TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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TRENDS IN LONG-TERM CARE

(San Francisco, Calif.)

THURSDAY, FEBRUARY 12, 1970

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
San Francisco, Calif.

The subcommittee met at 9:30 a.m., pursuant to call, in the Nourse Auditorium, 275 Hayes Street, San Franciso, Calif., Senator Frank E. Moss, chairman, presiding.

Present: Senator Moss.

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

OPENING STATEMENT BY SENATOR FRANK E. MOSS

Senator Moss. The hearing will come to order.

I'd like to welcome you here today as the Subcommittee on Long-Term Care, of the Senate Special Committee on Aging continues its studies of the vital issues and problems confronting the infirm elderly today. Your presence here indicates your concern with the problems of this the most underrepresented minority group in our society. We plan to hear from distinguished groups of Californians today. We regret that all of the invited participants could not be with us. We are here on this Lincoln's Birthday to help complete a record we are building on several nationally important questions. Inevitably, we must deal with problems, and unfortunately we sometimes give the impression that there's nothing positive in the nursing home industry. This is far from true. We hope to emphasize the positive here today, as well as to focus on problems. We hope to hear about the nursing homes of the future, so we ask the question: How can we best care for our increasing elderly tomorrow, and in the future? Perhaps, the question would be better phrased in terms of what future generations will do with us.

That these questions are important is obvious from statistics. There are presently 20 million elderly in the United States; someone has estimated that 15 years from now the over-65 population will comprise 33 percent of the U.S. population, and a much higher percentage of voting population. Of those 20 million elderly, almost 1 million persons are presently housed in some 23,000 nursing homes.

We have a number of witnesses. I didn't come to make a speech myself. Our purpose here is to compile a record, as I explained infor-

mally before the hearing began. These are what we call oversight hearings. They are not directed against any specific piece of legislation that is being considered, but rather to determine how the law we have presently is functioning, how the departmental regulations are functioning, what has or is happening in the administration of the law in connection with nursing homes, and then what the needs are, what the nursing home administrators and others have been able to do, and hope to do, to improve the care for our elderly citizens.

We are going to have our witnesses come and sit in groups today to save the parading back and forth of individual witnesses. So, I'll call several to sit as a panel, and then we will hear from each in turn and question as we go along.

The Mayor of San Francisco has asked Mr. Bernard Schussel, the executive director of the mayor's Technical Advisory Committee on the Aging to represent him this morning, and he will give the opening remarks.

Mr. Schussel, if I pronounce that correctly?

STATEMENT OF BERNARD SCHUSSEL, EXECUTIVE DIRECTOR OF THE MAYOR'S TECHNICAL ADVISORY COMMITTEE ON THE AGING, SAN FRANCISCO, CALIF.

Mr. SCHUSSEL. I am Bernard F. Schussel, the director of the office of the aging of the office of San Francisco, speaking on behalf of Mayor Alioto. He sends his sincere regrets that he is not personally able to greet you and your staff on behalf of the people of San Francisco. Mayor Alioto asks me to stress, and to look into the problems of long-term care for the elderly. My statement will be brief, because on the agenda today, are two members of the mayor's Technical Advisory Committee, and others who have been serving on a subcommittee, concerned with this very problem; a horrifying statistic for San Francisco is that over half of our elderly citizens who need placement in long-term facilities are placed out of their city, as far away, some of them, as far away as San Bernardino County, to the south, and Humboldt, to the north, which is almost at the Oregon border. There is no need to tell you what this does to relationships, to two persons who have been married for say, 50 years, and other relatives and friends who cannot visit the elderly patient.

What happens to the doctor-patient relationship? What happens to the patient's social workers and others in the help provision of styling as a result of these couples' exclusions of low-payment rate, administrators to facilities to the elderly in urban areas such as San Francisco where loss is much greater? Senator, we would recommend, in order to give better care to our senior citizens, that there might be an active legislation for Medicare, Medi-Cal patients, beginning on the cost of care that there be a single course sending from an agency such as to set basic standards, which might set basic standards for appropriate care throughout the Nation, and set standards of care in order to provide restorative services such as physical recreation and other rehabilitation programs.

Thank you, sir, for affording me the opportunity to speak to you today.

Senator Moss. Thank you, Mr. Schussel. We appreciate the greetings of the mayor and the concern that he and you have with this problem. This is a rather startling figure you provide in saying that half of your older citizens must go out of the city of San Francisco in order to be adequately cared for in nursing homes, or long-term care homes, and we note your recommendations. Certainly we need a solution. Thank you.

We will now have a panel of witnesses consisting of Mrs. Gladys Straus, nursing home proprietor and member of the mayor's Technical Advisory Committee for the Aging; Mr. Leslie Minkus, project director, California Rural Legal Assistance Senior Citizens Project; Miss Nancy Rose, social service department, Mount Zion Hospital and Medical Center; Monsignor Timothy O'Brien, Catholic Charities Organization; and Mr. Sam Yuen. I understand that Mr. Yuen has not arrived, but will ask him to come to the table as soon as he arrives here and in the meantime we do welcome you people who have come to testify. Each of you has a background in the work we're concerned with and we look forward to hearing the statements that you'll make.

We'll ask Mrs. Straus if she would lead off as the first witness.

STATEMENT OF MRS. GLADYS STRAUS, R.N., NURSING HOME PROPRIETOR AND MEMBER, MAYOR'S TECHNICAL ADVISORY COMMITTEE FOR AGING, SAN FRANCISCO, CALIF.

Mrs. STRAUS. Senator Moss, I am Mrs. Gladys F. Straus, R.N., F.A.C.N.H.A., a member of the American Nursing Homes Association, California Association of Nursing Homes, Rest Homes, Homes for the Aged; a past president of the San Francisco Nursing Homes Association, National Geriatrics Society from whom I received an award for "outstanding contributions to the geriatric profession," and a member of the Technical Advisory Committee Mayor's Committee Office of Aging. I am also a retired Army nurse.

When I opened my nursing home in August 1953, this 38 bed facility was the largest proprietary home in San Francisco. In these 16 years we have seen the standards of care in nursing homes raised to such an extent that almost every phase of health care can be expertly handled. I am gratified to have had the privilege of contributing my small measure toward this accomplishment. Although we are certified to accept Medicare—extended care—our speciality, shall I say, has been long-term chronic illness care. After 16 years, I believe that I am well qualified to present the problem of the long-term care patient—not emotionally but objectively as possible considering the close day-by-day contact with this type of health care.

We have lived and suffered some through the days of OAS, MAA and now Medicare and Medi-Cal. Every phase had its standards and its certification to insure adequate and good nursing care for the elderly. There can be no argument where the care of the elderly is involved. Such care must be insured for all regardless of race, color, creed, and so forth. Requirements for certification are costly, to say the least—a social work consultant at $25 an hour; a dietitian at a slightly lesser figure; physical therapist at $30 an hour, occupational, craft, recreation, speech therapists at this hourly rate. In order to be certified to accept Medicare and Medi-Cal patients, the vendor must

provide all these services. We don't even talk about all the free pharmaceuticals that must be provided—aspirin, laxatives, and so forth.

It is a very trite statement to say that San Francisco is different from any other city in the world—but it is true. On the affirmative side, Senator, this is an extraordinarily beautiful city. I'm sorry it had to rain during your visit here, Senator. San Francisco is a peninsula. This creates the problem of real estate and the high cost of property wherever it is available in this city. You, no doubt, are also aware that the cost of living index ranks San Francisco either the first or second highest in the country—therefore, higher salaries for employees and for every kind of labor and service.

It is important at this time to note that the proprietary nursing home or convalescent hospital does not receive any subsidies from any communal or fraternal organizations, nor are there any "Fund" moneys available to them. This free enterprise business must survive only on its own investment and the income from the patients whom they serve.

On the other hand, these very same facilities pay taxes, which include moneys for the care of the medically indigent. No owner or administrator objects to this—we know that it is our right and privilege to help those less fortunate than ourselves and to be an integral part of the community in which we live. Those of us in San Francisco who work with and for the medical indigent are truly concerned about their welfare.

I am grateful that Mayor Alioto has seen fit to appoint me to the Technical Advisory Committee of the Office of Aging. Now, I can really let my voice be heard on behalf of those who are unable to let their voices be heard and I do like to talk.

The average age in the long-term care facility is between 82 and 87 years. Percentagewise, there are less than 10 percent of the patients who are under 70 years of age. The largest number are those suffering from the crippling diseases such as strokes, arthritis, muscular debilitating diseases, and chronic brain damage. These are people who cannot benefit to any great extent from rehabilitation. However, these are still very warm living human beings with the normal emotions of human beings even though some are completely unable to relate their desires and their needs. Often they are unable to tell us that they are hungry or thirsty. Their every need and want must be anticipated by those who take care of them.

Senator Moss, I am not being melodramatic when I say to you that these are the "forgotten people" in our midst. Many patients have no living relative in the whole wide world, and many of their friends are no longer among the living. Yet, here they are, living and breathing, and dependent upon someone else to take care of their needs. This is not the civilization that condones putting these people away from civilization in a cave or a forest to await their demise. It is really not true that the elderly patient in a nursing home sits out his life waiting for the Angel of Death to make his appearance. Most of the elderly sick know that this is their last home on earth, but they live each day to their fullest capacity.

The big problem is not the patient, but is the "do-gooder" who comes into a home, is half a century younger than the patient, and determines within half an hour what is good and what is not good for

the patient, in accordance with the mores which their generation represents, not the generation of the elderly. This is a real generation gap—many of these visitors have never had a grandparent living in the household—there is a real lack of communication.

I cannot help but recall the time we wanted one of our more alert patients to participate in a craft program. She would not have any part of it or any other program in which she would be an active participant. "I want to just sit and enjoy doing nothing," she said.

There are a large number of medically indigent persons who were born and raised in San Francisco and who have lived here for half a century or more and who for the last few years of their lives are sent to other communities because there is no room for them in San Francisco. There are aged parents whose only child is unable to visit because the travel distance is too great, and they cannot remain in San Francisco as there is no place for a medically indigent person in this city. Is there really no room? Is every nursing home occupied to capacity? I am certain that many of these medically indigent persons could have found a home here if the facilities in San Francisco were financially able to support them.

You may not know that the maximum reimbursement for a Medi-Cal patient is $14 a day. It takes only very simple mathematics to figure out that this is only 58⅓ cents an hour over a 24-period. Patients require 24-hour care. Where in heaven's name can one get 24-hour nursing care, feeding, housing, laundry, food, services of therapists as needed, recreation, gowns, wheelchairs, walkers, and yes, even tender loving care for $14 a day. A hotel room costs more for just a bed. Any community sponsored, religious or fraternal home will agree that this is a ridiculous rate of pay in San Francisco. It might be sufficient in other communities, but not in San Francisco.

Yes, there are Medi-Cal patients in local nursing homes. Why? Because many of us will not send a patient out who has been with us for any lenght of time, has used up all of their money and now must seek Medi-Cal support. The management tries to overcome this loss by increasing the rates for the private patients.

I ask you, is it fair for a private patient to virtually subsidize the Medi-Cal patient? Why do we still keep the patient knowing that this is not fair to the one who is paying his own way?

Senator, I have been in this business for more than 16 years and I know what the emotional trauma is for the partially paralyzed person who is moved. He will eventually make some kind of an adjustment but will never be as well as he had been prior to the move.

In all deliberations it is important to keep in mind that we are dealing with human beings who have feelings, who have fears of the unknown, who need the reassurance of security every day, who need friends and people to talk to. We are not dealing with a can of sardines. No two patients are exactly alike. In San Francisco, good nursing care cannot be given for $14 a day, and any health care facility that does not give good and adequate care has no right to exist.

I speak now of my own facility which is far from modern and which is uncommon in that we operate on a ward basis. We believe that the elderly person needs the companionship of his peers and that he has a fear of being alone. Our actual cost of care is more than $16 a day and there is no facility in this community that can bring their cost so low. This is due to the fact that we do not have the cost of recent

construction, furnishings, equipment which is needed in a new facility. Yet our Medi-Cal reimbursement is about $65 a month less than that paid by the private patient who receives the very same care; the same meals, and all of the same ancillary services. No one except my partner, my chief nurse, and I know which patients are private and which are not.

As a taxpayer, I feel the financial squeeze of higher taxes and consequently would take opportunity of offering a suggestion. There are those elderly persons who have given their property over to their children, thereby qualifying as medically indigent and then applying for Medi-Cal a few years later. This really bugs me. I would suggest that this property be sold and that the medically indigent person be self-sustaining. The only time I would not suggest this is when a spouse is still living. I am sure that this would create quite a substantial saving for the State government so that a more adequate reimbursement could be made in behalf of those really indigent.

Frankly, I cannot grieve for the children whose aged parents have used up their money for their own care thus leaving the children without an inheritance. But I do grieve for the parent who is shunted out of the community which has been such an important part of her life

You know that the requirements for titles 18 and 19 are practically the same. Can you really understand why one regulatory concept provides a reimbursement based on a reasonable cost of care and the other on a cost of care which must not exceed $14 a day? It makes absolutely no sense especially when the ceiling is far below the actual cost. However, just as senseless is the reimbursement for Medicare. For example: a facility is certified for 50 ECF patients and only one of those patients requires physical therapy at $30 an hour. The bill comes to $300 for the month. Medicare reimbursement for this would be $6 or 1/50 of the bill. So really who can afford to take even Medicare cases? Only that home which is almost solely inhabited by Medicare patients.

I previously mentioned the phrase "forgotten people." I must emphasize that it is important to rehabilitate each patient to the maximum potential but many patients cannot benefit from rehabilitation, and that is why the problem of long-term care has become such an important issue. The trend today is for the nonprofit facility to become a rehabilitation center so that patients can be sent back to their homes or to apartments provided for them. This would be fine if the patient were completely physically independent. However, there are many who require housekeeper services, all the therapies, visiting nurse, physician, social worker and so forth over an 8-hour period. Who is around the other 16 hours? I may be completely wrong, but I do believe that people in their 80's and 90's need better care than that and can get it for a lot less money in a home.

It is not enough to say "too bad" when an elderly person falls down and breaks a hip at 8 p.m. and lies on the floor all night waiting for someone to come in at 9 a.m. That theory is not good enough for my mother * * * so, Senator, it is just as bad for anyone else's mother or father. Add this danger of being alone for such a long period of time to the fact that a housekeeper costs at least $16 for an 8-hour day, plus rent, laundry, food, utilities, and everything else which far exceeds the $14 a day from Medi-Cal.

Senator, community funded facilities must recognize the fact that there cannot be "forgotten people" and that no new policies should be permitted which would eliminate the long-term care patient. Granted they would then receive, or I should say, continue to receive Medicare reimbursement. Hospitals are building ECF sections or wings and they are in a position to give adequate rehab services as well as outpatient care. Many nursing homes are also geared to this kind of health care.

Therefore, a community facility like Laguna Honda here in San Francisco, should open its doors to the long-term care patient who is medically indigent, especially because this home gives excellent care. Help us to bring back the 2,000 San Franciscans who belong here, not 30 miles away.

The immediate problem, then, is for more realistic reimbursement which would encourage nursing homes to accept the long-term care patient. I would also suggest that there be extracted from titles 18 and 19 the statement that there be no private subsidy by relatives or friend, but rather that this be on a voluntary basis.

We are proud of the high standards which nursing homes in California have. We want these high standards to be maintained. In order to do this, reimbursement from Government programs must pay their proportionate share of the costs for this care. Medi-Cal patients in California constitute about 65 percent of all patients in nursing homes and Medicare patients constitute another 10 percent. The remaining private paying patients should not be required to subsidize those on a Government program.

Senator Moss. Thank you, Mrs. Straus, for your very fine statement, I appreciate what you have to say. I understand your feeling of concern about medically indigent patients who no longer have the facility to pay for their own care, and must therefore rely on reimbursement at the $14 maximun—this is not enough, as you say. How many of these patients have you kept in your home?

Mrs. STRAUS. We have one-third of our population, our patients are on Medi-Cal. Up until 2 years or a year and a half ago, we did accept Medi-Cal patients and now with the increase in union wages, and whatnot, we have been unable to continue, and frankly, the only Medi-Cal patients that we are continuing to accept are those who have been in our facility. I mean, if somebody's been with me for 11 years, or even 5 years, or for 3 years, what am I going to do with an 87–88-year-old person who looks to us for anything and everything that she needs? Send her to strangers to make an adjustment?

Senator Moss. But you're no longer able to accept new patients who must come in on Medi-Cal?

Mrs. STRAUS. Yes.

Senator Moss. Well, this does create a serious problem, and I am sure contributes to this exclusion from the city that you're talking about, elderly people have to leave the city to go where their costs are considerably less to obtain nursing care.

Mrs. STRAUS. Yes. When you consider our costs here, and our salaries and everything else, which are fairly high in San Francisco, yes.

Senator Moss. Perhaps it's because the average age of people in your home is so high that you feel there is more emphasis on rehabilitation, and return. Don't you think that there are a number of older

people, that could be helped, get their health restored, be rehabilitated and return to live for a time in their own home?

Mrs. STRAUS. We have in a 38-bed facility, we have almost a complete turnover every year of patients who have gotten better and gone home. Last year our annual census was 35 admissions, and 35 who had gone home. Not those who died, but those who have actually gotten well, and gone home. You have a mild stroke patient who needs maybe 3, 4, 5 months of care, and then they're able to go home. And then they can be home, shall we say a year, 2 years, until they get another stroke.

