESCRIPTION OF NEW LEVEL

It was to become effective last year and was intended for patients who required more nursing care than they could get at home (or in a board and care facility), but did not require the full range of services offered by nursing homes with skilled nurses on duty 24 hours a day.

In intermediate care facilities, it was determined, registered nurses would be on duty only eight hours a day, five days a week (generally 9 a.m. to 5 p.m., Monday through Friday), and other staff and licensing requirements applicable to nursing homes would be reduced accordingly.

(As with nursing homes, the patients' private doctors would not be on the house staff but would be on call.)

In California, the state pays nursing homes as much as $14 per patient per day—an annual cost, in fiscal 1971–72, of $232 million for some 60,000 patients.

By channeling the healthiest of these patients into intermediate care facilities—where the state would pay $10 per patient, per day—the state estimated it could save more than $10 million per year.

(Revised estimates indicate a net tax savings of $13.7 million for fiscal 1972–73.)

DISASTROUS PRACTICE CHARGED

But doctors and nursing home officials charge the Reagan Administration's commitment to reduce government spending has * * * into disastrous practice.

"Look, I don't want our tax money blown all to hell on welfare either." says Dr. Edgar L. Tversky of Los Angeles.

"But I don't want the state sending one of my really sick patients from a nursing home into some intermediate facility with no nurses on duty at night or weekdays either.

"If my patient dies of a heart attack, I don't want to be wondering if that's what did it."

Some doctors already are wondering.

In San Diego, a 77-year-old heart patient spent a year in a nursing home. Then she was transferred—against her doctor's wishes—to an intermediate care facility. Seven days later, she was dead.

In Los Angeles, another woman's physical and emotional condition began deteriorating almost from the moment she was transferred—also against her doctor's wishes. She died in three weeks.

And at one San Fernando Valley nursing home, an 80-year-old heart patient died four hours after she was told she was to be transferred, and an 84-year-old diabetic was moved from the same facility and died a week later.

A third patient in the same nursing home suffering from emphysema and congestive heart failure, was transferred to an intermediate care facility. Two days later, he suffered a relapse and had to be rushed to an acute hospital. Two days after that, he died.

Tony Riggio, administrator at Community Convalescent Hospital in San Gabriel, says the state's "wholesale reclassification of nursing home patients into intermediate brings up the old question of whether you would rather let a guilty man go free or hang an innocent man.

"Only a small percentage of the people who come in here don't really need our kind of treatment," Riggio says, "but the state's trying so hard to cut costs that they're not just reclassifying these people. They want to move seriously ill people out, too—people who need nurses nearby all the time.

"The state knows this is an easy way to save money because there's so little resistance from the people who get hurt—the patients. Sick, old people aren't likely to fight back or vote against you."

When the intermediate care program was created, it was promised that careful medical screening would precede any determination on precisely what level of care a particular patient required.

But many experts say this is not the way things have worked out.

When a Medi-Cal patient applies for admission to a nursing home, the nursing home sends the state a report of his condition, signed by his physician.

That report—a "treatment authorization request"—is checked first by a state-employed nurse, then by a state-employed doctor (a "Medi-Cal consultant").

If either the nurse or the doctor is uncertain about how to evaluate the patient, a state nurse may be sent to the nursing home to question the patient further.

The Medi-Cal consultant makes the final decision on whether the patient should be approved for nursing home care or if he only needs intermediate care. But the consultant generally makes that decision without having examined the patient himself.

Though many private physicians told The Times they had not been consulted by the state about their patients, Dr. Gaston Baus, a Medi-Cal consultant in Los Angeles, insists that no treatment authorization request is denied without a state doctor having spoken to the private doctor.

"The only exception," he says, "is if we can't reach him after two or three calls."

But even if the Medi-Cal consultant approves the patient for nursing home care, the patient may still be moved to an intermediate care facility later, after one of the state's medical-social review teams visits the nursing home.

The review teams, each consisting of two nurses and a social worker, make annual visits to all nursing homes to determine which patients actually belong there and which require only intermediate care or residential care—or no care at all.

The team questions—but does not physically examine—every patient in the nursing home, checking his medical charts and forwarding their report and recommendation to a Medi-Cal consultant who, again, makes the final decision.

DECISIONS BASED ON REPORTS

State authorities say their doctors usually make their decisions from written reports provided by the teams and the nursing homes—unless the patient's own physician disagrees with the team's evaluation.

"Then the Medi-Cal consultant will call the private physician, and if they can't resolve it, he'll go out and examine the patient himself." says Dr. Morris M. Rubin, chief Medi-Cal consultant for the Department of Health Care Services.

Nurses on the review teams are "trained to know exactly what information the doctor needs," Dr. Rubin says. "We don't have a lot of doctors, so they can't go to all those nursing homes."

(There are only three full-time and two part-time Medi-Cal consultants for approximately 450 nursing homes and 25,000 patients in Los Angeles County, for example.)

Another high-ranking official in the Medi-Cal program agreed with Dr. Rubin, and said:

"Any decent doctor should be able to make his evaluations with the reports he gets. He shouldn't have to go examine the patient."

But many private physicians disagree. One who has spent most of his career evaluating the capabilities of many transfers—almost 3,000 by Feb. 1, 1971.

In recent months, however, the Medi-Cal consultants have been much more stringent in using the nursing home's initial written reports—the "treatment authorization requests"—to screen out from the very beginning those patients they do not think require nursing home care.

Ironically, however, the decision to transfer a patient from a nursing home to an intermediate care facility can end up costing the state more money, not less.

Mentally or emotionally disturbed patients have been moved to intermediate care facilities, where reduced staff and security made them a nuisance, if not a menace, to other patients. They were then returned to the nursing homes, at considerable administrative expense to the state.

The state spends even more money when a physically ill patient suffers a relapse after being transferred from a nursing home, and must be taken to an acute hospital.

In one such case, the patient ran up a hospital bill of almost $3,000 in 22 days—enough state money to have kept her in the nursing home for almost seven months had she not been transferred.

The state insists that relapses and returns are rare.

"Our records show the rate is very low, not even 5%, way below that," says one Medi-Cal official who agreed to have his subordinate show those records to The Times.

CAN'T FIND RECORDS

But the subordinate, after checking with others in the department, said there were no such records. "We'd have to call around and make a study," he said.

One intermediate facility, in Alameda, already has made a small study of its own. In a recent six-month period, the administrator there said, 85 patients were admitted. Of those, three died, 12 had to be transferred to acute hospitals and 21 were returned to nursing homes.

Doctors and nursing home officials readily admit that a broader study almost certainly would not show anywhere near that high a percentage of returns and relapses, but they ask—in the words of one—"just how many deaths and relapses do you need before you look at something beside percentages and dollar signs?"

These critics say the single aspect of the intermediate care program that confuses them the most is the lack of clear delineation between precisely what medical conditions require continuous skilled nursing care (in a nursing home) and which conditions require only intermittent nursing care (in an intermediate facility).

"There's absolutely no pattern to their evaluations," says Miss Harriett DeBolt, director of nursing at one San Gabriel Valley nursing home.

LACK OF GUIDELINES

"We have no guidelines, no way of knowing what kind of patients they'll want us to keep and what kind they'll say don't need us. Some heart patients and diabetics can stay, for example, and others, in the same condition, maybe worse, get transferred. The same with the mental cases.

"If we're going to have intermediate care, we should have clear guidelines, doctors to examine the patients and some assurance that no really sick patients will be moved."

State officials, however, say there are certain conditions that preclude a transfer to intermediate care. Patients who are "consistently incontinent or unable to get in and out of bed by themselves are automatically classified for nursing home care," they say.

But they add, firm guidelines are often impractical since "each case must be judged individually, on its own merits. Patients differ considerably, even if their basic conditions are similar."

Critics say the medical-social review teams are not much help in resolving these dilemmas.

"They'll come in and ask a patient if he'd like to go home," says Mrs. Victoria Hibarger, a registered nurse and administrator at Rinaldi Convalescent Hospital.

"He'll say he'd sure like to go back to his beach house in Laguna, so they'll tell us he's getting better and should be intermediate.

"But he may be senile and confused. He never had a house in Laguna."

CURSORY EXAMINATION

Dr. Earl Clampett of Covina said he saw a review team walk past one of his patient's rooms, look inside and keep going.

"He was standing up, so they decided he couldn't be that sick," Dr. Clampett says.

"They didn't know that terminal cancer patients sometimes get a little stronger just before the worst. They said he should go to intermediate. He died within a week."

State health care service officials say such charges are "preposterous." But many doctors and nursing home employees complained of the "superficiality" of review team interviews—and of what they see as the ignorance of the review teams and Medical consultants on geriatric medicine.

A recent study of nursing patients by the California Nursing Home Assn. showed that:

—The average age of patients is 75 to 80.

—Most suffer from at least two major disabilities (generally heart disease, stroke, paralysis, diabetes, arthritis or slowhealing fractures).

MANY GET WORSE

Most are either incontinent, bedfast, unable to feed themselves or emotionally or psychologically disturbed.

Because of their advanced age, almost all get progressively worse, particularly if the level of care is diminished.

However, Dr. Earl Brian, former director of the Department of Health Care Services, says a 1970 federal study of California nursing homes showed that 45% of the patients did not actually require that level of care.

During the first two years of the intermediate care program, he said, state studies indicated "about one-third of the patients in nursing homes could safely be transferred to intermediate care or board and care facilities."

The decision that a patient needs only intermediate care is "always a medical decision," not an economic one, Dr. Brian insists. "No patient has ever been moved out of a nursing home against his doctor's advice."

"Some doctors object at first," Dr. Brian admits, "but then our review team doctor meets with him and examines the patient. Once everything is explained, it usually works out. If there's any doubt, we lean in the direction of the patient We don't move him.

CHANGE OF MIND TOLD

"The patient's doctor may agree he can be moved, then tell the patient and the nursing home he disagrees with us. They have a habit of doing that."

Several private physicians interviewed by the Times took exception to Drs Brian's statements.

Dr. Andrew May of Oakland said the state has ordered many of his patient moved, despite his objections.

"I won't call Dr. Brian a liar," he said, "but they moved four of my patients in the last month and I opposed moving all four of them."