You have a broken hip patient, who certainly is rehabilitated, and sent home, but when you have a very severe stroke patient, who is completely incapacitated, or you have a patient with chronic brain syndrome who is unable to do anything, who doesn't know how to pick a spoon up and feed herself. This is still a human being, sir.

Senator Moss. Well, yes, and I agree. I'm glad to have you explain that, because as I heard your testimony I gathered that you felt that an effort should not be made to rehabilitate and return people to their homes.

Mrs. STRAUS. No; I said there are some who are.

Senator Moss. I think we would have to agree on that, that there are some that are not susceptible to rehabilitation, to the point that they cannot return to their homes, but is that the best we can do?

Mrs. STRAUS. Yes; sir. The ideal situation, as far as we're concerned, as I say, every person who leaves our nursing home on their own two feet is a good recommendation for me.

Senator Moss. Well, thank you, Mrs. Straus. And I congratulate you on the work you're doing. You've devoted your life to this most worthy cause and we're glad to have your testimony. It does help, as we say, make the record so that we can look at it and find out what is being done, and what should be done. Your recommendation that there be a scale geared to the cost of living in a particular city, or area, certainly is one that ought to be examined very carefully.

I will now ask Miss Nancy Rose if she will testify.

STATEMENT OF MISS NANCY ROSE, SOCIAL SERVICE DEPARTMENT, MOUNT ZION HOSPITAL

Miss ROSE. Many Mount Zion Hospital patients are transferred to extended care facilities after the acute phase of their illness is over. In 1969, the Mount Zion Social Service Department was involved with 25 to 40 such placements monthly. Workers formed impressions of some facilities, but we realized that we knew little specifically about differences among them. Consequently a survey was planned in the interest of making better discharge plans with patients.

Over a 3-month period I visited the 20 San Francisco extended care facilities, four private San Francisco facilities, and four extended care facilities in neighboring counties. During the first visit I spoke at length to each administrator or head nurse in order to find out as much specific information as possible. A tour of each facility was also included. Fourteen San Francisco extended care facilities were revisited in order to observe a specific program—such as physical therapy, occupational therapy, or recreation. This visit gave me an opportunity to talk informally to many patients and staff members

since I spent as long as 3 to 4 hours in many facilities. The survey does have specific limitations. Neither the time nor the multidiscipline approach necessary to assess the level of nursing care was possible in this study. The survey emphasizes the restorative services such as physical therapy, occupational therapy, and activities each extended care facility has to offer. The facts and figures quoted in this paper were collected from August through October 1969. Changes have probably occurred in some facilities.

Extended care facilities are primarily a business enterprise. The majority of the extended care facilities just fulfill the minimum Medicare requirements. The more services they provide the higher their costs and, therefore, the lower their profit margin. The conditions of participation are often not specific enough and are not strictly enforced. Most extended care facilities even though they claim to be rehabilitation oriented are severely lacking in this area.

Section 405.1124 of the Medicare Code reads as follows:

(f) Standard: Restorative Nursing Care. There is an active program of restorative nursing care directed toward assisting each patient to achieve and maintain his highest level of self-care and independence.

(1) (iii) Making every effort to keep patients active and out of bed for reasonable periods of time, except when contraindicated by physician's orders, and encouraging patients to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities.

The occupational therapist and the physical therapist are the two professionals employed by most extended care facilities to help each patient reach his maximum potential. Let's look at what they actually do.

An occupational therapist is usually employed by each facility. Only five out of the 20 extended care facilities use occupational therapist to help patients achieve independence in daily living. What does this mean to the patient?

John F., 70-year-old divorced male, recently had a CVA (stroke). His right side is partially paralyzed. After his stay in the hospital, he is transferred to a nearby extended care facility. He has always been independent but now finds himself to be almost helpless. At the end of his Medicare days, he is transferred to an extended care facility in San Rafael—to spend the rest of his days. John F. typifies the majority of patients who receive no training in self-care.

In two of the five extended care facilities who do teach self-care, there is no followthrough by the staff. The aides find it faster and easier to dress and undress the patients themselves. What does this mean to the patients?

Mary L. has had a CVA. Three times a week the occupational therapist works with her and teaches her how to dress herself. She slowly learns how to make her dead arm and leg cooperate. Mary L. is proud of her ability to be more independent. Unfortunately, the rest of the week she has to submit to the schedules of the aides. Mary still finds it a humiliating experience to be dressed and undressed by someone else—as if she were an infant, especially after she has spent so many weeks learning this task.

Physical therapy is also on a minimal and sometimes sporadic basis—although physical therapists were employed more frequently

than occupational therapists. Thirteen extended-care facilities employed a physical therapist between one and a half to 8 hours daily. Three others had physical therapists on-call only.

In one extended care facility a patient had not walked for 6 years. After a few months of intensive physical therapy, the man is now walking and will soon be able to go into a semi-independent living situation.

This same extended care facility had not employed a physical therapist for a few months. What does this mean to a patient?

Mary J. was bedridden. From lying in the fetal position day after day, her leg tendons were very tight. In order to avoid contractures, the physical therapist had to forcibly straighten out her legs. I watched this being done while the physical therapist's aide held down Mary—while she screamed in pain. This very painful procedure could have been prevented by frequently changing Mary's position in bed and giving her simple range of motion exercises.

Often staff fails to continue exercises when the physical therapist is not present even though section 405.1124 of the Medicare Code reads as follows:

V. Assisting patient to carry out prescribed physical therapy exercises between visits of the physical therapist.

The administrator's attitude toward restorative services is often reflected in his use of the physical and occupational therapists. When the occupational or physical therapist arrives, his first task is to round up his patients. This entails going into each room to see if the patient is ready. Often an aide must be called to change a patient or to complete morning care. Then the therapist must transport each patient to and from the therapy or craftroom. Often these rooms are in the basement and require the use of the elevator. Valuable and expensive time is wasted before the therapist can actually work with the patient in a professional manner.

The most neglected area seems to be in the area of patient activities.

Section 405.1131 of the Medicare Code reads as follows:

Activities suited to the needs and interests of patients are provided as an important adjunct to the active treatment program and to encourage restoration to self-care and resumption of normal activities. * * * Suitable activities are provided for patients unable to leave their room.

Television is the only activity in five extended-care facilities. Fifteen extended-care facilities use the occupational therapist to lead activities. Ten of these facilities employ the occupational therapist only twice a week from 1 to 3 hours per session. The majority of patients are not involved in activities even when the occupational therapist is there. Usually the occupational therapist has a group of no more than six patients—often only a couple are involved. No effort is made to provide activities for bed patients. Several extended-care facilities have very successfully employed recreational and craft therapists.

Except in a few facilities, there is not sufficient space to accommodate all the patients who are able to eat in the dining room even though section 405.1134–1 of the Medicare Code reads as follows:

Dining areas are large enough to accommodate all patients able to eat out of their rooms.

Some facilities have no dining area at all. Patients must eat in or by their bedside, or in the hall.

Social services is also an area that is neglected. Section 405.1130 of the Medicare Code reads as follows:

(c) Standard: Social Services Training of Staff.—There is provision for orientation and in-service training of staff directed toward understanding emotional problems and social needs of sick and infirm aged persons, and recognition of social problems of patients and the means of taking appropriate action in relation to them. Either a qualified social worker on the staff, or one from outside the facility, participates in training programs, case conferences, and arrangements for staff orientation to community services and patient needs.

In the majority of facilities the social worker's primary function is to transfer patients to an extended-care facility in an outlying area. Usually the social worker is employed such few hours that her services are minimal. Five San Francisco facilities do not even have a person with a master's degree in social work available to their staff. Two very large facilities use a social worker only 1 hour each month. Only two facilities employ professional social workers full-time. Neither of these are proprietary extended care facilities. What does the lack of social service mean to a patient?

Grace P., age 67, recently widowed, has metastized cancer of the breast. She is deeply depressed by her recent losses—her change in body image due to a mastectomy and the loss of her husband of 45 years. She is considered a "good patient" because she is cooperative and not a nursing problem. Mrs. P. becomes more and more withdrawn as her depression increases. At the end of her Medicare stay she finds herself unexpectedly shipped to an extended care facility in Oakland. No one has had the time to really talk to Mrs. P. She is passed off as just another senile patient.

In-service staff orientation training is also an area which is neglected. If an extended care facility has any type of training it is usually directed toward the medical rather than the emotional and social needs of the patients. The social worker is not usually involved.

In general, most extended care facilities tend to infantalize patients, just as the old-style nursing home did. Extended-care facilities are more sophisticated now and do provide a few more restorative services but not enough to really help people toward substantial self-care. Even though patients are helped out of bed—into a wheelchair—they are allowed to vegetate in a very unstimulating and nontherapeutic environment.

Many administrators bitterly complain that they do not have the funds to create the type of facility most beneficial to the patients. It appears that the Medicare regulations would meet the needs of the extended care facilities' population if they were enforced. Somehow the gap between what is required and the reality of the services provided must be narrowed.

Let's look at how the quality of care can be improved now.

1. Medicare must begin to strictly enforce their regulations.

2. Medicare and Medi-Cal payments must be reviewed and if necessary increased in order to provide the quality of care necessary to restore people to maximum functioning.

(*a*) Payments must be based on reasonable costs in San Francisco.

3. Existing extended care facility staff must be better utilized. For example:

(*a*) Patients should be ready when the physical and occupational therapists arrive.

(*b*) Aides should transport the patients to and from the therapy rooms. This would maximize the time the therapist spends with each patient.

(*c*) Range of motion exercises must be a routine part of the daily schedule.

(*d*) In-service training classes should be frequently held to teach the nursing staff how they can assist the patient with simple range of motion exercises, self-care, and physical therapy. The social worker must also participate in order to help the staff focus on and better understand the human aspects of care.

(*e*) The occupational therapist's main emphasis should be on teaching patients self-care rather than on activities.

4. We must begin to humanize the present impersonal and sterile care the patient is now receiving.

(*a*) A daily, ongoing activity program is essential.

(*b*) Any person who is qualified to set up and lead an activity program should be paid by Medicare or Medi-Cal. Retired teachers, playground instructors, or other creative people often do a fine job.

(*c*) Staff can be trained to provide activities for patients.

(*d*) Alert and willing patients can also be trained to lead activities and help the staff. In one extended care facility, alert patients who volunteer are paid to help feed other patients.

(*e*) We cannot legislate love but can pay and train concerned community people to establish a meaningful relationship with an elderly person in an extended care facility. Too often these people do not have any friends in the community.

(*f*) Community volunteers can also be enlisted.

5. Social workers must begin to fulfill the role that has been spelled out for them in the Medicare regulations.

6. The distance between the proprietor and the actual extended care facility should be minimal.

(*a*) Less than five facilities have proprietors directly on the premises.

(*b*) Corporations often own a number of extended care facilities in the area. This means that an administrator who is hired must go through many channels before even simple changes—which cost money—can take place.

7. Extended care facilities should contract directly for their services.

(*a*) At the present, many facilities contract through an agency for their physical and occupational therapist services. This means that the agency charges the extended care facilities approximately $15 an hour for a physical therapist. The physical therapist is paid a monthly wage—which breaks down to be approximately $5 an hour. The agency receives $10 and Medicare is charged $15. Let's cut out the middleman.

8. Medicare and Medi-Cal rates must be equalized in order to stop the exodus of the elderly out of this city and county.

Even if attempts were made to strictly enforce the Medicare Code, it is doubtful if patients' needs would triumph over higher costs and therefore decreased profits. It seems contradictory to expect businessmen to be committed to an underlying philosophy of rehabilitative patient care when this would mean lower profit. With the present situation it is self-defeating to restore a man to his maximum potential. Often Medi-Cal patients are sent to an extended care facility in an outlying area. They remain at the extended care facility for many months or even years—until their death. There is no incentive to restore a man to even partial independent living—he becomes a custodial patient. I strongly feel that if private enterprise cannot provide the high quality facility necessary to help restore people to maximum potential—at a reasonable cost—another means must be found

Nonproprietary facilities should be established. The total health community should be focused on restoring the patient to his highest level of functioning without regard to economic profit.

On a longterm range we must stop the system of grading the elderly according to their current ailments. I envision several alternatives. The first would be a total community designed especially for the elderly. The emphasis would be on health rather than on sickness. Activities to meet the many different interest levels of the residents would be available. An elderly person might even be able to select his own living arrangements. Some might prefer to still do their own cooking while others would definitely want communal meals.

When a person becomes ill, the first attempt would be to treat him in his own room. If necessary, he would be transferred to an acute hospital. He would then return home when the acute phase of his illness is over. Where he then goes within the community would depend on the level of medical and nursing care needed. The resident will already be familiar with every aspect of the community. No place will seem new to him. His friends would be able to visit him and give him the support that is needed. Some sectarian homes for the aged already have established such a community. Often a person has spent many years as a volunteer to the home before he actually becomes a resident. The resident feels that because he has given many years of service he is more able to accept the help he now needs. He is also very familiar with the community and the community is familiar with him.

I also envision the possibility of not segregating a person because he has committed the crime of growing old and in many cases infirm. Our basic attitudes toward the elderly must first change before we will allow an elderly person the right to remain an integral part of the community. I can envision home services which will allow an elderly person to remain at home if he so chooses. Why can't we provide a person with food, housekeeping, medical care, and an attendant when necessary. Many of our elderly want to stay home.

It would probably be less expensive to provide simple home services than to build expensive facilities to house our elderly. The extended care facilities in outlying areas are now misused for this purpose. Unfortunately, the elderly are still considered to be useless in our society. The extended care facility, as it now operates, tends to exemplify our attitude toward the old, sick, and infirm.

Senator Moss. Thank you, Miss Rose. That was a very fine and extensive statement based on the study that you've made. I noted that your recommendations were set out in a very specific fashion and that's what we want. You raised again this age old problem that we have had before us of whether proprietary nursing homes can adequately function because, as you suggested, maybe the incentive is not to rehabilitate and discharge, but to just maintain the status. We heard from Mrs. Straus who said that she felt that it was a proud achievement whenever a patient left that it was an accomplishment to achieve this degree of rehabilitation.

Except in a case where the proprietor lives right in the nursing home, it has been argued that there may be—there is no incentive to rehabilitate.

Miss ROSE. Again, that would depend on the individual administrator.

Senator Moss. Sure, and your stating the needs of skilled therapists in these various fields points up again the necessary costs of caring for these elderly people. I'm glad you underlined the need for physical therapy, and rehabilitative therapy, and social therapy, because sometimes we get so wrapped up in taking care of the physical needs that we tend to neglect the fact that the psychic and social needs of the elderly are every bit as pressing as their physical needs. But having trained people available for all of these things obviously adds to the cost and, therefore, adds to the problem, which you said we must examine, and readjust the rate structure so that there would be equalization, and improvement to the point where we will not have to have people leave the city because of the expense.

You are at the present time with the Mount Zion Hospital, is that correct?

Miss ROSE. I am a clinical social worker there.

Senator Moss. Well, we appreciate that testimony, Miss Rose. Any staff questions?

Thank you very much.

We will now hear from Mr. Leslie Minkus.

STATEMENT OF LESLIE MINKUS, PROJECT DIRECTOR OF SENIOR CITIZENS PROJECT OF CALIFORNIA RURAL LEGAL ASSISTANCE

Mr. MINKUS. I am Leslie A. Minkus, project director of the senior citizens project of California rural legal assistance. This project is one of several throughout the country funded through the National Council of Senior Citizens with a grant from the Office of Economic Opportunity, the purpose of which is to develop new ways for dealing with the legal problems of the elderly poor.

In my capacity as project director I am a member of the Technical Advisory Committee on the Aging, whose function is to advise the mayor on the problems of the elderly in San Francisco. One of the problems which the committee has recently begun studying concerns the large number of elderly San Francisco residents who have been placed in out-of-county nursing homes because of the refusal of private nursing homes to accept long-term Medi-Cal patients—that is, title 19 beneficiaries—at the maximum rate of $14 per day allowed by the State. The problem is virtually unique to San Francisco

because of its particularly high cost of land, construction, labor, and food. As far as we can determine there is no similar problem in other bay area counties or, indeed, in any other part of the State.

The uniqueness of the problem to San Francisco does not detract from its seriousness. Based upon the most recent figures supplied by the Francisco Department of Social Services, I would estimate that of the total of approximately 5,500 San Francisco residents who are Medi-Cal beneficiaries under the old age security and aid to the totally disabled programs (which includes both cash grant and categorically linked persons), approximately 1,500 are living in nursing homes outside of San Francisco. This is almost double the number of residents who are in private nursing homes in San Francisco, and the contrast becomes even sharper since it can fairly be assumed that virtually none of the out-of-county placements are voluntary.

The Health Facilities Information Center of the San Francisco Medical Society—which serves as a central clearinghouse for nursing home bed vacancies in the nine bay area counties (San Francisco, San Mateo, Santa Clara, Santa Cruz, Alameda, Contra Costa, Solano, Napa, and Sonoma)—reports that for over a year not one Medi-Cal beneficiary needing long-term care has been placed in a private San Francisco nursing home. Moreover, the agency reports that the pressure created by the placing of San Francisco residents out of the county is beginning to lead to a shortage of Medi-Cal long-term beds in San Mateo County as well. The center also indicates that the majority of Medi-Cal beneficiaries who are also eligible for Medicare are accepted in San Francisco, but are moved out of the county after the 100-day Medicare benefit period expires, I need not emphasize the deleterious effect of such treatment, since it frequently means a change of physician, hospital (if acute care becomes necessary), and the loss of contact with friends and relatives.