When The Times asked Dr. Brian's office to check their records on those four patients, it turned out they had, indeed, been transferred against Dr. May's wishes.

A spokesman for Dr. Brian then said patients are sometimes moved, despite their doctors' objections, "if the doctor can't medically justify his objections to the department."

Dr. Brian says much of the criticism of intermediate transfers is selfish in origin.

VESTED INTERESTS CHARGED

"The nursing home people are howling about how concerned they are about the well-being of their patients, and that's just a lot of self-serving crap, "Dr. Brian says.

"They're just hiding their vested interests behind that. If we paid them the same for intermediate care as for nursing care, we'd never hear a complaint. They'd cut their services, get the same money and increase their profits."

There is, of course, considerable merit in some of what Dr. Brian says. Nursing homes clearly do have a vested interest in opposing intermediate care. It does cost them money.

But at nursing homes which always operate at or near capacity, it would seem the vested interest Dr. Brian imputes to the industry would be diminished considerably.

Ben Yellin, administrator at Arizona Convalescent Hospital in Santa Monica, is in such a position.

"I've always got more patients trying to get in than I have beds available," Yellin says.

"I could care less if the state wants to move some of mine to intermediate care. But if it hurts the patient, it's wrong—and I'll fight it."

TRANSFERS ORDERED

Yellin was particularly incensed in March when a medical-social review team ordered several of his 72 patients transferred to intermediate care. One of them died even before the move could be made.

To help the doctors safeguard their patients' rights in this program, state officials say an "involved and very sophisticated" appeals procedure, known as a "fair hearing," has been developed.

Any patient ruled ineligible for nursing home care may request a fair hearing, and state officials say he may bring in a doctor—neither his nor the state's—to testify on his behalf at state expense.

But none of the material the state sends the patient on his fair hearing specifically mentions the outside doctor, and only 10 patients have asked for one. Only one of those 10 hearings has actually taken place. The patient won it. The other nine still are pending.

In all, almost 1,400 requests for fair hearings have been filed. But only 76 of these have been held (and only 40 decided—38 in favor of the state).

The Department of Social Welfare, unable to keep up with the demand for fair hearings, has recently made arrangements with the Office of Administrative Hearings to take over and wipe out the backlog.

By August the state expects to be hearing 600 cases a month.

But there is some question if many of the hearings already requested can still be legally held—or the patients legally transferred should that be the decision of the hearings.

Federal regulations say:

"Prompt, definitive and final administrative action will be taken within 60 days from the date of the request for a fair hearing."

Attorneys for several nursing home patients say the state is "out of compliance" because of the long delay. They appear to have a court decision to support them.

APPREHENSION TOLD

Nevertheless, nursing home officials are apprehensive that the new fair hearing procedure will enable the state to effect even more transfers in the months to come.

"The hearings themselves are a farce, a kangaroo court," says Lonnie Parsons, a Northern California nursing home administrator. "You have one group of state people reviewing a decision made by another group of state people. It's cut and dried.

"If they're going to have a lot of hearings now, they're really going to be moving those people out—fast."

At present, only 3,720 patients are in intermediate care facilities in California. The state believes at least 20,000 more of the 60,000 nursing home patients also can be safely transferred.

What really has prevented the state from reclassifying more patients so far has been the shortage of intermediate care beds. There are only about 1,000 in Los Angeles County, for example—less than 10% of what the state would like.

Why are there so few intermediate care beds?

ISSUE OF PAYMENT

Even with the minimal level of care required, few facilities believe they can break even on the $10 per patient per day rate.

Jack Hall, whose 90-bed Westlake Convalescent Hospital includes 24 intermediate care beds, says, "You can hardly get a motel room any more for $10. How are we going to provide a room, meals, a nurse from 9 to 5, physical therapy and all that for $10?"

The state permits—in fact, encourages—nursing homes to commingle nursing home and intermediate patients in the same facility, but the nursing homes have not been too enthusiastic about that.

Dick Spencer of the California Nursing Home Assn. says mixing patients has been a strategic ploy by the state, designed to shift the onus for moving patients from the state to the nursing home.

"The state used to order the patients moved," Spencer says. "That put the state in a bad light. Now the state just notifies the nursing home that extended care funding is being stopped, effective such-and-such a date, and a lower level of care is recommended.

RESULT OF OBJECTION

"If the nursing home or the doctor objects, the state just says the patient can stay there, as an intermediate care patient—if the nursing home will accept $10 a day, instead of $14.

"That shifts the onus to the nursing home. Technically, the state isn't making the patient move. The nursing home either has to keep the patient at $10 and lose money or order him to move."

Fred Hiestand, an attorney with the Senior Citizens Project of California Rural Legal Assistance (CRLA), says the state now has an even more effective ploy.

"Instead of telling the hospital the patient has to be transferred," he says, "they try to convince the patient's doctor to discharge him from the nursing home voluntarily. That saves the state the time and expense of a fair hearing and all.

"Most doctors don't want to get involved in all the paper work and red tape and aggravation of fighting a case anyway. Besides, the doctor knows if he fights for one patient, the state could always order six or eight of his other patients moved, too. Then he'd be spending all his time fighting Medi-Cal.

PRESSURE ON DOCTORS

"So he gives in.

"That's why the state can say hardly any patients are moved over their doctors' objections. If the doctor objects at first, they just wear him down."

But not all doctors have been worn down. Many just refuse to sign the discharge orders. "I won't fight them," says one, "but I'm making damn sure they take the responsibility for whatever happens. It's their fault, not mine, if a patient dies."

State officials say it is "ridiculous" to imply a cause-and-effect relationship between intermediate reclassifications and subsequent deaths.

Most people in the nursing home field agreed—and still agree—on the need for intermediate care.

Not only would this enable such patients to be treated apart from the more seriously ill patients—and the often depressing atmosphere of the nursing home—but it also would save money for the state . . . and the taxpayers.

"We know it's an emotional thing when a patient has to move," says Mrs. Ione Wheeler, staff administrator for the state's long-term care programs. They may find it traumatic, but there's no way anyone could prove they suffered permanent damage because of it.

SEEN AS FATE

"If they die, they probably would've died anyway. Most nursing home patients are just at an age where they're likely to die at any time."

Private physicians and nursing home officials concede it is virtually impossible for them to prove that either a lower level of medical care or the emotional and physical stress involved in a transfer is directly responsible for the deaths of their patients.

But there have been several studies showing the damaging impact of environmental changes on the institutionalized sick and elderly.

One such study, in 1970, showed mortality rates increased 700% when institutionalized geriatrics were transferred to another facility—even one with the same level of care.

"The aged individual becomes increasingly more dependent on his immediate environment," the study said. When the old are also sick and institutionalized, that dependency is magnified, the study says—and so is the trauma that results from sudden change in that environment. The emotional stress and physical disabilities begin feeding on each other. The patient's condition deteriorates.

ITEM 2. CHINLE EXTENDED CARE FACILITY

DINE BITSIIS BAA AHA YAA, INC.,
WINDOW ROCK, NAVAJO NATION, ARIZ.,
Chinle, Ariz., August 4, 1972.

To: Senator Frank Church.
From: Chinle Extended Care Facility, Dine Bitsiis Baa Aha Yaa, Inc.

INTRODUCTION

The Chinle Extended Care Facility was planned, developed and built by the Navajo People to provide nursing care in the Navajo Nation for members of the Navajo Community. It was planned that patients who required post-acute hospital care can be transferred to the Chinle Extended Care Facility for continued nursing care thereby relieving hospital beds for more acutely ill patients. It was planned so that Navajo patients no longer have to be placed in nursing homes located several hundred miles away from homes and relatives.*

* See map, p. 2532.

SERVICE AND STAFF

In developing the Extended Care Program staff-pattern and service were designed (1) to provide nursing care for patients who would only require skilled licensed nursing convalescent care for short periods, for patients who would recover and return to regular community living; (2) to provide long term, 24 hour a day, nursing care, and (3) to provide residential care for patients who need a safe and hygenic sheltered living, for those persons unable to live independently in the community, and need periodic preventative and maintenance health service.

Although, the Chinle Extended Care Facility was built primarily as an extended care facility, there exists an *urgent* need for long-term nursing care, residential care and total nursing care. It is the goal of the Chinle Extended Care Facility to develop a balanced health care program that includes extended care, nursing care, residential care, total nursing care and an additional home care program to meet the most urgent health needs of the Navajo People, and to provide for the best use of the Chinle Extended Care Facility and staff.

FUNDING NEEDS UNANTICIPATED

A. Total care patients

In order to qualify for funding and provide the best possible patient care, the Chinle Extended Care Facility must strive to meet the highest standards of national certification groups such as the Joint Commission on Accreditation of Hospitals.

In one year of operation we found a tremendous need for patients who require total skilled and personal care just for preventative or maintenance measures. The staff required to provide this service had to be doubled and the cost was greater than that required for patients who are able to provide for some of their own self care as feeding, elimination and body movement. About 75% of the request for admission is for total care patients—these have very few self-care skills; they are confined to beds or chairs; unable to feed themselves; unable to bathe themselves; unable to control their eliminations; unable to position themsevles comfortably; unable to communicate or participate in any social exchange. The cost for this type of patient is almost double that required for self-care nursing patients. Funding programs for this type of care is very expensive.

B. Physical therapy

The tremendous need for physical therapy by all types of disability was more than anticipated. Physical Therapy needed ranges from help with movement of fingers to helping patients to ambulate. Again, to do an effective job requires a staff consisting of a professional and skilled workers. Again, funding source find this service secondary to other priorities.

C. Occupational therapy

As with physical therapy occupational therapy was not indentified to its full need at the onset of the Chinle Extended Care Program. Occupational therapy again requires help with each individual ranging from teaching patients to use the fingers again, i.e., how to hold a spoon, to complete occupational rehabilitation. Again, this service cost money which funding sources do not consider high in the priorities.

D. Recreation

No person admitted to the facility does not need a large amount of activities in which they can participate and enjoy. The Task at Chinle Extended Care Facility is not typical of any other nursing home across the United States. Our patients do not knit; they do not play checkers or read newspapers—their leisure activities are different and *are yet* to be identified. Those identified are expensive as silver work, leather work or rug weaving. Again, this task is not considered a priority service for patient by funding source.