The problem is compounded by a variety of factors. First, there is the lack of public facilities. The Laguna Honda Hospital—the public hospital which had in the past accepted many long-term care patients—has established as its first priority the rehabilitation of extended care patients. As a result, they have virtually no room for any additional long-term patients, and any conversion of their acute care facilities to long-term facilities would in their view be prohibitively expensive.

A second factor which, in my view, has aggravated the situation is the difficulty of obtaining adequate home health services for those patients who would prefer to be treated and could be treated outside of an institutional setting. I think that this particular problem deserves some discussion because it illustrates many of the problems of the title 19 program as it has been implemented in California.

Prior to July 1, 1969, there was no restriction on the number of home health visits which could be provided to Medi-Cal beneficiaries. After July 1, the State, by regulation, required that if more than 10 visits were to be made within a 6-month period, all visits over 10 would have to be authorized in advance by the Medi-Cal consultant. Theoretically, the determination of the consultant should be based on an evaluation of the medical and social information provided him by the prescribing physician and the home health agency. However, when the treatment authorization requests (the forms on which prior authoriza-

tion is requested) were sent to the Medi-Cal consultant in San Francisco, in July and in August, it became clear that the device of prior authorization was being used not to control overutilization of services from the social-medical point of view, but rather simply as a fiscal device to deny home care in those cases in which the cost of such care exceeded the cost of placing the patient in a nursing home.

One voluntary agency was able to continue necessary care for its patients, but only because of its having funds available from the United Bay Area Crusade to make up approximately $30,000 of services uncompensated by Medi-Cal. UBAC funds are not going to be available to subsidize future services for this agency's patients and it is possible, if not likely, that the result will be that those Medi-Cal beneficiaries whose care was being subsidized by UBAC will either be placed in out-of-county nursing homes, or will simply receive reduced care.

Another voluntary agency, which was not so fortunate as to have substantial UBAC funds available, has reduced the number of requests for prior authorization from 35 in July to four in November. The reason is clear—the authorization simply will not be approved and it becomes a senseless waste of time of the physician and the provider to prepare and submit the Treatment Authorization Request when it is clear that it is an exercise in futility.

It admittedly is difficult to estimate how many people who have been placed in nursing homes would not have needed to be so placed if the home health agencies were permitted to provide care in accordance with the best medical and social judgment of the prescribing physician and the agency staff, but it does seem clear that expansion of home health services, on an appropriate basis, would be of some help in alleviating the Medi-Cal nursing bed shortage.

This problem raises another issue that I think it appropriate to note here—and that is the absolutely critical shortage of housing for the elderly poor in San Francisco. It would little profit a person to receive home health services on an intermittent basis unless his home met some minimal standards of safety, sanitation, and decency. And yet with a low-rent-vacancy factor of essentially zero, thousands of elderly San Franciscans are being displaced as new projects move forward. While there is clearly an interrelationship between housing and health for all segments of the population, that relationship is more direct with the elderly whose needs are different and more pressing. One official of the San Francisco Department of Social Services has estimated that as many as 50 percent of the elderly patients in nursing homes do not need the intensive care the facility provides, but are there simply because there is no other place for them to go. If this is even remotely accurate, an adequate supply of decent low-cost housing for the elderly would clearly do much to relieve the pressure on extended care facilities in San Francisco. In short, it is virtually impossible to separate the problem of long-term extended care facilities from the problem of inadequate housing facilities when one talks about the problems of the elderly in San Francisco.

The irony of the present situation is that, by all accounts, there is actually an excess of nursing home beds in San Francisco, if one is a private patient, or a short-term Medicare patient. It is only a Medi-Cal nursing bed shortage that exists. Figures for calendar year 1969

are not yet available, but between 1966 and 1969 the number of long-term care beds increased from 1,205 to 1,690, while the occupancy rate decreased from 92.4 to 83.2 percent. From all indications this trend has continued in 1969 and will continue in 1970, particularly since there are 1,030 beds in various phases of construction and another 1,211 whose construction has been approved by the city. (In addition, over 1,000 new beds have been proposed to the San Francisco Health Facilities Planning Committee.) In short, it is not beds that are needed, but beds which are available to Medi-Cal patients on the same basis as other patients.

It is clearly much easier to state the problem than to find a solution, but there are, it seems to me, some constructive steps which can be taken and some ideas which can be explored.

While I do not believe that the answer lies in an expansion of proprietary extended care facilities, some things could be done with the existing facilities. Private nursing home operators argue that the reason why long term Medi-Cal beds are unavailable in San Francisco is that the costs of doing business in San Francisco—particularly the costs of labor and land, construction, and food—make it impossible to provide adequate care at the State imposed maximum rate of $14 per day. While an obvious response to this problem is to raise the State maximum to take into account the differential costs in San Francisco, I am concerned that such an increase, by itself, would contribute to the serious inflationary trend in medical care. Before any adjustment is made it seems to me important that a management audit be undertaken of several representative nursing homes in San Francisco. Such an audit would provide information not merely on the costs incurred by the facility, but most significantly would provide information relating to the efficiency with which the facility is being operated. At the completion of such a study, the nursing homes could, on the basis of the information provided, enter into an agreement with the State to provide care on the basis of some kind of prepayment and/or capitation basis, which care would include all services presently provided. If such a demonstration program were properly conceived, it would provide incentives for economy at no loss of patient care.

I am afraid that there is no present disposition on the part of the State to make any changes which might have the effect of increasing costs—no matter how justified—of the Medi-Cal program, but hopefully a study such as I have suggested would serve as a basis for payment plans at a more propitious time. Without the information which would or could only be provided by such a study, it would be difficult to avoid the inflationary thrust of a system which compensates on the basis of "reasonable" cost—no matter how "reasonable" is defined.

Another possibility, and one which has been put into effect in San Francisco, derives from the fact that because of the extremely high cost of commercial land, most extended care facilities are proposed for construction in residential areas. This requires the approval of the city planning commission, which must issue a conditional use permit. The permit is granted only if there is a determination that a need exists for the facility and that the facility will not be detrimental to the residential area. It is the position of the San Francisco Planning Commission that no need presently exists in San Francisco for

higher priced extended care facility beds, and consequently, that no facility will be granted a conditional use permit unless it agrees to accept Medi-Cal patients in the amount of approximately one-third of the capacity of the facility. In fact the Commission believes that San Francisco is so over-built with respect to extended care facilities that approval of any additional facilities, regardless of their agreement with respect to Medi-Cal patients, is problematic at the present time.

A third fact to consider is that in the area of extended care facilities—like in most other areas of medical care—the consumer is really unable to make any intelligent judgement about the care he is purchasing. It is my belief that under these conditions the notion of so-called free enterprise competition becomes relatively meaningless. The patient (or his family) can judge the relative merits on the basis of the most superficial evaluation. There is no particular premium placed on quality of care or increased efficiency. All reputable operators of proprietary homes with whom I have spoken—while vigorously defending proprietary institutions and proprietary medicine—have been equally vocal in their assertions that the honest operator of an extended care facility who attempts to provide quality care in accordance with Federal and State regulations as well as common notions of decency, is discriminated against by the present system. Under such circumstances it is difficult for me to believe that all the pressures in the direction of laxity, inadequate care, ignoring of regulations and the like will not finally lower the standards for all care.

I think, in short, that serious thought should be given to greater public ownership of these facilities. It is ironic that a law which purported to bring the poor into the "mainstream" of medical care—to eliminate the duality between "public" (i.e., "poor" homes) and private homes has succeeded, at least in San Francisco, of further exaggerating the problem of one kind of care for the poor and another for the nonpoor.

In addition, and for much the same reason, I think that there ought to be subsidies, write-downs, and other financial incentives to encourage the development of nonprofit facilities, both extended care and, perhaps more importantly, intermediate care facilities. Such facilities, operated by churches, labor unions, and other nonprofit sponsors, could, with the benefit of such subsidies, provide adequate care to those individuals who are simply left out of the present system. In this connection, it should be noted that for the bulk of people we are talking about, the facility is their home—and likely their last home. The intangibles of a home, the sense of community, of concern, of warmth—are vital to maintaining the quality of life in these facilities. I think that these factors are much more likely to be present in the case of an institution which is not constantly faced with the need to show a profit.

I have no specific proposal for such underwriting by the Federal Government, but I would think that the House Committee on Banking and Currency might well be interested in developing a legislative package which would respond to this need. Such legislation might be complemented by the funding of some demonstration facilities by the Office of Economic Opportunity, which could incorporate new ideas of staffing, provision of care, financing, et cetera.

I should conclude by stating what must be evident from my testimony—that I have no simple answer to the problem of long-term care. If I could leave the committee with one thought, though, it would be the thought that with respect to the elderly, the difference between medical care and simple support—the difference between so-called extended care facilities and simple, decent housing—is substantially less than with other segments of the population. What is needed is a variety of alternatives—home care, board and care facilities, intermediate care facilities, extended care facilities, acute care facilities. And what is also needed is the realization that many if not most of these facilities are home—and the last home that many people will ever have. Perhaps that thought alone will lead to the devising of creative solutions.

Thank you.

Senator Moss. Thank you, Mr. Minkus, for that fine statement, and your strong recommendation that some attention be given to adequate housing for the elderly. I am distressed to hear that there is such a shortage of housing, that it's presently difficult, or impossible for elderly people to acquire the type of housing they need here in this city. I am glad to have you point that out for us in your testimony, and I concur with you that there ought to be a variety of alternatives.

I think we certainly should give some attention to this later point because what comes through all the time is that these people are individuals. They can't be classified all at any specific classification, and what's good for one, isn't good for another. There ought to be a number of alternative ways that these elderly people can best get the care they need, retain their individuality, and the social nature and their creativeness and whatever else they have to offer to society.

At the present time you are working on a project with a grant from the Office of Economic Opportunity, is that correct?

Mr. MINKUS. We're developing a training program, we are training older people to act as—primarily as individual advocates for other elderly people, and particularly in the health care area; so what we propose to do, when the training is completed is, in effect, have individuals who are able to represent people before, perhaps, the Social Security Administration, the welfare services, the county hospital, perhaps the county jail and any area in which elderly people have health problems.

Senator Moss. I see. That's a very interesting project, and I'm glad to have you outline it for me.

We must move along.

Mr. MILLER. In your statement you say one official states that as many as 50 percent of the elderly patients in nursing homes do not need the intensive care the facility provides, but are there simply because there is no other place to go.

Could you provide us with the name of this official, when he made this statement and any supporting information that might have led him to make it?

Mr. MINKUS. I'll try and provide that information.

Mr. MILLER. All right.

Senator Moss. Thank you.

Now, Monsignor O'Brien. We didn't give you as much notice as we would have liked but we appreciate your willingness to come here and testify this morning.

STATEMENT OF MONSIGNOR TIMOTHY O'BRIEN, CATHOLIC CHURCH ORGANIZATION

Monsignor O'BRIEN. My name is Monsignor Timothy O'Brien for the Archdiocese of San Francisco, past president of the Catholic Hospital Association, and a member of the State health planning council. I spend all my time in the area of health care. I am very glad that you did not give me notice. I'm very happy that I did not have to write a paper, and think you would be very happy, because between Gladys and Nancy and Mr. Minkus they said what I would say. So you would have had a repeat.

I know Gladys because I know her facility. It's in the parish where I happen to live and what she said about her facility is very true. I only wish it could be said about all the others. I mean that. But unfortunately, that isn't true. I have to agree with everything that Nancy said because I'm also a social worker with an M.S.W. after my name, and I would concur in many of the points she made. In reference to what Mr. Minkus said, he stole the last two points I have.

I happen to be chairman of a study on home health agencies being conducted by the Bay Area Social Planning Council which will be giving its report next month. And, you have hit those high points. The only other observation I would like to make is to go back and look at the commitment that as a country we gave to the elderly when we enacted Medicare and Medi-Cal, and pardon me, I'm a Californian, so I call it Medi-Cal. It's—I know—called Medicaid in other States.

Senator MOSS. Medicaid.

Monsignor O'BRIEN. I think it's important that we recognize that commitment, and as a country, ask what are we doing to really live up to—what went before was a statement of ideals, and today we have to look and ask, have we made the ideal a reality, or what are we doing about it? I think we have to look at our attitude, our attitude toward the elderly and particularly as has been indicated today to the poor.

We made a commitment—it's been called mainstream medical care—it's been called equal opportunity—it's been called equal service for equal type of illness. It's been a statement of saying there will be no discrimination on any basis in regard to care for the elderly and I think some of the testimony this morning has indicated that we're having problems with that.

I think it's also very important that we have diversity in types of programs, but it is more important that there be a continuity among these programs.

The one point I think I would like to add to this narrative is that the continuity of service resulting from coordination between the housing, the facilities for the aging, the nursing home, the ECF and the hospital is lacking completely. The greatest human problem that an aging person has, is a concern with security. They would like to know how these services interrelate; where do they enter into the system. And entering in, do they have assurance that needed services will be there. Unfortunately, we have a weak-kneed transfer agreement from the acute hospital to the ECF. We have nothing in the relationship between the ECF and the nursing home and on down the

line. I would hope that we will try to encourage, and even offer incentives in the local community to ambulatory service and preventive services. A community plan of services for the elderly begins with coordination of existing services and then moves to develop needed services.

I'd like to make a comment about the Medi-Cal budget. It has been revised in the State of California, as of 3 days ago. At the moment it looks adequate, but only if you look at the gross amount of money. Many of us fear a problem because we seem to be going through a period of recession. Certainly the unemployment rate has increased, and so, although the budgeted money seems to be staying at about the same level, the number of people eligible in the State of California, will probably grow by about 4 million. In turn, the office of Health Care services has outlined about 13 steps it has developed to control benefits if this increase should happen, which they believe will happen. So I think there are some very serious problems not only here today, but perhaps it's going to get worse before it gets better and I would hope that we would renew our commitment to make this program work.

I would also like to point out one final thing and it's what Nancy, and I think Mr. Minkus indicated, it's this: That as people get old they want a sense of community. They've had organizations that have been community to them, whether it's church or a fraternal organization or a national organization; many types of organizations with which people form community, and form relationship. Such organizations are a second family in life. I would hope that these organizations would be encouraged to develop programs so that the loneliness they face is overcome by having friends around. There are two levels of friendship, it seems to me. One is your immediate family and the other are those groups of people that you have come to know, and share with and work with. It's important that we encourage those organizations that represent groupings of people to develop the types of services and programs that have been outlined. It is frightening to the older people when they must go to a strange facility. How happier they will be if the facility is known to them and a part of their life. In the past organizations with a community-type of identity, the Jewish people with the Mount Zion, the Catholic with the Catholic Hospitals, the Masons with their Masonic Home. In San Francisco, we have a German hospital, we have a French hospital.

This is completely lacking in the nursing home field. So it's a frightening experience for the older person. They're going into a facility that is foreign to them. They have not been a part of it before their coming now as a patient. In their own way they know this unknown home will be their last home on earth.

I have here in front of me, the revised health budget from Congress and the latest, they tell me on what happened to the HEW budget and I look at hospital construction, and my beloved Hill-Burton program I find it is apparently being pushed aside. The Hill-Burton program never accomplished its purpose of developing nursing home facilities. I hope that the legislature, the Congress and the whole Government authority realize the need to encourage and if you will, force churches and fraternal organizations and other groups that have a sense of community to build nursing homes.

We have been trying. You might wonder what this big binder is. I'll tell you briefly.

It's an idea, a program to develop a facility in San Francisco in the Mission District, which is the poverty area right off of Market Street. It will be a nursing home facility which includes intermediate care. The location has a very high concentration of aged. The presence of aged in their own homes encourages us to develop ambulatory care. In this way the aged will begin to know our program, and work with it while they're still in their flats. For it's basically a flat and apartment area. The people will have had contact with it and then as they have need to, as they move toward the end of their lives and face illness, they will have a sense of oneness with this facility. Entering into it will not be a frightening experience, nor a separation. They will not be leaving everybody to go home to God, because when I go home I want to have a lot of friends around me.

Thank you.

Senator Moss. Thank you, Monsignor O'Brien, and that's a very thoughtful and eloquent statement, and one that impresses me greatly, especially your comments about developing an identity of nursing home facilities. The idea that a person would be already feeling at home when he was admitted to a nursing facility. In fact, he would be rather drawn to it in a way as he became infirm and had to have care. This way it would be a place he'd want to go and he would not seek out some place that was strange about which he knew nothing.

I think this relates back, perhaps, to what Mrs. Straus said early in her testimony. She talked about the inability of the younger people that were hired to really communicate with the older people whose morals and ideals fitted into another generation. Well, this is an extension of that idea, it seems to me, if those older people have already established connections and feel identified with a facility and with a group of people that have similar basic backgrounds that they will feel at home, happy and content. So, that's a very good idea that you have given us here, and I'm concerned about what you said about the need of a continuity, or interrelation of a number of facets of the several programs in existence. I suppose the average person is just dependent really on a physician when he gets sick; he's sent some place and that's about the only way he gets started in the system, is that right?