E. Diet

Again with diets, the patients are unfamiliar with diet variation and restriction associated with licensed nutritionist and dietition. In order to make meals enjoyable requires home cooked meals—Navajo-style with Navajo taste.

FUNDING REQUIREMENT FOR ESSENTIAL SERVICES

Presently, the primary source of patient care funds are received from the Navajo Area Indian Health Services (USPHS) and the Navajo Area Branch of Social Services (BIA). Because the local funding source are funding many other programs designed for people in the same area the competition for funds is more acute. We feel we can only meet our funding need for comprehensive and effective programs if we receive funds directly from the Central Offices of the Health, Education and Welfare and the Bureau of Indian Affairs in Washington. If Indians are to be institutionalized, or any other senior citizen, funds must be available to adequately meet each of their individual needs otherwise services in the home, however limited, is preferred to an inadequate facility confinement.

Sincerely yours,

Mrs. Nancy Evans,
Executive Director.

ITEM 3. CHINLE AGENCY SAMPLE SURVEY

Dine Bitsiis Baa Aha Yaa, Inc.,
Window Rock, Navajo Nation, Ariz., August 4, 1972.

To: Senator Frank Church.
From: Dine Bitsiis Baa Aha Yaa, Inc.

A statement regarding care of the senior citizen in the home. The needs of the elderly residing in the Navajo Nation are complex, interrelated, and but inadequately met. Not only are these citizens in dire and serious need of improved conditions to meet basic physical requirements, but they also are experiencing neglect in the satisfaction of psychological and social requirements.

A broad sample of elderly residents in the target areas were interviewed in September 1970. This data provides an indication of self-assessed needs in eleven (11) major categories: employment, housing, transportation, spiritual well-being, water supply, health care, food supplies, mental health, personal care, activity opportunities, and income maintenance.

A summary of the results is compiled in the table below:

Table 1. *Frequency of requests for assistance by types of help needed and derived from 294 interviews with persons aged 65 years or older residing within the boundaries of Chinle Agency*

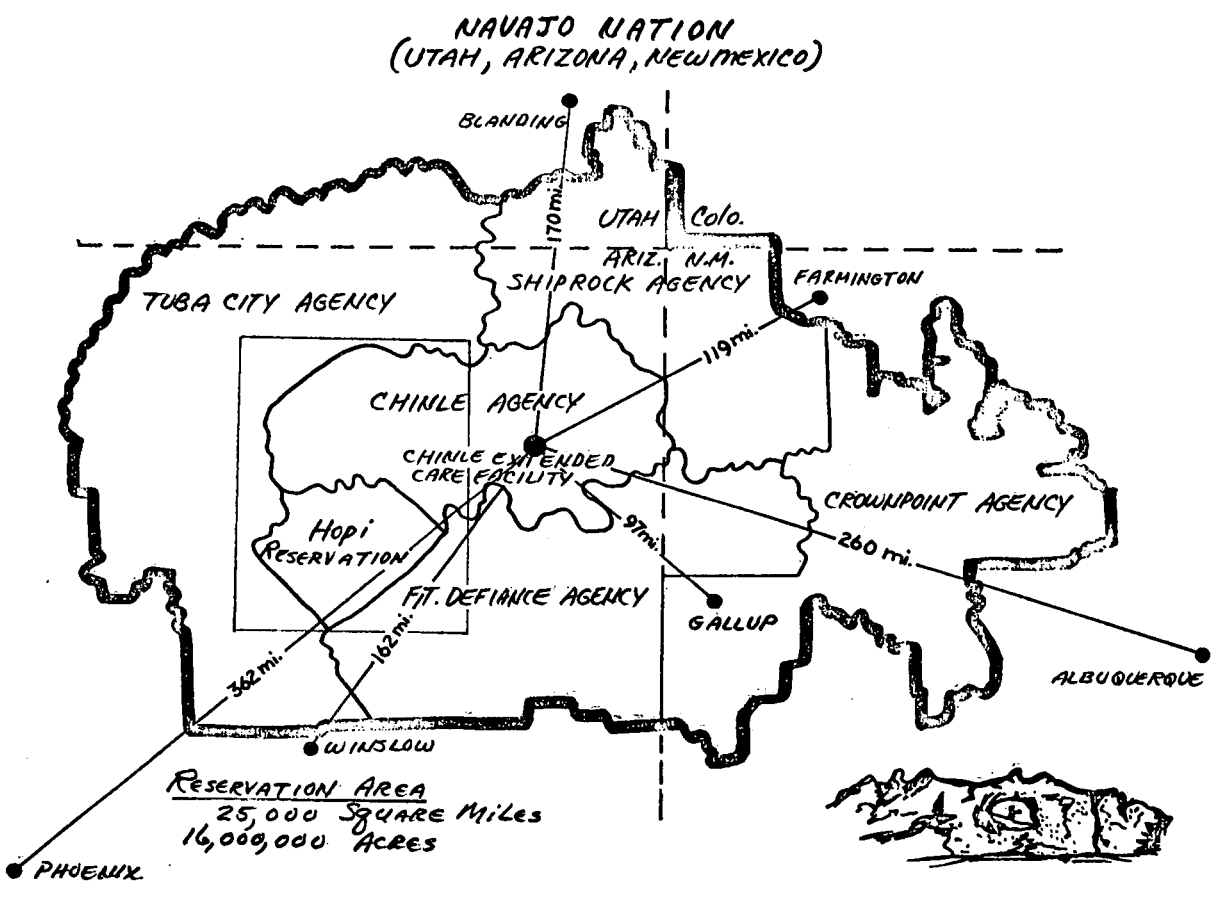
Type of help needed:	*Number of specific requests*
Housing	104
Health care	76
Employment	8
Personal care	40
Transportation	270
Spiritual well-being	24
Water supply	145
Food supplies	96
Mental health	8
Activity opportunities	8
Income maintenance	268

This sample data is a reflection of but 25% of the total population meeting the age requirement of this project. Indications are that the problems of the aged are multi-dimensional.

Of those interviewed, few mentioned custodial or institutional care. Most not only preferred to remain in the community but want meaningful roles in the family structure which if severed, could cause increased deterioration of the individual's ability to maintain himself.

In addition to the care of the aged person, there is also need to provide temporary and periodic relief for families responsible for their care. Some relatives are hampered from successful participation in employment because of the requirement of their elders. Others experience social isolation and inability to avail themselves of educational opportunities. Occasional opportunities to get into the community activities could preserve the social, psychological, and economic well-being of younger family members.

A carefully planned network of services for the olderly is needed to structure opportunities for employable persons to utilize their skills, on a paid or volunteer


NAVAJO NATION
(UTAH, ARIZONA, NEW MEXICO)
BLANDING
170mi.
UTAH
Colo.
ARIZ. N.M.
SHIPROCK AGENCY
FARMINGTON
TUBA CITY AGENCY
119mi.
CHINLE AGENCY
CHINLE EXTENDED CARE FACILITY
CROWNPOINT AGENCY
Hopi RESERVATION
97mi.
260 mi.
FT. DEFIANCE AGENCY
GALLUP
ALBUQUERQUE
362 mi.
162mi.
WINSLOW
RESERVATION AREA
25,000 Square Miles
16,000,000 Acres
PHOENIX

basis, in assisting the leaders of the community. Currently there is no established means of doing this although Indian communities throughout Arizona have expressed need to establish local means to meet the needs of the aged.

PROPOSITION

Home care projects for the elderly are needed. Such projects can be designed to maintain a supportative network of health and homemaker services in order that the elders may continue living in their own communities thus retaining familiar and acceptable patterns of living.

Such a program would:

1. Provide basic preventative and corrective health services in familiar surroundings to those who do not require institutional care.
2. Meet basic biological, psychological and social needs related to daily life without disrupting existing life patterns or demanding relocation.

Secondary objectives of such projects would affect the improved life conditions of other family members and the general welfare of the community. Examples of this impact would include:

1. Providing periodic relief to family members responsible for the care of aged relatives.
2. Maximizing effective utilization of already existing facilities and currently unused resources.
3. Providing significant employment opportunities for local residents.
4. Creating a model for other agencies attempting to serve the needs of the elderly.

Sincerely,

(Mrs.) Nancy Evans
Executive Director.

ITEM 4. RESOLUTION, NATIONAL AMERICAN INDIAN CAUCUS ON AGING

Whereas, the American Indians, Alaskan Natives, and Aleuts stand in a unique relationship with the United States Government, and

Whereas, reservation and tribal lands sometimes lie within two or more State jurisdictions, and

Whereas, the economic base of many reservation is very low and annual tribal income is very limited, and

Whereas, a resolution was adopted by the Indian Representatives assembled at the White House Conference on Aging on December 1, 1971, and

Whereas, portions of this resolution have not been recognized by the *1971 White House Conference on Aging Report to the Delegates from the Conference Sections and Specials Concerns sessions:* Now, therefore, be it

Resolved, That the Western Regional Conference of the National Council on Aging goes on record in support of implementing the necessary steps to begin the process to meet the following recommendations:

1. Projects for aging services and facilities for American Indians and Alaskan Natives be funded directly by the Federal Government to local tribes or duly organized tribal or inter-tribal bodies.
2. Federal funding of projects for American Indians and Alaskan Natives not be time-limited, but be continual funding for those projects which have proven successful and demonstrated the value of their services to the elderly American Indians and Alaskan Natives, level of funding to be contingent upon the ability of the tribal group to provide their own financial support.
3. The matching fund requirements for aging projects for American Indians and Alaskan Natives be adjusted or waived, dependent upon the financial ability of the tribal group involved. When applicable, the in-kind matching the tribal group could provide would be accepted as having met the requirement for local matching of Federal funds.
4. That an Indian Desk be established in Washington, D.C. to head the Indian Administration on Aging; and be it further

Resolved, That copies of this resolution shall be submitted to President Richard M. Nixon, to the Secretary of Health, Education and Welfare, Elliot Richardson, Senator Church, Dr. A. S. Flemming, Special Consultant on Aging to the President, and to the Secretary of the Interior, Rogers C. B. Morton.

This resolution was duly adopted on the 11th day of April, 1972.