Monsignor O'Brien. I think some of the frightening parts—some of my friends in the health department aren't going to like what I say—but the entry point at the present time, unfortunately, is the hospital door. You come in at the top and you slowly work down. I hope, and I think much is going on in this field, a great deal of study to look at the point of entry and the point of entry has to be at a more humanly stage for a person. However, it's got to be a point of entry that offers a person that comes into the hospital—they can move from the hospital into a ECF under Medicare. I think we have to develop this and we might have to turn around and say, is point of entry into the system, it is before the hospital, and I think a lot of work needs to be done in this area.

Senator Moss. Well, there ought to be an entry point, before the acute need of a hospital.

Well, is there anything from the staff? I do appreciate, your summation, Monsignor, you've helped us a great deal. We're delighted that you came to testify and you may be excused.

Is Mr. Yuen here now? He was not here earlier.

Would you come forward, please? Mrs. Vera Hale has come because Mr. Yuen is not able to be here, and she'll read his statement, is that correct?

We're glad to have you do that, Mrs. Hale.

Mrs. Hale is the director of Self-Help for the Elderly, and she's here to read Mr. Yuen's statement.

STATEMENT OF MRS. VERA HALE, SUPERVISOR OF SELF-HELP FOR ELDERLY

Mrs. HALE. I am supervisor of the Self-Help and Mr. Yuen is director, and he's very sorry he couldn't come today.

Self-Help for the Elderly has found the problem you've heard again and again today among the Chinese community. There are not enough extended care facilities, and many of the people in Chinatown do not speak English or speak very little. They may have worked and lived in that community and had no need of learning English. When it comes time for a nursing home or extended care facility, they, too, are concerned with the idea of community. They want to be in a home obviously where someone speaks their own language.

On Patrero Hill, there is one nursing home, but this one has a long waiting list; otherwise, the closest one is Hayward. If they go into the one at Hayward, they cut off almost all their connections with their friends in Chinatown, many of whom are also elderly and unable, or have great difficulty using transportation to visit them. Many also have the problem of being accustomed to Chinese food and extended care facilities that do not provide this can bring not only a psychological crisis, but also a digestion problem for some of the elderly too, in Chinatown, with 19 percent of the population over 65, and this is slightly higher than for the citywide percentage which is about 12 percent. We also, I'm sure some of these things, the language and the food, would apply to the Spanish-speaking community also and we're concerned with part of what adequate care is, is making provisions for groups who need something special like language.

We are especially concerned with the things that happen to people who cannot get into an extended care facility because this is the kind of problem Self-Help for the Elderly deals with every day. We are the ones that have to help see they get an attendant, and get a home health aide and this is not usually available on an around-the-clock basis, and the problems of payment for attendants have made it difficult to keep an attendant on a regular basis. We are forced to use the idea of keeping people in the community, but we don't have the adequate support necessary to make it really effective, and many of the people who have attendants may also be incontinent and this is a problem that relatives as well as attendants find difficult to deal with. We have an example very similar to the one Mrs. Straus mentioned recently, of a man who lay on the floor of his motel room for 2 days until the manager came because he hadn't seen him for 2 days and the man was unable to

reach the lock on the door. We agree that housing is a severe problem; many of the elderly in Chinatown live in extremely crowded hotel rooms and minimal services available to them.

Senator Moss. We thank you, Mrs. Hale, for relating these problems as they apply in the Chinese community and I can well appreciate the special problem there of language, and food, as you've pointed out and this housing differentiation because of the crowded area, I suppose the Chinese do tend to live in smaller, more cramped quarters than any other elderly group and the needs of these people as was stated right at the beginning by all of the witnesses are very significant and we should be cognizant of the peculiar, special problems that the Chinese community offers.

Now, does this—does this Self-Help for the Aging group work just in the Chinese area, or does it work in the white area, too?

Mrs. HALE. Self-Help for the Elderly, there are two groups. In Chinese, the family name starts, the first name; there's Self-Help for the Elderly, and Self-Help for the Aging, and they're both under the councilship of the Council of Churches; Self-Help for the Elderly works just in the Chinatown, North Beach area. So our clientele is primarily Chinese, Filipino, and some Italian, and Mrs. Espinola Jackson is here from that group. I'm sure she'd like to say a few words.

Senator Moss. I think perhaps that would be a good idea and perhaps Mrs. Jackson could come forward right now, and be seated by Mrs. Hale and give us your comments on the wider area of self-help for the elderly and aging program.

Mrs. Jackson, please identify yourself for the record.

STATEMENT OF MRS. ESPINOLA JACKSON, COMMUNITY ORGANIZATION SUPERVISOR FOR SELF-HELP FOR THE AGING

Mrs. JACKSON. Espinola Jackson, community organization supervisor for Self-Help for the Aging, and I believe if I speak, you know, try to make a statement, it would just be repetition of all the other statements that are made, because indeed there is a problem not only here in San Francisco, but all over the United States and I don't believe that we can separate housing from health because we need regulation to establish adequate housing, so we do have a problem here in San Francisco, and the health problem I think I testified before, last year, and at that time I believe I stated that Medi-Cal was a fraud as according to the needs of the poor, because they have not been able to receive the adequate medical care; that when the program 19 came into actual service, actually Medicare for these poor people and to have people transferred from city to city and disposed from their home and the community is a very sad thing and when you're dealing with old men and I think we stated at that time, I think we must all remember we're all aging, we're getting there, and so we have to become more conscious of how we have to inform our Congress in these areas and I feel that since you are one of the Senate in Washington, D.C., that some priority should be made.

What are your priorities? If Medi-Cal are the priorities, we should see that more money is allocated in order to see that these facilities' needs are met in San Francisco and all over the United States. Because of the lack of facilities and the way the codes are, it's very impossible to see that these people are getting right medical care and the expense that is given to the people.

Senator Moss. Well, thank you, Mrs. Jackson. And the area in which you work is citywide, and you're speaking from this broader perspective.

Mrs. JACKSON. Yes.

Senator Moss. Are there other large ethnic groups other than the ones mentioned that are concentrated in certain areas?

Mrs. JACKSON. Well, I believe you'll find this in an area where there is black people, you know, you have a large area of black people where there is Spanish, you know, they are in that area.

This city is segregated all over, so you can't say you might find a little, but still everyone is segregated throughout the city and medical services are segregated as well.

Senator Moss. They tend to unite in ethnic groups and therefore serve and receive service in that way?

Mrs. JACKSON. Yes. And lots of these people are not being served at all, and I believe in the concept that you spoke of earlier to see that there are medical facilities in the communities which these people reside, so they don't have to come out of their area, like in the Chinatown area; but these people will not come out of their areas. Once they get from Chinatown, they're lost. And the Spanish community, they're lost.

And when they're going into the hospital, there's nobody even there to interpret for them, so they don't know the needs of these people.

And this happens in Chinatown and if a person goes out to San Francisco General there's no one there to interpret, and this man is not going to get the service he needs.

Senator Moss. That's a very good point to make and one of which we ought to be conscious.

Thank you very much, Mrs. Hale and Mrs. Jackson, we appreciate your coming to testify for us this morning.

We'll have a 5-minute recess.

(Short recess.)

Senator Moss. If you'll resume your seats, we'll resume our hearing.

We are now going to hear from a panel of witnesses whom I'd like to have come to the table here.

Mr. Elliott Silver, administrator, Pacific Heights Convalescent Hospital; Mr. Clinton Jones, legislative relations representative of the California Association of Nursing Homes; Dr. Crawford Bost, chief of the department of health, and geriatrics department of public health; Jerome Hansen, public advisor for the department of public health.

Come forward, please.

Thank you very much, gentlemen; I appreciate having you here, and we'll look forward to hearing your testimony.

Mr. Silver, will you lead off, please?

STATEMENT OF MR. ELLIOTT SILVER, ADMINISTRATOR, PACIFIC HEIGHTS CONVALESCENT HOSPITAL

Mr. SILVER. My name is Elliott Silver, and I'm the administrator of Pacific Heights Convalescent Hospital.

Let me begin with a statement which totally supports the concept of insurance for aged, ill persons.

As our population grows, one of the largest sectors of growth is the population above 60 years of age. Facts reveal that older persons are more susceptible to diseases and other medical problems which cause them to be hospitalized. Because of their advanced years and the nature of their illnesses, the course of hospitalization is usually more lengthy than that of younger age groups.

The types of facilities that provide health care services today are generally classified as follows:

(*a*) General acute hospitals.
(*b*) Nursing homes.
(*c*) Home care agencies.
(*d*) Physicians' offices.
(*e*) Outpatient clinics.

The general acute hospital has served a multiplicity of community needs. These are: (1) emergency care, (2) diagnostic work, (3) surgery, (4) intensive care, (5) cardiac care, (6) convalescent care, (7) rehabilitative care (i.e. when a patient becomes ill, he goes to a hospital until he is well enough to go home).

The nursing home has served as a long term residential facility rendering minimal medical care to the patient who is unable to take care of himself at home (usually 65 years or over).

Home care agencies have in recent years rendered essential intermittent nursing care to patients supposedly unable to leave their place of residence.

Outpatient clinics render essential medical care for those patients able to go to such facilities.

Physicians' offices render medical services and diagnostic work for those patients able to travel to their offices.

In the early 1960's the Medicare program was put into effect. This program philosophically encompassed all of the existing health care services as outlined. In addition, it attempted to create progressive and new levels of patient care but in reality new terminology was coined for existing health care services. Ideally and philosophically, the goals are set up by the program were what the aged ill needed but the resources to provide the required care were not available. The available resources (acute care, nursing homes, et cetera) that had existed for some time were required to function under the new program without benefit of clear-cut definition of the new levels of care which were to be covered under Medicare.

The health care industry has existed for many decades. New approaches and methods have been developed during recent years. Progress has been phenomenal and is borne out by increased-life expectancy. Probably due to fear of change, existing health care facilities have been unable to meet the demands of Medicare. It can be said that the philosophical program created called Medicare does not exist. Because of the discrepancy between the philosophy and the reality of modern patient care, the administration of Medicare is muddled. The facilities which deliver health care do not measure up to the concepts of the program.

As defined earlier, the acute facility has been the answer to all health care delivery. This does not mean that the acute facility is geared to, or able to provide, all health care at reasonable costs. It merely means that in the past and currently society has accepted

this role. The nursing home has engaged in the housing of patients who have chronic illnesses. Neither facility is equipped to perform as intended by the Medicare program.

Recent releases to the press have indicated the soaring costs of medical care. Health care will soon be unreachable to the general public. I would like to propose that the health care industry follow the successes of other industries in this country. There is a need to specialize to create increased productivity within the health care industry. What is sorely needed is (1) chance, (2) establishment of written guidelines and criteria, (3) reasonable reimbursement, (4) establishment of meaningful communications between providers, consumers and Social Security Administration, (5) manpower to implement and oversee meaningful programs of health care delivery.

In line with the above thinking, the most important step is to define levels of care and for all parties to formally agree to uniform definitions for each category of care. To do otherwise is to continue an already confusing state of affairs.

Inpatient care should be separated into four levels:

(1) Acute care: medical center or general hospital.
(2) Subacute care: extended care hospital.
(3) Intermediate care: convalescent hospital.
(4) Custodial care: nursing home.

Outpatient care includes:

(1) Home care: home health agency.
(2) Ambulatory care: outpatient clinics.
(3) Outpatient care: physicians' offices.

Following is a program which I feel has merit. It delineates levels of care. If followed, patients could receive the care needed and prescribed by their physicians. It would further allow that care to be delivered at reasonable rates. Moreover, it would further industrialize or allow specialization in the health care industry. It would eliminate the necessity of existing facilities to try to provide services of which they are incapable. It would eliminate the false concept that nursing homes are extended care facilities or that general hospitals are extended care facilities.

It would define and create the limitations needed to provide the proper level of care at the proper time.

It would eliminate the misconception that extended care is long-term care. It would follow guidelines already established by learned agencies.

It would establish new licensing requirements.

Finally, it would establish sophisticated methodology to deliver quality health care at reasonable rates.

We have levels of care which are acute care provided in the medical center of general hospitals, and these facilities will provide the following and no more:

They provide emergency care; they will provide diagnostic work such as X-ray, laboratory, physical examination; they will determine the rehabilitation potential of patients. They will determine the disposition of patients.

They will provide surgery; they will provide the medical postoperative care; they will provide intensive care. Their average length of stay

will be between 5 and 14 days. Their staffing patterns will be between 7—6 and 7 hours of professional care per patient, per day: X-ray, laboratory, nursing care, medical staff, therapy staff.

There will be subacute care facilities, which will be called extended care facilities. They will provide an extension of acute care with emphasis on intensive rehabilitation.

We have a coordinated staff effort to return the patient to the fullest level of self-care; they will provide physical therapy, occupational therapy, speech therapy, recreation therapy, rehabilitative nursing care, diet therapy, vocational rehabilitation counseling, medical-social services.

The length of stay will be between 30 and 50 days. The staffing pattern will allow 4 to and 4¾ hours of professional care per patient per day: Nursing care, therapy staff, physican visits.

The intermediate care or the convalescent hospital provides a continuation of extended care, but less intensive care. It will support patients who have begun to plateau but who need continued care until the plateau formally ends. The length of stay thereof, 30 days. The staffing pattern will allow 2 hours professional nursing care, restorative care, per patient per day, which would include: nursing, therapy, physician visits.

Custodial care: Supervision for patients who are unable to care for themselves.

The length of stay will be long-term if needed; staff pattern will be 1 hour of professional care per patient per day: Nursing care, physician visits.

In order to best utilize existing structures, it would seem appropriate to engage in regional surveys of present resources and to convert facilities to fit within this proposed framework. It should be clear by now that superimposing new concepts on to old frameworks is impractical and unworkable.

I am aware that these ideas are nontraditional and will be resented or misunderstood by most people in today's health care industry. Acute hospitals cling to subacute patients and nursing homes vie for extended care patients to fill their beds. The concept of a separate facility for extended care patients is alien to both of these existing facilities.

If there were more definitive separation in levels of care, both these industries could specialize in their own area of expertise (acute care; custodial care) and would be happier doing so.

Together with a group of progressive medical people, an attempt to develop an extended care hospital has been established. This committee is now presented with statistical data proving the workability of this concept of patient care. (More information is available upon request specifically regarding concepts of extended care.) This facility has elicited little or no support from within the industry itself but it has attained a degree of acceptance from progressive individuals within the field of patient care.

I would like to suggest a formal pilot program to study the advantages of separate levels of care be set up in San Francisco. This program should encompass this new type of facility in comparison with a more traditional facility. The program should last from 3 to 6 months. Results should then be compared and rules as to approved

methodology should be instituted, initiated and followed through. In this way, maximum utilization of services will be accomplished. with reduced costs and proper care for patients.

Individuals, upon visiting this facility indicated they were not ready to look at the need for changing systems or licensing in health care services because it is too complicated. I feel that, if we as a unified people are unwilling to look at what changes are needed we must be willing to live with the so-called abuses which have resulted.

Senator Moss. Well, thank you very much, Mr. Silver. That's a very thoughtful and helpful paper that you've presented to us here.

Other than the extended-care hospital that you speak of, has there been any other effort that you know of to create the different types of facilities as you have described them here?

Mr. SILVER. No; the trend is quite to the opposite. The concept is that the general hospital must be all things to all people.

Each general acute facility must have all of its own equipment and the concept of specialization or industrialization, whichever you want to use, I think is very critical to the industry; that not every general hospital needs a cobalt machine to treat cancer. In a city that has 700,000 and approximately 18 acute facilities, it seems to me it would be a waste of money to spend that kind of dollar on 18 cobalt machines when probably one will suffice; 700,000 people don't have cancer.

It would also seem kind of ridiculous to supply cardiac care units in each major hospital. In a city like that there are not that many people who are cardiacs.

There should be specific specialization. What a hospital does, what it's supposed to do, so it does not cling to patients in order to either keep its beds full to create new jobs, or to create problems for itself that it's not adequately able to handle.

A facility should be created that would adequately handle this kind of problem, and do nothing else.

Senator Moss. And it's your view that by doing that we could reduce the cost of medical care by eliminating some of the duplication and overlap?

Mr. SILVER. Let's look at it this way, Senator: Assume you have two facilities, one whose rate is $50 and one whose rate is $25 a day. The one whose rate is $25 a day must out of necessity keep their patients probably 100 days maximum length of program because they're not able to provide the services that the other facility is able to provide.

The facility at $50 is able to reduce, not by 50 percent but maybe by 70 percent, the length of days. Mathematically there are dollars saved. This has been a proven fact.

Senator Moss. Well, with the pressures that we have from increasing costs of health service, why any kind of program that will improve the efficiency and therefore hold down the hospital costs, is certainly one that we ought to be examining.

Mr. SILVER. By the same token it seems kind of ridiculous to spend $175 a day on a patient that is in a hospital when they don't need the intensive care that is rendered in a general hospital.

Mr. MILLER. I have one question which obviously suggests itself: You're speaking of the hospital, a specialized hospital doing its specialized role.

My question is: Who is going to determine where this specialization is allocated among various hospitals?

Mr. SILVER. I think that this should be a community effort, I think with participation of all.

Mr. MILLER. Now, are you not really saying that the heart of the matter is that there has to be a totally integrated community effort to determine the allocation of medical resources and services?

Mr. SILVER. Absolutely. The longer it takes, the more money it's going to cost.

Senator Moss. Well, thank you, Mr. Silver.

We'll now hear from Clinton Jones of the California Association of Nursing Homes.

STATEMENT OF CLINTON JONES, LEGISLATIVE RELATIONS DIRECTOR OF THE CALIFORNIA ASSOCIATION OF NURSING HOMES

Mr. JONES. Thank you. I am F. Clinton Jones, legislative relations director of the California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged, Inc.

This organization is the California State affiliate of the American Nursing Home Association, headquartered in Washington, D.C., and with which we know you are well acquainted.

On behalf of Mr. Dean Renfro, the State association's president, as well as the entire membership, may I express the gratitude of the organized long-term care profession that you, Senator Moss, and your subcommittee members and staff are again demonstrating by your presence here, your continued concern for California's aged, infirm and chronically ill.

Association representatives, including the speaker, have testified during your previous visits to the Golden State and we again appreciate this invitation to appear.

Mr. Renfro has asked me to transmit his sincere regret in not being here today.

Unfortunately the shortness of notice of this hearing made it impossible for him to break previous commitments involving programs serving the membership.

However, despite the brief time for preparation, Mr. Renfro has directed me to assist your committee in every possible way.

The association is particularly greatful for this opportunity to apprise you and through this public forum to warn Californians and the Nation that organized efforts are now underway to discount and erode the new, higher standards of nursing home care for the welfare, aged and medically needy.

These are the quality standards long demanded by the public for their elderly loved ones, and the very high standards that you, Senator Moss, and your fellow Senators and associates worked so long and diligently to help secure. I refer specifically to the Federal title XIX standards promulgated last summer, which eliminated from Medi-Cal participation the so-called "part-time" nursing home with inadequate, and in some cases, no professional nursing staff.

Now, if a present proposal in California to undercut these new standards is implemented here, we have good and sufficient reason to fear that an increasing number of elderly and medically needy citizens eligible for and receiving Medi-Cal services in nursing homes will be reclassified as not needing such care, They will be relagated to a lower level of service not requiring title XIX standards with the

motivation of economizing on Medi-Cal and shifting the recipients to a new Federal-State program known as intermediate care.

Now, in fact if the present proposal is implemented in California, the medically needy—those nonwelfare cases without sufficient family resources to pay for extended illness—face the prospect of being reclassified out of Medi-Cal with no place to go, because present Federal requirements make them ineligible for intermediate care.

At present, Medi-Cal patients in nursing home beds approximate 45,000 elderly and medically needy.

This proposal, based on a small, inadequate and highly questionable survey, assumes that 50 percent do not require such medical care, and many of those as needing only board and room.

We cannot, of course, speak for the other title XIX States with Medicaid that may be contemplating intermediate care, but California today, in the considered judgment of the association leadership, is dangerously close to inviting a return, a tragic regression, to the part-time, mostly unskilled nursing home, though it may not officially be called by that name, for obvious reasons.

To date, there has been no governmental publicity or legislative review of this projected version of intermediate care.

The proposal, which also contemplates a flat-rate payment formula, is reminiscent of the thoroughly discredited M.A.A. days of the early 1960's—which I am sure are remembered by this committee—when government actually fostered low standards of nursing care by a low, low flat rate * * * and a low and a lower-still level of care * * * which penalized responsible operators and rewarded unscrupulous ones who profited only by cutting back on food and personnel.

But the prospect of regression in aged care quality in the name of "economy" is more than a matter of rates. It is first a matter of honest and humane determination of patient needs—then all the economy and efficiency possible. This combination appears to be compromised in the present proposal.

As one California State Senator expressed the issue succinctly during a hearing prior to the new title XIX standards—and I paraphrase:

"I just don't see how you can have a nursing home without nurses on different shifts, whenever elderly patients need them."

Neither can the California Association of Nursing Homes et al. Even though the title XIX standards caused decertification from Medi-Cal of several score nursing homes—some of them our members—the association has consistently supported and actively worked for the higher standards throughout the 3 years until their adoption made them binding upon the States.

Prior to and throughout Medi-Cal, the association has bent every effort to cooperate with government and help make the program economical, efficient and sensible. The association has supported prior authorization procedures and utilization review * * * to assure that patients receive only the duration and extent of skilled nursing home care they truly need as prescribed by competent medical judgment.

The association has long been active in education-and-training programs for its administrator-members, cosponsoring innumerable courses, workshops and seminars with the University of California and the University of Southern California.

The association was one of the first among the States to respond to the mandate of Congress for licensing of nursing home administrators.

The Governor vetoed our 1968 bill as unnecessary and premature; our 1969 measure passed one house but was stalled when legislators were mistakenly advised the Federal Government would not enforce this requirement on California. Now we are again endeavoring to get a licensing measure to professionalize nursing home administration.

The association supported no less than four bills in 1969 to control and eliminate abuses and cheating in the Medi-Cal program. All four are now law.

The association also supported a measure that is now implementing comprehensive health planning in the Golden State, hopefully discouraging overbuilding and fostering more orderly growth of health care facilities.

The association and the long-term care profession in California have been notably patient in continuing to live with inadequate—or at best marginal—reimbursement in both the Medi-Cal and Medicare programs. Despite national press stories implying runaway rates, I assure you that our nursing homes are being held to an absolute $14-a-day maximum for Medi-Cal, with no adjustment for increasing costs in the Governor's 1970–71 budget.

You are, of course, familiar with last year's 2-percent and 1½-percent reimbursement cutbacks in Medicare facilities. In light of the startling nationwide increase in costs of medical care, and with the $100-a-day hospital bed in clear sight, nursing home beds with each passing day are proving more and more government's very best bargain buy.

In regard to Medicare problems, I am sure your committee is being kept informed by the American Nursing Home Association, particularly of the continued delays and denials of claims by fiscal intermediaries; so I shall not take your time in review.

As for Medi-Cal, denials of renewal claims in the Blue Cross southern California region have been running some $200,000 per month since December, a very excessive figure, However, this is currently an administrative—not legislative—problem, so I shall move on.

Returning to our concern over impending intermediate care and lower standards * * * permit me to make the California long-term care position very clear.

The State association was one of the very first among the State associations to support the original concept of a level of service less than title XIX's skilled nursing home services, but providing more than board and room.

Congress authorized this concept of a Federal sharing program in 1967. In early 1968, the California association sponsored enabling legislation, and developed a detailed position paper recommending how the new Federal program could be most appropriately and economically implemented here.

Fortunately, the Golden State already has most elements of intermediate care readily available in over 3,600 residential care facilities, all licensed by the State department of social welfare or the counties acting as its agent.

During the 1968 session, the State administration asked our support of their measure, AB 389, Chappie bill, giving the State board authority to integrate the "out-of-home" care provided by social welfare licensed homes with medical care provided in public health licensed nursing and convalescent homes serving the Medi-Cal program.

The association readily and willingly became the principal supporter of this measure, believing that both Government and the private sector were on a common course promising both economy and an evaluation system with integrity that would both protect the patient essentially needing medically oriented services and at the same time save Medi-Cal funds by assigning appropriate cases to less costly residential settings with incidental added services as needed.

Instead, the proposal now pending calls for re-establishment of "part-time" nursing homes, certified as intermediate care facilities by the State department of public health * * * the very type of semi-skilled nursing home finally decertified as undesirable a few months ago.

Even more disturbing is the likelihood that few residential care facilities may be certified for intermediate care. This is because Congress in 1967 specified that an intermediate care facility (even if it be part of some other type of institution) must meet State licensing requirements for nursing homes, which in California substantially differ from residential care homes. This is mostly a matter of differing structural requirements, making alterations quite costly.

To date, the State of California has shown no interest in revising its licensing requirements for nursing and convalescent homes; thus the prospect is that only those facilities—plus those constructed as nursing homes but accepting 100 percent intermediate care certification—might provide intermediate care services.

Thus, it should be apparent that in practice, reclassification of Medi-Cal patients to the lower level may well be paper transactions, with the patient staying in the same bed, or in the next room. It matters little if the faction of separate and distinct parts of facilities is insisted upon. The net result is essentially the same: part-time, partly skilled nursing homes for an increasing number of transferees * * * and two standards—two levels of care for aged, infirm, and chronically ill patients in closely adjoining beds. Shades of M.A.A.

One proposed regulation specifies that intermediate care facilities must not have hospital beds; instead, regular beds for a homelike, noninstitutional atmosphere. But only nursing homes, already full of required hospital beds, can qualify! This is hardly practical.

Another proposed regulation spells out the procedures and makeup of evaluation teams, to determine case by case which Medi-Cal patients are to be reclassified. The plan is so bureaucratically complex that it is estimated it would require no less than 400 teams working full time to process Los Angeles County alone. This is hardly economy.

The proposed regulations further present a revealing degree of intent concerning the evaluation teams. All members must be Government employees. There is sparing provision made for the patient's family physician to confer if he disagrees with the reclassification; but with all levels of government struggling to save every possible dollar, it seems quite clear that the independent medical judgment of the physician—the very heart of our American system of delivering medical care—is about to be sacrificed to bureaucratic expediency. This is hardly integrity.

In conclusion, the foregoing statement broadly outlines the areas of greatest concern with Medi-Cal at this hour—long-term care's

concern for the future of hard-won high standards of patient care in nursing and convalescent homes equipped to provide such care without compromise. We will gladly prepare and file with you more detailed documentation as the committee requests.

Let me reemphasize that the State association is not opposed to a competent and orderly evaluation of patient needs within the title XIX program, including the availability of an appropriate lower level of care that will substantially reduce net Medi-Cal costs while properly caring for those truly not requiring extensive, on-going medical and nursing attention.

We have already developed and presented California such a plan, primarily utilizing the uniquely suitable residential care facilities I earlier described.

In any event, there is no need—in California at least—for a return to the inadequately staffed, already discredited nursing home of the past.

Nor is there any justification for a "meat ax" approach to evaluating the condition of aged and infirm patients so that the result reclassifies a predetermined percentage of bodies and thereby saves a preprojected number of dollars.

The association is aware that all this is a California problem. But we all know that the challenge to high standards of patient care is being sounded in every commonwealth of the Nation.

This last week the press has been filled with cross-country datelines imploring that "something must be done" about the cost of Medicaid and Medicare.

From one end of the land to the other, the cold, hard fact is emerging that the individual States cannot long continue to fund their shares of the existing title XIX program.

It is time for a national reassessment of publicly paid health care priorities: who is to be eligible for what amount and duration of comprehensive health care, and how it is to be funded.

The State association is aware of your committee's intense interest and concern. We hope that you and the Congress can agree that the wholesale chopping of standards—at the particular expense of the hapless aged and chronically ill—tempting as it may be in some quarters—is by no means an easy solution to the problem.

Senator Moss. Thank you, Mr. Jones, for your fine statement.

You agree, I think, generally with what Mr. Silver had to say in his testimony; that really what we need are various levels of care and a method of assigning people to the appropriate kind of care that they need.

Mr. JONES. Yes. That's right.

Senator Moss. Well, I appreciate what you have outlined for us, and the California problem is similar to the problems we're finding in other States as we hold these hearings.

We are indeed coming to a crisis situation now, and we must find a solution for it, and I'm glad to have your paper here for our record to help us.

Now, Dr. Bost, and Mr. Hansen, I don't believe have come with a prepared statement, but I would like to ask either one of them to comment on the two statements we've had before us to any extent that they would like to do this.

I appreciate their willingness to come here, and to give to the committee their viewpoint and their comments.

So I will ask Dr. Bost, perhaps first, and then Mr. Hansen.

STATEMENT OF DR. BOST, DEPARTMENT OF PUBLIC HEALTH, STATE OF CALIFORNIA

Dr. BOST. I am Dr. Bost, from the State department of public health, assistant chief, medical, of the community health services and resources program. I bring Dr. Saylor's regrets and those also of my chief, Dr. Longshore, one of the deputy directors of the department, neither one of whom could come today because of the short notice.

I would like to comment about several points and if you would not mind, I'd like to say that I come really as a resource person, not to make a presentation. I did listen this morning to some of the papers and I would like to include a remark or two concerning those papers.

Monsignor O'Brien brought out a very good point, one that we, certainly from the standpoint of public health, are extremely interested in; that is the continuity of services and programs. In all of these programs we've had other illusions to this today too, but in California we have recently passed and now have in operation, assembly bill 1340 and 1341, which will aid greatly to assist in making these programs really continuous ones.

I feel health planning will be a great step in this direction in that we will through such mechanisms have area and regional approval for the construction of new facilities or changing bed capacity of existing ones so that we can avoid some of the things that Mr. Silver has alluded to in the way of having unnecessary duplication of equipment.

In addition to this, I would like to defend the nursing home industry for many of the problems stressed this morning—and have resulted from rapid expansion of the need for these facilities. I draw to your attention that in California in the period from 1960 to 1969 nursing homes have doubled in number.

They've increased from 667 to 1,194, and in this same period the number of beds have increased from 16,819 licensed beds to 84,445 beds. A massive increase of this sort is bound to bring problems. We are just beginning, I believe, to settle down and shake out some of the major problems we have had so far as licensing and certification of the facilities are concerned.

I think Miss Rose's paper placed emphasis on some of these problems in a like fashion; she mentioned particularly, some of the difficulties in manpower and in activity programs. As to the question of the proprietary home; I believe our own studies would show that proprietary homes do have a place in our programs. One other comment I would make is that the classification of facilities and services, as Mr. Silver has presented them, at some variance, with what is generally accepted and utilized about the country at this time. This criticism does not deny that we shouldn't think of alternatives but I do believe that we're having difficulties enough in classifying patients who belong in certain types of facilities at this time. To add to these programs at this time another concept might set us back quite a bit.

So far as the intermediate care program in California is concerned Mr. Jones reveals that we have a difference of opinion.

We are debating these differences with the California Association of Nursing Homes, among others, at this time. I'm sure that we will come to a solution that will be most satisfactory for the State.

If I could answer any questions in regard to licensing or certification, or to the program activities, I'd be happy to do so.

Senator Moss. Thank you, Dr. Bost.

Isn't there, though, a holdover in a general hospital of patients longer than is merited considering the lower cost of the intensive-care facility compared with the larger expense of the acute hospital?

Dr. BOST. I think Mr. Hansen can probably answer this far better than I, but I'll make one comment and that is the concept of extended care facilities is just beginning to penetrate throughout the country. When you come to think about it, we have some differences of definition, this morning. Extended care to us means the extension of hospital care, but this has not been the usual concept of the purpose of extended care facilities.

Senator Moss. Well, now on the certification of nursing homes, which is what you deal with primarily, is there a tendency now to excuse the high standards laid down for registered nurses and lower the quality of care?

Dr. BOST. Currently, I don't think it excuses any of the conditions of participation. We do render consultation activities to these facilities to help them and we do allow them a period of time to meet standards.

It's impossible to get all the personnel that we need in some areas, such as outlying areas.

So I wouldn't say that we can excuse them in any sense, but we do have to work with the facilities to help them meet these standards demanded in conditions of participation,

Senator Moss. What would be the time frame, how long a time could be extended to let them bring themselves up to meet the requirements?

Dr. BOST I think this would depend on which condition of participation we were talking about, for instance, social activity and social workers. These are going to take a long time. There isn't personnel to meet the standards which we have to live by, and it will take a long time to reach this status. In the case of nursing care, it certainly is an extremely short time unless a facility is doing the best it can in their locality to recruit someone, and there just isn't anybody there. Then we have to allow an extension of time.

Senator Moss. What about the field of physical therapists, and others that Miss Rose was talking about?

Dr. BOST. I think that as far as physical therapy standards are concerned and conditions of participation, except for the physical features that she was speaking about, this is having a room set aside on a patient floor, her suggestions are valid.

I think she made some excellent suggestions in this respect, but many of these homes have been built for a long period of time and wouldn't fit comfortably in such demands.

Senator Moss. What sort of requirements do you have on the certification so far as the physical facilities are concerned? I'm thinking of space and fireproofing and so on.

Dr. BOST. Well, we have very clear and very definite regulations in our licensing laws that apply to the amount of space, the width of halls, the window space, the protection of the patient from the standpoint of safety and from fire protection.

Senator MOSS. You probably read in the press that we recently had a hearing that grew out of the fire in Ohio where the floor covering seems to have been the factor.

Dr. BOST. Yes.

Senator MOSS. Do you have any standard on that?

Dr. BOST. We have recommendations on this which are not in our regulations, I believe I brought along a copy of these.[1] We have talked with people in the industry, the standards our fire marshal in the State demands are met by the regulations which we have.

I think Mr. Hansen has a current statement from the fire marshal.

Mr. HANSEN. I have the statement from the fire marshal.

Senator MOSS. Well, if you could supply it to me and will have it then in our file to illustrate the point. What I am concerned about is the need perhaps to increase the standards that have been applied because of the event that occurred in Ohio. Some of the patients actually were strapped to their beds and had no way of moving, and most of them not being ambulatory didn't have a chance with the fire and the black smoke.

I appreciate it, Dr. Bost. I wish we had more time to continue the coloquy, but we are a little pressed for time.

I'd like to have the comments of Mr. Hansen from the Department of Health Care Services.