JOE BRASWELL,
Chairman, Indian Caucus Resolution Committee.

ITEM 5. ACCESSIBILITY OF EXTENDED CARE FACILITIES FOR SENIOR RESIDENTS ON THE SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY

AUGUST 4, 1971.

PURPOSE

This report is to give evidence of the need for assistance to develop a program designed to promote advocacy from organizations to the elderly poor to alleviate poverty through services to be obtained at extended care facilities on or near the Salt River Pima-Maricopa Indian Community. There are fourteen (14) extended care facilities that the Bureau of Indian Affairs, Indian Health Service and State Welfare contracts with which to handle cases needing the services in the greater Phoenix area (Mesa, Tempe, Phoenix). If the patient receives welfare, he will be able to compensate for services by contributing what he can with the Bureau of Indian Affairs paying the differences.

TARGET AREA

The Salt River Pima-Maricopa Indian Community is situated between the cities of Mesa, Tempe and Scottsdale. It is eighteen miles to the inner-city or metropolitan Phoenix area. The population of this community is approximately 2,410 with approximately 84 residents being senior citizens who may be eligible for extended care services or other services that may be available through the Community Action Agency's Senior Opportunities and Services program, organizations, etc.

SENIOR OPPORTUNITIES AND SERVICES

The Salt River Pima-Maricopa Community Action Agency manages, as one of their program components, the Senior Opportunities and Services program. This program concerns itself with the improvement of living conditions of the elderly poor, ie: homemaker services, transportation assistance, feeding programs, outreach and referral and other health services. At present, there is a staff of four (4) working in the program. With an approximate total of one-hundred (100) clients, (2000 total individual services in a 12 month period) the Senior Opportunities and Services staff, as a result of being understaffed, frequently request assistance from the Senior Citizens Committee to contribute some volunteer assistance.

SENIOR CITIZENS COMMITTEE

The Senior Citizens Committee is an organization which raises funds through drives, food sales, etc, for the purpose of erecting and maintaining and staffing a senior citizens center. However, the efforts of the committee, although commendable, are not being rewarded rapidly. There were senior citizen feeding programs being conducted by the Senior Citizens' Committee, but due to sanitary conditions of the facility at which the feeding program was being conducted, the program came to a halt. The Senior Citizen Committee have since been trying to gain access to a proper and sanitary facility location but to no avail at this time. The Senior Citizens Committee infrequently assists the Senior Opportunities and Services program staff when requested. Volunteer assistance include such functions as homemaker services, cook, housekeeper, home repairs, etc. Attempts for establishing a closer working relationship between the Senior Citizens Committee and the Senior Opportunities and Service program have been unsuccessful. During the month of February, five students from the Department of Architecture, at the Arizona State University, as a class project, voluntered to assist in designing and constructing a Senior Citizens Day Center with activities to include accommodations for those wishing to stay overnight, minor medical services, social center activities, arts and crafts, senior citizens who wish to volunteer to teach Pima or Maricopa stories and legends may be free to do so at the nearby Day Care Center, Head Start or day schools. Unfortunately, the Senior Citizens Committee did not agree completely to the planning of the students from the Architectural Department. As a result of the conflict of interest, the students pursued another project elsewhere.

SENIOR CITIZENS IN NURSING HOMES

As stated before, there are fourteen (14) extended care facilities within a radius of fifty miles who cater to the needs of patients that are recommended by the Bureau of Indian Affairs, Public Health Service, Department of Public Welfare.

At present, there are five (5) nursing homes with a total of eleven (11) elderly Indian patients. Of the total, there were six (6) Pimas and three (3) Maricopas from the Salt River Pima-Maricopa Indian Community, and two (2) Yavapai-Apaches from the Fort McDowell Indian reservation which is adjacent to the north of Salt River.

A survey was conducted by the supervisor of the Senior Opportunities and Services program to determine the eligibility of those elderly Indians living on the Salt River Indian Community for entering a nursing home or extended care facility. Out of the 84 residents who are senior citizens and are receiving services of one kind or another from the Senior Opportunities and Services program, there are 31 who have been determined to be in need of or should be in an extended care facility.

NEED FOR A SENIOR CITIZENS CENTER

The Public Health nurse assigned to the Salt River Indian community has, at different occasions, interviewed elderly Indians on the reservation as to their attitude toward the establishment of a Senior Citizens Center. The replies indicated that they would be in acceptance of such an establishment. This would allow them to remain close to families and friends. The thought of entering a "nursing home" for the elderly citizens of the reservation automatically dictates isolation, unfamiliar surroundings, different eating and working habits, a different culture.

SUMMARY

Few of the senior citizens are aware of the existence of extended care facilities but are content with the services being provided by the Senior Opportunities and Services staff and the Senior Citizens Committee, but due to the lack of sufficient staff, full attention cannot be devoted to fulfill all the needs of the senior citizens. A center on the Salt River Pima-Maricopa Indian Community would be far more convenient for the senior citizens. They would not be so far removed from their families and friends.

ITEM 6. LETTER FROM MR. FRELL M. OWL

PINEY GROVE CAMP,
Cherokee, N.C., July 25, 1972.

Mr. RONALD MOORE,
Chairman, Council of Elderly Indians,
Phoenix, Ariz.