STATEMENT OF D. JEROME HANSEN, DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA

Mr. HANSEN. Sir, I am D. Jerome Hansen. I am a health program advisor known in this State as Medical advisor. My director, Mr. Mulder, sends his regards.

He was previously committed. I concur with Dr. Bost's comment and appreciate the remarks that the prior speakers have made. I found them to be, in most part, quite accurate and reflective of the situation in California.

I think I should turn to the fire marshal problem right now, due to the fact that Dr. Bost has just been talking about it.

Medi-Cal requested under the provisions of Section 1902(a)(28)(F) title XIX of the Social Security Act to have an exception from meeting the Federal standards by implementing and putting, into effect the California State standards.

The California fire marshal in March of 1968 made the statement that the nursing home industry in California was in compliance with standards and the health and the safety of the patients was protected. We received from the Department of Health, Education, and Welfare a response to our request for exception from the Federal standards, and at that time they pointed out that they felt that we probably were not in compliance with three points of Federal requirements of the National Fire Safety Code.

[1] See appendix, item 1, p. 535. "Procedure for Approval of Fiber Floor Covering in Hospitals and Nursing Homes—California."

We have discussed this matter with our State fire marshal's office. He feels that of these three points that we are now in compliance with two of them because, in the intervening time, he has changed his regulations. The third point has to do with one or 2-hour fire resistent construction. As an aside, I should state that I am really not an expert in this area. The fire marshal advised me that he has a staff working on this. He feels that the Federal interpretation regarding the third point concerns language in the California Code which is not directed to nursing homes, but rather is directed to other types of construction.

Therefore, the State fire marshal's office advised me yesterday that they feel that this State is in compliance with current standards. I was unaware of your testimony that you received yesterday, and I did not ask him specifically about the flame factor of carpeting.

Senator Moss. We thank you. In this carpeting matter, actually I think it should be said in defense of the Ohio Nursing Home, that the carpeting there apparently passed the Federal standard.

So what we're looking at now are some tougher Federal standards because the carpeting there did ignite, and it was the factor that caused the death of 32 of the patients in the home.

But I appreciate your comments on that, and we have our problem to deal with at the Federal level, and on standards too.

Do you have any other comments you want to give us, Mr. Hansen?

Mr. HANSEN. Dr. Bost did give you the statistic as to how many nursing home beds we had.

I feel that he left out about 6,000 more beds we call long-term care (mental) beds. These are licensed by the Department of Mental Hygiene and are for people who have physical and mental illnesses. We have, I believe, closer to 91,000 licensed nursing home beds in California.

Senator Moss. Are these institutions proprietary?

Mr. HANSEN. They are licensed and are predominantly proprietary.

Senator Moss. Predominantly proprietary.

Mr. HANSEN. The last review of these facilities suggest that there is, statewide about an 18 percent vacancy rate throughout the State, and this varies greatly from county to county.

Senator Moss. I see.

Well, thank you very much, gentlemen. You've all been most helpful and have given us good testimony for our record. We appreciate it very much.

Thank you.

We have one final panel. And we want them to come forward now.

Mrs. Milton Schiffman, of the National Council on Aging, and Mr. Lloyd Halvorson, who is the executive director of the California Association of Homes for the Aging.

We are most pleased to have you. We have had a number of occasions to meet with Mr. Halvorson as a witness and otherwise and we're very glad to have you, Mrs. Schiffman, representing the National Counsel on Aging.

STATEMENT OF MRS. MILTON SCHIFFMAN, WESTERN REGION FIELD REPRESENTATIVE, NATIONAL COUNCIL ON AGING

Mrs. SCHIFFMAN. Thank you.

As a regional person, I'd like to talk about the situation in some other States than California.

I'm terribly distressed that title XIX has not been implemented in Arizona.

On the Indian reservations in the State of Washington, and in the State of Arizona, I hear a cry for more nursing homes.

I believe we have to worry about the whole range of services. We would do better perhaps to have more homemaker and attendant services, which now can be paid for in most States out of welfare funds.

I hear sad stories of what happens when older people or agencies try to collect from Medicare for home health services.

I believe we can solve a tremendous problem in long-term care if we could give people homemaker services at the point that they are needed. We might, for instance, keep people out of long-term care facilities for a while. We might bring them out of the nursing homes more rapidly. Among our older people, we have many varying age groups. There are groups now over 90 and 95, and 80 and over 85. Very often, when they have a severe illness, they cannot leave the nursing home. Then our spell of illness clause in our Medicare bill makes it difficult for them. They might be in for a hernia operation or a broken hip operation, come back, need skilled nursing care, but not be eligible for any payments under Medicare; this makes extreme difficulty for both the nursing home and our older people.

Our Medicare reimbursement formula has made some problems for the poor. A study that the Council on Aging has just completed wherein we interviewed 50,000 individual people from 12 communities showed that of the older women who live alone, 58 percent live on $1,000 a year, and of the couples interviewed, two-thirds live on $1,500 a year. So there's really poverty among our old people.

How then can they manage when they're ill? How can they possibly manage to meet their own expenses?

Now, the rigid interpretation of the home health agency services under Medicare has possibly made more problems, has cut more health agency budgets, and upset more visiting nurse agencies than any other thing we know about. A good deal of this trouble comes from the rigid interpretation of what a health agency is, namely, in this instance, that payment can be made in nursing homes or hospitals to do cleaning, shopping, cooking, or laundry, but these services will not be paid for to maintain a person at home. The formula will pay to change dressings and give enemas, but these services do not suffice to keep an older, ill person in his own home.

We know older people ought to live in their own homes; we know they ought to be in their own communities. We know the present law, as it's working, tends to keep people in the facility once they're in because there isn't enough homemaker service for them. They remain in a total facility and pretty soon they are alienated from their families.

When Medicare stops paying, people pauperize themselves.

The very fine nursing homes can't keep the poor any longer because the Medicare reimbursement formula means that if two or three patients in a nursing home pay less than the Medicare rate, the rate paid by Medicare goes down for all patients.

This means that the poor can't stay in the really fine nursing homes. Usually, it means they are shipped out of town. We have one nursing home that had to send 40 patients at one time, out of town because of this strict interpretation of this formula.

Now, we know it's much less expensive to keep people in their own homes and somehow we need to do something about the legislation to cut down on this interpretation.

Medicare is not to blame; the law is a very good one, it's the fact that the States have not allowed enough money in the Medicaid formula to pay for nursing homes.

I don't know if I'd want to change the formula so much as I'd like to see the States really pay the costs of care.

Senator Moss. Thank you, Mrs. Schiffman, for your comments and what you've said is of course so very true.

The eligibility problems of these elderly poor who find that they've used up their entitlement and have no place to go and since the amount of payment is so low. The result is the transferring of the patients out of the city. This does present a very severe problem.

Now, you say that you would like to see the State assume their responsibilities and making their contribution, but we constantly hear that the State does not have the money and only the Federal Government has the money.

And I suppose that there's something to that fact. Resources of some States are much less than others, and I don't know how we're going to make sure that all the States can hold up their end. Perhaps we're going to have to change the formula to include more Federal money.

Mrs. SCHIFFMAN. Maybe that's what we need to do. Maybe there needs to be a Federal health legislation program because many of the States don't implement Federal legislation. Arizona is a State with a tremendous number of ill older people which has not implemented title 19.

Senator Moss. I think there's more talk and more thinking about having the Federal Government expand its activities into this social welfare field. Presumably this would include Medicare and then at least we could have uniformity rather than the present situation where some States are quite different from others because of their inability or unwillingness to make an equal effort in that field.

We appreciate the fine work you do, Mrs. Schiffman, and are glad you came here today.

Now we'll have Mr. Halvorson, executive director of the California Association of Homes for the Aging.

We are pleased indeed that we have you with us today. You helped us before with testimony before the committee. Thank you.

STATEMENT OF LLOYD HALVORSON, EXECUTIVE DIRECTOR, CALIFORNIA ASSOCIATION OF HOMES FOR THE AGING

Mr. HALVORSON. Thank you, Senator Moss.

I am Lloyd W. Halvorson, director of the California Association of Homes for the Aging. First, I appreciate some of the comments that were made by previous speakers. I perhaps ought to add that I have served on the board of directors of the American Association of Homes for the Aging, also on the National Council on Aging, Mrs. Schiffman represents, and the State associations which relate to the 10 western States.

It's a distinct pleasure for me to again be given the opportunity to speak before your committee, Senator Moss.

I've appreciated you personally and your concern and interest for a great many years and that of the entire U.S. Senate as a committee on aging.

Our recommendations are centered around the assumption that the subcommittee is not studying specific programing as much as it is seeking to determine what ought to be the policies and concepts within the apparent and expected trends in long-term care. And we presume upon the patience and durability of the subcommittee by attaching five association publications and listing of eight recommendations. I'm only going to refer to the eight recommendations. You have the entire paper before you. There's no need for me to repeat it.[2]

No. 1. We urge the subcommittee to seek ways in which the already established laws and provisions which were created to assist and encourage the private sector to house and care for elder persons may be implemented more easily, and successfully.

No. 2. We suggest the subcommittee recognize that residential care in addition to extended care, skilled nursing care, intermediate care and home health care is a definite and important part of long-term care.

No. 3. We ask the subcommittee to include community service designed to provide several forms of care to the elderly who continue to live in their own home, and we urge that this developing area of assistance be strengthened and encouraged through improved grant programs more easily obtained and through new Federal definitions.

No. 4, we ask the subcommittee to devise means in the Federal programs of fiscal assistance to the nonprofit projects for the elderly, whereby the homes and their sponsors will be able to expand their facilities and services into a total approach, the complex or campus concept.

I would like to interject there was a comment made that the nonprofit nursing home is very much in the minority and that there ought to be more provision in the Federal programing for it. I would remind those who so spoke, and I need not remind your committee that section 232 in the National Housing Act, is exactly designed for that purpose.

But as I said in my first recommendation, perhaps is another area that needs some implementation on already existing programs that make it difficult to get that program underway.

[2] See appendix, item 2, p. 541.

No. 5, we suggest to the subcommittee that the matter of available manpower for the various levels of care is a mounting problem. There simply are not enough qualified persons to staff the services required and those that are demanded under existing regulations. We believe the subcommittee should develop ways and means both for education and training programs and for the establishment and acceptance of substitute staff categories which would be acceptable to the requirements for the operation of these service programs.

No. 6, we strongly suggest it is essential that a basic rate formula be created for the reimbursement of services. This is a matter that will require considerable study; it is extremely important in our estimation that some such system be devised, if we are to reduce and hold down the administrative costs of Medicare and Medicaid, which now consumes such a high percentage of the medical tax dollars. I feel this is a subject that is going to require in-depth approach. We in our association are ready to assist in such study.

No. 7, we ask that the subcommittee include a study of the changing character of the persons now entering the retirement year. We believe these new retirees from now on make it necessary for considerable revision of our present policies, concepts, services, regulations, and even physical structure.

And finally, No. 8, we urge the subcommittee to recognize the alternatives which are being employed by older persons when they first reach the decision to move from their home into some different plan and pattern for their lives.

We suggest, for instance, that the use of old hotels as residences for the elderly is one of these alternatives. And we believe there is serious need to review the arrangements, safety, and fire protection, and so forth, in such hotels. I might even go so far as to say, I think they are a menace in many instances. And something must be done about them.

We feel that the subcommittee should recognize that there are these and other activities which are a part of the total program of rehabilitative care which our Nation offers and all should be required to achieve high standards of operation and sustain a high quality of whatever housing and ordinary care they profess to offer.

These, in brief form, Senator, are the recommendations which our paper contains. If I can answer any questions I will be happy to do so. Again let me say I'm grateful that we were invited to participate today.

Senator Moss. Thank you, Mr. Halvorson, for your usual fine response. When you're asked for your contribution you always respond and your fine paper will be printed in our record.

I've had a chance to leaf through it briefly so I know it's very complete and sustains the recommendations that you have given to us.

You are correct in your assumption that we're trying to assist in this field of long-term care; trying to decide how we can adopt the best suggestions to improve both statutes and the system generally. What we learned here today have been extremely helpful and we are getting similar information from other parts of the Nation in hopes of getting a genuine cross-section of problems as they exist in various places.

I'm glad to have Mrs. Schiffman because she can speak more broadly than just for California.

I was particularly interested in your recommendation, Mr. Halvorson, about finding a way making nursing facilities available to the elderly before they have to move out of their own homes.

Mr. HALVORSON. Let me add a word, Senator.

It's my feeling—and It's shared by a great many people I know—that the fact of need, the demand for care, and the rising cost of it is making it mandatory that we move rather quickly into a community concept approach whereby we enlist and utilize the services of the agencies which we already have.

Secondly, as to this matter of cost of care, if we do it properly, we can reduce and delay and even eliminate certain illnesses and needs of older persons which in itself will reduce costs.

Our homes for instance, are engaged in a very extensive program of providing what is called meals-on-wheels, providing at least one good hot meal a day to those persons who are seeking to maintain themselves, but aren't doing the proper cooking. Even that in itself is a preventive measure as well as a sustaining one. And it's certainly easier and cheaper and happier for the person to have that kind of assistance than to wait until they have to be hospitalized.

I feel this can only be done in a coordinated program. And I feel this is something which at the Federal level, could be given considerable assistance and encouragement.

Senator Moss. Thank you very much.

I agree with you and would like to see us be able to do that.

This is all the witnesses we have listed. However, Mrs. Marjorie Colvin of the Citizens Committee for Welfare Recipients has asked to speak, and I think we can spare 4 minutes even though it's late.

And we would be happy to hear you, Mrs. Colvin.

STATEMENT OF MRS. MARJORIE COLVIN, CITIZENS COMMITTEE FOR WELFARE RECIPIENTS

Mrs. COLVIN. Yes; I'll briefly give some credentials since I'm not used to speaking before Senators.

I don't have a masters degree in social work; in fact, I don't have a B.A., because I couldn't pass Spanish and lacked 15 hours there. But I spent 13 years in the field of social work, and approximately 10 years of it in specializing in geriatrics in San Francisco County when the medical aid for the aged program came in 1962. Cases No. 1 through 72 where patients which I had served and were the first certified for MAA because I had anticipated the regulation having participated in the White House Conference on Aging.

I think many of the problems have not been outlined here. The biggest problem has not been mentioned, and that is we do not relate the totality of personal problems, rather we isolate the problems of geriatrics, and medicine and do not relate that to the problems of the war, the problems of the space expansion program, of all our other experiences including crime going on within this country; and I think frankly a lot of us who deal with a lot of problems on a sort of workmanship basis providing answers instead of going to the patient and the relatives, and that's who I go to for the answers.

For eight and a half years I worked at a hospital which I respected and loved very much and for a salary which I could have beaten somewhere else.

I left it when that hospital asked me to do something that was not in the interest of those patients, and that was to move them out because the cost of care wasn't being paid by the State of California. And I went somewhere else to work when I found somewhere where I could work honorably and when I can't be honest with my clients, I shall leave that place. And that is well understood.

With me today, is the chairman of the Citizens Committee of Welfare Recipients who brought her mother to this hospital in tears and who did not want to bring her mother there, and did not until she kept her there for years; and when she left her mother, sure she was going to hate the place and righteously, it wasn't the most beautiful place; but it did have a high level of care.

But it had acute patients. One had to take nitroglycerine on 1 day and that would classify her as acute, and she was then extended care because she had a bed sore and it was classified, and then she was custodial because she had burns held up the next day with the use of sugar and heat lamp. And if you classify those patients according to the regulations every single day you would discover you would have to move them from room to room, ward to ward, because that's how often their classifications change. We have regulations; we have too many regulations. So we need some answers to some problems that are not just regulations or new laws.

One of the answers is pay the cost of care regardless of what it is. I can give some examples of the patients needs; one very important patient, one little woman who had been 10 years in this hospital and extended care facility for 132 patients. The most important night of the week to her was Friday night because she wanted on Friday night for supper a can of canned ravioli and a bottle of beer; her doctor said she could have it and the facility was the type of facility whose dietitian is willing to go out of her way to provide it for her.

To the patient it was a delightful experience. It kept her going a long period of time and it was worth going into. I don't think we're looking at the individual. We're talking about code, regulations, and care, and what we are needing to talk about is what the patient needs. What the patient needs is hope, and the personal interest, and the commitment of employees who will be committed to the care of patients.

If the institution is commited to the care of patients and not to regulations and certifications, we can supply good care.

There are many things we can do. As far back as 1962, 81 nursing homes over the State of California were inventoried as to their costs and that's where we got our cost-figure; starting out at $12.72 per day. One of those nursing homes is in San Francisco County, but the Federal Enabling Act Title XIX says "the cost of care shall be paid," the board and such.

The city of San Francisco at that time could have brought a suit against the State for not paying the cost of care; that has never been done. In fact, it will be up to some welfare rights organization to do it and the relatives will solve the problem; the families will solve the problem if you continue without doing so.

The State of California is still faced with the problem. It still could correct that inequity, and there are still many other related questions to which it does not address, but to which the relatives are beginning to address themselves.

I don't think there's a big generation gap. But, Senator Moss, there's something that you can do and which the welfare rights organizations and which the citizens committee, welfare recipients, which many of these diverse organizations are spreading up and unifying on.

You can do—and that's something which one other organization in San Francisco is going to do locally—you could start the drive to put on the ballot in November of 1970, "Should it be the policy of the United States that the United States immediately cease fire and withdraw all troops from Vietnam so the Vietnamese people can solve their own problems and we have the funds with which to solve ours."

And that would include the problems of geriatrics, the problem of aging, the problem of the DSS, moreover the problems of all the people in America.

Senator Moss. Thank you, Mrs. Colvin, for your very eloquent statement. And I certainly agree with you. You can't isolate problems into little cubicals. You have to look at the whole broad spectrum. And perhaps we have been giving our attention too much to the narrow point that we have before us.

And I agree with you that more important than anything else is to have sympathetic loving care of the elderly people, preserving their dignity and their identity and give them means of expressing themselves. Certainly anything that degrades them to premature acceptance of a custodial condition is wrong and regrettable.

Mrs. COLVIN. There are more of them than my statement perhaps implied.

Senator Moss. I see.

Thank you very much, Mrs. Colvin. We are glad to have you come here and express yourself.

I want to thank all of you who have stayed here through this long morning. It's been very profitable, and helpful as far as the committee is concerned.

Certainly we want to find solutions to problems that plague our seniors because their problems—like Mrs. Coleman said—if we have people who are disadvantaged and uncared for and suffering in any way in our society, it reflects on us all.

Thank you very much.

And the hearing is now adjourned.

(Whereupon, at 1 p.m., the subcommittee adjourned.)

APPENDIX

ITEM 1. PROCEDURE FOR APPROVAL OF FIBER FLOOR COVERING IN HOSPITALS AND NURSING HOMES—CALIFORNIA

The following information has been prepared as guidelines to assist hospitals and nursing homes licensed by the State Department of Public Health in meeting the requirements for carpeting and in the selection of the appropriate type, method of installation, and maintenance.

I. Licensing Requirements

The following excerpts from the Hospital Licensing Requirements, Title 17, California Administrative Code, apply to carpeting and are specifically concerned with safety and sanitation:

"310. General Maintenance. The institution shall be clean, sanitary, and in good repair at all times. Maintenance shall include provision and surveillance of maintenance services and procedures for the safety and well being of patients, personnel and visitors."

"332. Written Manual. A written manual on cleaning, disinfecting and sterilizing procedures shall be adopted by the hospital and nursing home and all procedures pertaining to cleaning, disinfection and sterilization shall be in accordance with the manual. This manual shall include procedures used in care of utensils, instruments, solutions, dressings, articles and surfaces."

"421. Floor and Base Finishes. (a) Floor Finishes. Floor finishes shall be smooth, easily cleanable, waterproof and durable. Upon written, appropriately documented request, the Department may grant approval of the installation of carpet."

II. Procedure for Requesting Approval

Facilities are required to apply in writing to the Regional Office, Bureau of Health Facilities Licensing and Certification, for approval prior to installing fiber floor covering in any area. The application must include:

1. A floor plan showing the area to be covered, with each room labeled as to function, and a color code and key if more than one type of material is to be used.
2. A sample of each type of carpet, backing material and padding proposed for installation with the manufacturer's label containing specifications attached.
3. Test data to demonstrate the reactions of germicides, medications and other stains frequently encountered in hospitals upon the face yarn and other components of the carpet materials.
4. A written manual, or section from the manual, which outlines procedures to be used in maintaining the floor covering in a safe and sanitary condition. The manual should contain cleaning schedules, name, type and concentration of germicides to be employed and equipment to be provided. Items of equipment for dry foam shampooing and for spraying germicides and vacuuming should be listed. Fogging with germicides is not an effective substitute for direct cleaning methods.
5. A written plan for monitoring the hospital environment by culture methods, which includes the fiber floor coverings and a time schedule for making the cultures. The facility is requested to send a copy of the results of cultures, in table form, from at least four selected areas, including at least one patient's room, to the Bureau of Health Facilities Licensing and Certification, unless specifically exempted. The results must be on file in the facility.

A simplified method for bacteriologic sampling of surfaces is described on pages 6–8. A suggested form for reporting results is on page 10. The Hospital Infections Committee may request additional tests, air sampling or other laboratory methods to maintain surveillance.

6. Flame spread rating identification of all materials to be used for soft floor covering when specified for Federal support under the Hill-Harris Act. The rating must be 75 or less, as determined by an officially recognized laboratory, or the manufacturer may certify separately in writing that the materials comply with the Flame Spread Rating Requirements. Testing shall be in accordance with American Society for Testing Materials Standard No. E 84–61.

7. A statement that the owner or licensee agrees that if after testing or inspection by the Department, the carpeting has not been maintained in a satisfactory condition or has become a serious potential hazard to patients or personnel, the Department has the authority to require its removal or replacement.

III. Areas in Which Fiber Floor Covering May Be Installed

1. Hospitals:
   - Patients' rooms (except for communicable diseases).
   - Corridors (except within surgical or obstetrical operating suites).
   - Patient dining areas.
   - Employees dining areas.
   - Physician, nurses, employees lounges or locker rooms.
   - Nurses stations.
   - X-ray departments.
   - Central supply.
   - Elevators.
   - Recovery.
   - Intensive Care Services.
   - Administrative areas (including flower and gift shops).

   Individual requests for other areas may be granted in special cases.
2. Nursing Homes:
   - Patient rooms.
   - Corridors and elevators.
   - Administration, supply, storage.
   - Employees lounge, locker and dining areas.
   - Patient dining areas.
   - Patient recreation, sun porches, therapy lounge areas.

   Individual requests for other areas may be granted in special cases.

IV. Suggested Specifications for Fiber Floor Covering in Health Facilities [3]

1. Material and Construction

Woven or tufted through the back non-vegetable face yarn and backing fiber, manufactured in a level pile height, permanently bonded to a cushion composed of natural or synthetic latex.

The floor covering should be waterproof and sealed to the floor in all areas. Pile yarn should be manufactured in a round cross-section, 0.3 delustered 1053/3 ply 100% continuous filament, commercially textured, yarn dyed nylon. Other fibers may be approved depending on the technical data supplied, such as cotton fiber backing in combination with synthetics.

2. Minimum Specifications

Quality	Level pile	High, low pile	Level pile with pattern
Pitch	216	216	216.
Rows	8	8	8.
Yarn ply	3	3	3.
Pile height	0.125 inch	0.125 to 0.185 inch	0.125 inch.
Pile weight	16 ounces per square yard	19 ounces per square yard	16 ounces per square yard.
Total weight	103 ounces per square yard	103 ounces per square yard	103 ounces per square yard.
Tuft bind	10 pounds	10 pounds	10 pounds.

All yarn should be high tensile strength fibers. All backing material should be treated with plasticizer.

3. Sponge Rubber Cushion

Weight 76 oz. per square yard. Woven fiber covering should be permanently bonded to a maximum 3/16″ sponge rubber cushion. Sponge should be guaranteed resilient for the lifetime of the face yarn.

4. Foam Rubber

[3] Prior approval is required to install any fiber floor covering in licensed health facilities See p. 535.

Foam rubber bonded to face and backing yarns may be approved. Minimum specifications should be: density: 17 lb./cu. ft; thickness: 3/16 in.; compression set: not over 15%; compression resistance: 5 lb./sq. in.; delamination: 2 lbs./in.; ash content: NOT OVER 50%.

Heavy traffic, especially with wheeled vehicles, is an important cause of early wear when foam rubber with lesser specifications is used. It should not exceed 3/16" in thickness.

5. Exceptions

Exceptions may be considered as improvements and innovations in fiber floor coverings for use in hospitals and nursing homes are made.

V. Suggested Guidelines for Installation of Fiber Floor Covering

1. General

Experience has demonstrated that certain aspects of installation are important to long life of carpet material and continued safety to patients and personnel. These suggestions offer standards which are considered minimal.

The responsibility for choice and installation of fiber floor covering should be shared by the facility and the floor covering contractor. The Department must examine floors after installation for adherence to Title 17 of the California Administrative Code.

2. Scope of Work

This work to be done under the floor covering contract or subcontract should include all labor, tools, materials, and services required, sufficient to complete the installation in the areas as indicated on drawings, according to the manufacturer's detailed instructions. The Floor Covering Contractor should inspect the subfloor before starting work. He should notify the General Contractor in writing, with copy to the owner, of any obstacle to satisfy completion of the work. The Floor Covering Contractor should be finally responsible for the quality of the installation.

The General Contractor should prepare subfloors by thorough dry broom cleaning and removal of droppings of grease, oil, paints, varnish, sprinkled cement plaster or other materials which are obstacles to proper installation. Cracks should be elininated with latex or other effective filler.

The Floor Covering Contractor should have responsibility for damage to property or injury to persons attributable to his work. He should be responsible for the protection of his installation until final acceptance.

3. Working Area

The Floor Covering Contractor's activities should be confined to allotted spaces or areas.

4. Proposal Form

The Contractor should furnish the following information as part of his bid or quotation, to be incorporated into the contract documents, if accepted:

(*a*) The manufacturer and brand name of material

(*b*) The installer

(*c*) Layout drawings which show all areas where each type, color, and texture of material is to be installed, and location of seams. Seams should be minimal.

(*d*) Guides recommended for maintenance of the floor covering. The contractor should conduct training to indoctrinate hospital personnel with effective maintenance procedures.

(*e*) Extra material to be included. Five percent extra yardage of each material is suggested. When installation is completed the extra yardage and scraps should remain the property of the owner.

5. Supervision of Installation

The manufacturer or Floor Covering Contractor should supervise the installation of fiber floor covering.

6. Quality of Carpet, Backing and Cushion Materials

Experience suggests that fiber floor covering wherever installed in hospitals and nursing homes should comply, in general, with similar specifications. All floors in a facility influence the environment of almost all other areas. Adequate maintenance of all floors, particularly carpeting, is also essential.

7. Mandatory Requirements for Approval of Carpet Floor Covering

(*a*) The floor covering must be waterproof[4] and easily cleanable.

[4] To be "waterproof" the fiber floor covering should be so constructed and sealed in such a manner that water cannot penetrate to the base floor at any point, either through face yarn, or by openings in seams or cracks at edges.

(*b*) Maintenance procedures must be written.

(*c*) The surface must be smooth, level and maintain its uniformity without evidence of separation at seams or from backing materials.

VI. Suggested Methods of Monitoring Floor Surfaces

1. Program or Plan

Each facility should have a carefully planned and uniformly executed program for monitoring the floors and other surfaces at evenly spaced intervals by means of cultures for bacteria. In time, when the results of a series of cultures, each obtained from a specified site, are available, a baseline bacterial count will become apparent in individual facilities. The technique is intended to be a measure of the bacteriologic cleanliness of the facility. Fluctuations in colony count on cultures taken in series may indicate the need for improvement in housekeeping, laundry methods or other services. The bacterial baseline may be termed a "hygienic index." Sufficient sampling is necessary to evaluate the expected effects of weather, use of the area, influence or children, the aged, maternity and other services as well as time of day on the baseline bacterial count or "mean."

Evidence that a program of this kind is being carried on and that the results are being considered in a logical way for practical purposes is a valuable asset to patient care, as well as for administrative purposes. Such carefully accumulated information is of educational value to the staff at all levels, especially for the guidance of the Infections Committee.

A minimum of four sites should be selected for cultures throughout the facility including at least one patient's room. The other sites should be selected from the following areas: intensive care units, maternity and nursery services, the surgical suite, X-Ray department, corridors, lobbies, pharmacy, laboratory, staff lounges, administrative offices, laundry or kitchen, as specified in the plan. Culture sites should include floors of all types, hard surface and fiber floor coverings, above the floor surfaces, walls, and equipment as appropriate.

For consistency and accuracy of results, all aspects of the program, including the making of cultures, counting the organisms and reporting of the results should be performed by an individual trained in microbiology.

2. Procedures

a. To assure uniformity and consistency:

(1) The same trained person should perform the work.

(2) The same sites (minimum of four) should be chosen for cultures in series. If another site in an area is cultured for some reason, the results should be separated from the regular series for purposes of interpretation.

(3) The same media and culture technique should be used for all cultures for routine monitoring. If another technique or media is indicated, the results obtained by the variation should be separate from the ongoing program.

(4) The same time interval between the groups of cultures should be observed. The interval recommended is not less than six months for regular monitoring.

(5) The same time interval, within practical limits, should be observed since the previous cleaning, after the last shampoo or other wet cleaning, and since germicide was last employed. Useful information is obtained by making a series of cultures in the same manner before cleaning as well as after cleaning for the first several months.

(6) The same number of cultures should be taken at each site. A single group of cultures cannot establish a baseline unless a great many are taken from each site. Two samples from each site in series at six-month intervals will eventually provide a "base."

b. Identification of Species of Organism.

The desired results of culturing is to provide a measure of bacterial cleanliness. Determining the number of organisms grown is the objective. The species of bacteria or fungi found is not important to this limited purpose.

Sometimes, organism identification and characterization are necessary to the epidemiology of infections occurring within the facility. Such identification would be additional to routine monitoring.

c. Technique and Media.

Several methods are satisfactory. The least inconvenience will be incurred if a minimum number of cultures are taken at each site and a simple technique with a single type of media used.

The Rodac Impression Plate, with nutrient plain agar has given satisfactory results for many microbiologists since 1964.[5] It is suited to surface cultures, including fiber floor covering. Presterilized plastic, disposable Rodac Plates are available, sealed in plastic film, 20 plates to a roll. When filled with a solid media it provides a disc 5.7 cm. in diameter, 0.5 cm. thick, with a surface area about 35 sq. cm.

To take a culture, the Rodac Plate cover is removed and the exposed agar pressed to the surface to be sampled. The cover is replaced and the culture incubated at 37° C. for 18–24 hours. A groove on the outer edge supports the cover. The number of organisms picked up on the exposed surface is determined by counting the number of colonies on the plate. Grid lines at the bottom of the cup in the plate assist in counting.

d. Reporting Results of Cultures.

The sample form indicates the type of data that should be reported.

Each culture should be labeled for site from which taken with sufficient detail to locate it accurately and for results to be meaningful. Examples:

Patient Room 104 SW, not occupied.
Patient Room 105—near window—2 beds occupied.
Toilet, Patient Room 105—2 bed room occupied.
Center of Hall, outside intensive care unit.
Under chair SE wall, waiting room.
Nurses' desk in nursery.

e. Preparing Rodac Plates.

(1) The cup portion of the sterile Rodac Plate should be filled with 15.7 cm. of sterile nutrient agar, or sufficient to bring the meniscus of media to the top of the cup. Air bubbles in the media and overfilled plates should be discarded.

(2) Pipetting is a satisfactory method. Pouring may be used for filling by experienced personnel. The automatic pipette is the best but is often not available.

(3) Plates should be covered immediately after filling. These may be refrigerated at 4° C. for several weeks. Storage is most satisfactory if the filled plates are wrapped in metal foil.

(4) Stored plates should be incubated at 37° C. for at least 24 hours to confirm sterility before use for cultures.

(5) Trypticase agar, brain heart infusion agar, and tryptose phosphate plain agar are satisfactory. The addition of blood to make blood agar plates has disadvantages because of the frequency with which ubiquitous gram negative spreaders overgrow and make colony counts impossible.

VII. Methods of Cleaning Floors

The American Public Health Association Subcommittee on Microbial Contamination of Surfaces has recently studied methods for floor and surface cleaning in 17 hospitals to determine what methods were most effective.

The Rodac Plate technique was employed to determine microbial counts, and samples were taken from floor areas near patients' beds and on overbed tables. Of 2,430 floor samples, the mean counts were 230 before cleaning and 99 after cleaning. On overbed samples, the mean was 75 before cleaning and 32 after cleaning.

The authors of the study suggest the following range of microbial counts as evidence of effective cleaning: Floors: 0–25 Good; 26–50 Fair; 50+ Poor. Overbed table surfaces: less than 10 organisms

According to the report, the following procedure appeared to be the most effective method for floor cleaning:

(*a*) Spray a detergent-disinfectant solution on the floor.

(*b*) Allow it to remain at least 5 minutes, preferably longer.

(*c*) Wet-vacuum with a vacuum machine having a thoroughly clean pickup squeegee wand.

(*d*) Apply vigorous agitation and friction with a scrubbing machine having a clean bristle brush or clean nylon scrubbing pad. This additional step improves results.

(*e*) For mopping, use the double pail procedure or the two-step technique (go over floors twice). Mops should be autoclaved or laundered daily and thoroughly dried before use.

(*f*) Solutions: Detergent-disinfectants used should be either phenolic or quarternary ammonium type from reputable manufacturers having up-to-date registration with the U.S. Department of Agriculture.

[5] Hall, L. B., and Harnett, M.: Measurement of the Bacterial Contamination of Surfaces in Hospitals. *Pub. Health Rep.*, 79:1021–1024, November, 1964.

In California, carpets have been extensively used in nursing homes and hospitals in recent years. There are no national standards for acceptable microbial contamination counts for carpets. Hospitals in California have used the Rodac Plate technique for several years. The reported results for carpet are similar to those reported in this study. The same standard for hard floors should be applied to carpet installed in patient rooms, halls, and particularly in intensive and coronary care units. When carpets are cleaned on a regular schedule a disinfectant spray using a 2½ gallon garden sprayer is probably the most economical method of application. The process of vacuuming after applying the spray dries the carpet rapidly and completely. Phenolic germicides of 1–2% concentration have been used with satisfactory results.