DEAR RONALD: Long-term care for disadvantaged Cherokee Indians and non-Indians who live in the Cherokee area has been a subject for Cherokee Planning Board discussions for about two years. One of the specific outcomes of these discussions has been for members of the Planning Board to understand the difference between nursing homes and rest homes. So far the Board has made no specific recommendations or plans for either a nursing home, or rest home, or a combination of both.

There are only two certified nursing homes located in western North Carolina. They are located forty and sixty miles east of Cherokee. There are five rest homes located in the general area. All homes appear to be over-crowded and expensive.

Information provided by personnel of the U.S. Public Health Service at Cherokee indicates that there are from 12–15 Indian patients living on the Cherokee reservation who are in need of long-term care. None are currently residing in nursing homes and 4–5 are staying in rest homes. Nursing home patients are hospitalized in the 25 bed Cherokee Hospital. During the past year, two nursing home patients each occupied beds in the Cherokee Hospital for periods as long as eleven months. These beds might well have been used by hospital patients if a nursing home had been available.

It is evident that Cherokee Indians who need long-term care prefer to receive such care in the Cherokee community. Strong family ties, cultural traits, desire to remain among members of the extended Cherokee family, and a liking for native foods appear to be valid reasons for this attitude.

Sooner or later, the Cherokee Planning Board will make its recommendations to the Cherokee Tribal Council concerning long-term care for qualified patients. It appears that a nursing home to be used by Indians and non-Indians

and located within the Cherokee Reservation is preferable. It is likely that such a home might be owned and operated by the Eastern Band of Cherokee Indians.

A suitable site for a nursing home, rest home or a combination of each will be available within the year. This site is near the Cherokee Hospital and could be operated as a facility of the Health Service.

The Cherokee Planning Board will continue its deliberations concerning the need for a facility to care for patients needing long-term care.

We appreciate the interest of the Advisory Council on Elderly Indians.

Sincerely,

FRELL M. OWL.

ITEM 7. STATEMENT BY PHOENIX AREA INDIAN HEALTH BOARD

The Indian people in the Phoenix Area prefer to remain on their own reservation.

There is need for:

1. *Extended care* wings as a part of Indian Hospitals for the Indians who require skilled care.
2. *Nursing homes* for the disabled and aged who cannot receive adequate care in their homes.
3. Modified *Visiting Nurse Services* with supportive *housekeeping services* for the aged and handicapped who need special services in their homes.

The Indian people have special problems. Cultural and language differences, and economic problems in addition to the aging process, places some of the Indian people in urgent need of immediate assistance.

Although Indians have a special relationship to the federal government, and many of the acute episodic medical requirements are now met, there is as yet little money available to underwrite a program for extended care services on the reservation.

The Indian people have expressed strong interest in promoting special services for their aged and handicapped.

The attached statement was prepared by the Phoenix Area Indian Health Board Subcommittee on July 11, 1972 to guide the Area Director in seeking additional resources.

Attachment: Basic concepts regarding Aged and Handicapped, prepared by the Subcommittee of the Phoenix Area Health Advisory Board on July 11, 1972.

PHOENIX AREA INDIAN HEALTH BOARD SUBCOMMITTEE, JULY 11, 1972

BASIC CONCEPTS REGARDING AGED AND HANDICAPPED

Purpose

The reason for the Tribal-IHS-BIA Committee is to provide high quality health care and social services through a continuum of levels ranging from intensive in-patient to self-care at home.

1. The Indian people prefer to remain on their own reservations, i.e.:
   (*a*) Housing.
   (*b*) Home Care services (health home makers, health aides).
   (*c*) Transportation.
   (*d*) Recreation.
   (*e*) Vocational and rehabilitation (arts and crafts).
   (*f*) Education and training as to the needs of the aged and handicapped the use of resources (individual-family and community).
   (*g*) Hospital—i.e., in-patient, outpatient clinic, field health, environmental health, mental health, etc.
   (*h*) Extended Care:
      (*1*) Possible wing in existing hospitals;
      (*2*) Use of students, foster grandparents and adopted grandparents.
   (*i*) Supportive services, i.e., OEO–CHR's—Operation Mainstream and welfare. Also backup services for immediate needs such as home and general repair.
   (*j*) Communications (telephone).
   (*k*) Personal income maintenance (social security, welfare, tax benefits, V.A. retirement, etc.).
   (*l*) Nutrition.
   (*m*) Preventive services:
      (*1*) Mental or positive health;
      (*2*) Preventive focus;
      (*3*) Misuse of alcohol and drugs.

(*n*) Health Disciplines:
(*1*) Social service;
(*2*) Health education;
(*3*) Sanitarian engineers;
(*4*) Field health nurse;
(*5*) Physicians;
(*6*) Dentists;
(*7*) Pharmacist;
(*8*) Mental health consultants;
(*9*) Nurses;
(*10*) Dieticians, etc.

Phoenix Area Indian Health Board members present: Mr. Perry Sundust, Mr. Billy Kane, Mrs. Agnes Savilla, Mrs. Effie Dressler.

PERRY SUNDUST,
Chairman, Phoenix Area Indian Health Board.

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