CONSOLIDATED REPORT OF CULTURES

Name of facility: _____ Date of report: _____

Address: _____ Person doing cultures: _____
Street City

Type of Surface:
1. Hard floor—indicated by number or * in column after "site"
2. Fiber floor covering
3. Other

Culture method: _____
(i.e., rodac plate, swab, air, etc. note media, surface area or volume of air)

Date culture made	Site from which taken	Number of colonies	Date cleaned	Date germicide used	Remarks (include culture method if different from above)

_____
Name of Owner

_____
Address

_____
Date

BUREAU OF HEALTH FACILITIES,
Licensing and Certification,
State Department of Public Health.

GENTLEMEN: In accordance with the Hospital Licensing Act and Requirements, it is requested that approval be given for installation of carpeting in:

_____
Name of Health Facility

_____
Address

_____
City Zip Code

Enclosed is:

1. Floor plan(s) showing the areas to be covered, each room labeled as to function, with a color code and key for carpeting materials.
2. A sample of each type and texture of carpeting and separate pad or pad as part of carpet proposed for installation.
3. Each sample of carpeting and padding has the manufacturer's label containing specifications attached, or a written statement is supplied giving this information.
4. Copy of the written manual outlining the cleaning methods and procedures to be used in maintaining the floor covering in a safe and sanitary condition.
5. Copy of the plan for monitoring the hospital environment by culture methods, agreeing to send copies of reports of tests on flooring to this office.
6. Flame spread rating identification of all materials used for soft floor covering. (Necessary for Hill-Burton Act supported construction only.)

It is understood that if this carpeting is found by testing or inspection to have become a serious potential hazard to patients or personnel, the State Department of Public Health has the authority to require its removal or replacement.

Very truly yours,

_____
Signature

ITEM 2. PREPARED STATEMENT OF LLOYD W. HALVORSON, CALIFORNIA ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman, Hon. Frank E. Moss, and members of the subcommittee: My name is Lloyd W. Halvorson, Executive Director of the California Association of Homes for the Aging. This Association, usually referred to as "CAHA", represents most of the nonprofit, charitable Homes and facilities of California offering housing and care for the elderly. These member-Homes, sponsored by religious and fraternal organizations and other groups, provide their services at less than actual cost, relying upon their Sponsors and others for supporting funds to cover their deficit operations. In fact, it was noted in a special study in 1968, by the State Department of Social Welfare that 88.7% of the residents in these Homes and facilities, within the charitable sector, were partially or completely subsidized.

As a further introduction both to the Association and to its member-Homes, I am including with this prepared statement copies of certain CAHA publications:

1. A Report to the People of California, Part Two: "A Profile of the Nonprofit Homes for the Aging," dated March 1969.*
2. A Trends & Topics booklet, No. 1: "Today's Home for the Aging in a Changing Environment," dated September 1968.*
3. A Trends & Topics booklet, No. 3: "Nonprofit Homes Respond to Community Needs," dated March 1969.*
4. A Trends & Topics booklet, No. 4: "Rationale for Nonprofit Homes," dated March 1969.*
5. A mimeographed position paper concerning "Intermediate Care," dated October 1968.

I

Before offering our recommendations regarding the subject of this hearing, I wish to commend both the Special Committee on Aging of the United States Senate, and this Subcommittee on Long-Term Care, for their long history of consistent interest in and concern for the welfare and wellbeing of America's older citizens.

Also, I wish to commend the Subcommittee for its particular study of the "Trends in Long-Term Care." This is both a timely and a provocative subject. It exemplifies the Subcommittee's recognition of the fact that care for the elderly is a significant part of the total approach to meeting their needs. The subject further reveals a considerable degree of knowledge and involvement in this matter of care of the elderly, on the part of very busy Senators with a wide variety of many other important considerations, and this is an enormous encouragement to us at work in the field of the aging.

I am reminded of the statement of Senator Harrison A. Williams, Jr., Chairman of the Senate's Special Committee on Aging, in December of 1967, when he predicted that "today's 19 million Americans of age 65 or over will be almost 20 million by 1970, 21.2 million five years later, and 25 million by 1985." The Senator went on to say "we should be asking questions about the effectiveness of pioneering programs passed during the sixties to improve the lot of the elderly." I believe this hearing is a direct response to that urgent suggestion.

I also am reminded of the statement of Senator Frank E. Moss, Chairman of this Subcommittee, in that same 1967 report, in which he spoke of the serious needs in housing and other forms of shelter for the elderly. I have known Senator Moss for many years and I am very much aware of his constant concern both in this area of housing and in the matter of care for older people. I am sure he recognizes, as I believe all members of the Subcommittee do, that any study of long-term care must include the whole matter of housing and the facilities for care.

In other words, it seems to me the Subcommittee's purpose is to discover suggestions and ideas concerning long-term care, not so much desiring to enter upon new programs and concepts, as seeking to solve the problems which confront both government and the private sector and which confront older persons themselves.

At any rate, our presentation is based upon the assumption the subject centers upon policy improvements, in the light of changing concepts and trends, rather than upon the specifics of present or projected programming.

II

In keeping with this approach, I suggest to the Subcommittee a rather basic factor. We note that, whether the concern and interest regarding the elderly is voiced by members of Congress, members of State Legislatures or by other

*Retained in committee files.

leaders within the field of the aging, there seems to be a uniform statement being made that America must discover more effective means of housing and caring for its elder citizens, it must do so quickly, and it must do so at a cost which can be paid.

Further, such statements usually contain references to the fact that any such effort must be made jointly by the public and private sectors, working in concert as "partners."

Also, the Congress and the State Legislatures enact many laws, certainly in recent years, carrying a strong indication it is realized that older people have needs which must be met, and there is an urgent requirement in meeting them, for many forms of assistance to be developed.

Now the basic factor to which I draw the Subcommittee's attention is that, in spite of such statements and laws, there seems to be a paradox present which is proving frustrating and bewildering, both to government and to the private sector. For it is becoming more and more difficult and less and less possible for a significant follow-through to be effected, from the concerns and laws on the books, to the point where funds are allocated, procedures smoothed out with at least some of the stumbling blocks removed, and where there will be as consistent and as determined a concern on the part of government, to see to it the established plans and programs actually are found in the local communities of the nation, serving the elderly, as there is that laws regarding such matters are written and approved.

Our first recommendation, then, is that the Subcommittee pursue its study regarding long-term care, by seeking to discover as quickly as possible how governments, federal and state, can best implement those programs already established.

III

A few examples regarding this basic factor may be helpful:

1. In the National Housing Act there is what is known as Section 231, which provides a form of funding assistance which makes it possible for churches and fraternal groups to undertake these needed but expensive projects. However the Section 231 program is inactive. It is all but impossible for even responsible religious and fraternal organizations with proven ability to operate such Homes successfully, to develop these new Homes and facilities under this Section 231. Yet, the type of housing and care which this Section provides is seriously needed. We made a survey a few months ago, to determine the extent of legitimate waiting lists of older persons seeking residency in our Homes; we found there are more than 6000 older citizens in California on those lists. Closely related to the problems indicated, are the long delays which so often occur as organizations endeavor to complete feasible studies and obtain governmental approval for their projects. Such delays drain the organizations of their available funds and limit the number of projects which, even if all else were in order, they can sponsor.

2. The new program of the National Housing Act, known as Section 236, is designed to assist and encourage the nonprofit sponsorship of such projects to provide housing for persons of low and medium income. These also are very much needed, as are additional projects under the Section 202 of the National Housing Act. But there is no possibility, in either of these programs, for even the proposed intermediate or personal care, or limited nursing care. Yet I am sure it is the concern of the Subcommittee, as it is of all of us, that there must be found ways and means of providing some forms of assistance and care to those who move into these congregate arrangements. All of us realize these older persons seek residency in these Homes and facilities because of present or anticipated need. A problem very quickly develops for these residents if no means is available to meet such needs. Also, we know from our own experiences, that wherever we have been able to offer at least the minimal kinds of care, we make it possible for these persons to delay, reduce and even eliminate some forms of illness and/or dependency. Such assistance, of course, not only makes life happier, better and more constructive for our elder citizens, but it also goes a long way toward reducing medical costs.

3. In the field of Medicare and Medicaid there is another example of our concern. For instance, the regulations now insist that at least three days in an acute hospital must precede any extended care or skilled nursing care. But all of us know there are needs among older persons which do not respond to treatment within a rigidly limited space of time. We also know that if such persons are to receive the required care beyond that limit, and must therefore return to the acute hospital for another stay, we have created new problems for them and we certainly have not held down the medical costs.

4. The last example I would offer has to do with the new program called Intermediate Care. This is intended by federal statute to provide something less than skilled nursing care but something more than mere board and room, even if added to it are certain residential care services. Certainly, as the position paper included with this presentation attests, we in the Association see very real values in an Intermediate Care program. But we also see that such a program must definitely be a non-medical one, must not establish standards and requirements on a level with skilled nursing care, and must be lifted out of a medical setting, if the purpose of this federal program is to be achieved.

IV

Again in keeping with the approach toward policy rather than toward specific programing, we suggest these items:

1. The long-term care concept includes many levels of care: extended care, skilled nursing care, intermediate care and home health care. In addition to these degrees of care, *our second recommendation* is that the Subcommittee recognize that independent living assistance, which most of our Homes call "residential care," also is a part of long-term care. As I pointed out earlier, in this presentation, we have come to realize this area of care is an exceedingly important one, encompassing many forms of preventive, supportive, assistive, and protective services, all designed to help the older person maintain himself as long as possible as a healthy, active and productive member of society. I also mentioned that such care delays, reduces and even eliminates certain medical requirements for the elderly, with resulting savings both for the individual and for our public funds.

2. *We recommend, thirdly*, that the Subcommittee include in its policies regarding long-term care similar programs of assistance to the elderly who are endeavoring to continue living in their own homes. Local communities should be given increasing encouragement and assistance in developing cooperative and coordinated community plans for the elderly. While certain grant programs are supposedly available to assist, too many problems delay or prohibit the use of these grants. It will be of interest to the Subcommittee, that the philosophy and purpose of these voluntary, nonprofit Homes include the community approach to assisting older people. Many of these Homes already provide the use of their facilities, staff expertise, and the involvement of the Home's Board and residents in the community plans. Our nonprofit Homes are taking an increasing leadership in the State toward the development of such community efforts.

3. In this connection, we are suggesting to sponsors of our charitable Homes and facilities that efforts be made to expand their programs so as to create a complex or campus plan, in which it will be possible to provide every needed form of care as and when required. Certainly such a trend will do much to ease the problems now attached to the delivery of health services in which these older persons must be lifted out of their established surroundings and taken from their friends, and placed in a new environment in order to receive help. Such a moving about usually compounds the older person's needs. We know, of course, that not every Home and facility can develop this program. In such cases we urge that efforts be made to establish ongoing relationships with adjacent facilities for those services the individual Home cannot provide. *Our fourth recommendation* to the Subcommittee, concerning this matter, is that this trend also needs to be seen as a part of the long-term program, requiring some assistance and guidance.

4. In the new federal and State-implemented programs on comprehensive health planning there is the serious matter of manpower regarding the delivery of health services. It is all but impossible, in many areas, for registered nurses to be found, for instance, with which to meet the standards and requirements for certain facilities and programs. *It is our fifth recommendation* to the Subcommittee that this item also be reviewed, with the possibility that two plans may be developed: one, a much stronger and more easily available funding program to encourage educational and training plans for staff persons; and two, a new policy which will permit the development and substitution of categories of personnel, for specified types of services. Unless we move in these directions, and soon, a large share of projected services will be brought to a halt for lack of trained and qualified personnel.

5. Finally, we direct the Subcommittee's attention to the matter of reimbursement in the delivery of care. The tendency on the part of government is to seek to establish programs and requirements which clearly define each level of care within a prescribed type of facility. Obviously, if this were achieved, the problem of overview, administering and validating services to be reimbursed would be

simplified. But such a procedure would result in placing older people on some kind of a "belt line," in order for them to be moved from place to place in order to receive assistance and care. No one really wants to see that happen. The efforts so far, toward reducing administrative costs for Medicare and Medicaid, as everyone knows, have not been too successful; far too large a portion of the tax dollar spent on medical programs now goes to administration. *We recommend No. 6* that a special study be made to determine if some basic rate formula cannot be created to cover the reimbursement of services. Under such a formula, we believe, it would be possible for the Administrators of the Homes and facilities to provide the needed care as and when required, knowing that, unless certain pre-established conditions arise, the reimbursement program would be according to the basic rate. Within such a plan, too, the administrative costs on the part of government would be reduced enormously. The end result not only would be a saving of tax dollars but, perhaps more importantly, would be an approach to the care of the elder citizen on the basis of his or her personal need, as and when required, in the best possible place. We strongly urge this study.

V

It is our conviction that any study of possible trends in Long-Term Care certainly must include a review of the changing character of older persons. Those now moving into the retirement years of life bring with them backgrounds and interests, concerns and even demands, which are a far cry from those that have been typifying our elderly. It is our judgment this means every area of service, housing and care, as it relates to these new older people, must take into account that which is visible already and endeavor to anticipate the changes to come. If we do not do this in our planning and even regarding physical structures, I believe our Homes will be unprepared to meet the needs of the elderly and much less able to encourage their residency in our Homes. Equally I believe, and this is *our seventh recommendation*, it is essential there be put in motion now, studies and planning on the part of government regarding these expected new elder citizens.

In this connection we are gravely concerned about the number of older persons as they seek enjoyable, healthful and secure arrangements for their retirement years. It is increasingly apparent that many of these persons now attempt to do two things: Delay as long as possible the transfer of living arrangements from their own home to a congregate plan; and at the same time trying to establish an assurance that, as and when required, provisions will be available to assist them.

It is regarding this item that we offer *our final recommendation.* We urge the Subcommittee to study the present use of old hotels which are being converted into so-called residences for the elderly. To the best of our knowledge, the arrangements for older people in these old hotels lack proper safety and fire protection, lack the overview and licensing by any state agency and lack any forms of assistance for those living in them. Further, we urge the Subcommittee to review the so-called "cities" for the elderly in which those who have purchased arrangements find they must move to other plans as their needs become acute. We believe such transferring appears at a time when the older person is least able to handle it.

In Part One of our Report to the People of California, and I apologize that this publication is out of print so we could not include it with the materials given to the Subcommittee, there is a closing paragraph which, we feel, not only speaks to our philosophy regarding the care of the elderly, but also reflects the concern and interest of this Subcommittee:

"The goal of today's retirement Home in CAHA, then, is to participate in aiding all Older Californians—of whatever status or economic condition—of whatever race, color, religion or national origin—to continue as contributing members of society as long as possible, to bring about the most productive interaction between social agencies working with and for the older person, and to match the extension of life which science and medicine have provided, with a quality of living for these added years which will make them worth while to everyone."

[Enclosure]

RECOMMENDATIONS CONCERNING "INTERMEDIATE CARE" MADE TO THE BOARD OF DIRECTORS OF CAHA BY THE MEDICAL COMMITTEE OF THE ASSOCIATION, OCTOBER 24, 1968

A number of member-Homes of CAHA currently are offering personal services which are less than "skilled nursing care" but much more than room and board. In many instances these member-Homes also are licensed for and provide nursing and convalescent care, with some of them being accredited as extended care facilities.

In order to document these personal services (which federal legislation and regulations may define as being within the new category of "intermediate care") *it is recommended* that a study be made by CAHA of its member-Homes which currently provide personal services. Such a study should include documenting in detail the variety of personal services offered, the staff required for same, the relationship with other socio-medical services, the costs for such services, etc.

It further is recommended that the results of the proposed study be made available to the appropriate State Departments and Agencies of California which are involved in determining definitions and decisions regarding "intermediate care."

It is recommended that the general position of CAHA be that the provision of the personal services is sound public policy and should be encouraged and funded.

It is suggested that, if the encouragement and funding of personal services can be obtained within the existing types of facilities and programs, as found in the member-Homes of CAHA, it may not be desirable for California to participate in the federal "Intermediate Care" program. However, should it be found to be better to have such a new program activated in California, *it is recommended* that the "Intermediate Care" provisions be established as follows:

PHILOSOPHY OF CARE IN A HOME FOR THE AGING

The basic and overruling purpose and commitment of the nonprofit Home for the aging is to assume responsibility, on a long-term basis, for a comprehensive spectrum of continuing services to meet the ongoing needs of each resident.

In order to serve the best interests of older persons, Homes for the aging are multiple-function, socio-medical agencies providing sheltered care.

Older persons in these Homes or in other types of congregate living facilities, have the same rights and requirements as other citizens, namely, the right to self-determination, the right to privacy of person and thought, the right to personal dignity, the right to have social needs met and social roles fulfilled, and the right to good medical and personal care. These are inalienable rights and their infringement, or the failure to provide facilities for exercising them, violates the older person's prerogatives as a human being.

Accordingly, Homes for the aging are not disease-, treatment-, or patient-centered, but person-centered ("residents"). Because movement and flux are traumatic for older persons, fragmentation of care and services are avoided in a Home for the aging, and continuity of care is provided, from near self-sufficiency to total dependency.

Within this general framework, the full complement of care is provided as required for each resident, regardless of whether (a) he is able to pay for this from his own resources, substantially or in part, directly or through some form of life-care, or (b) some portion of the costs of his care comes from public assistance or medical assistance.

The federal "intermediate care facilities" program should be applied constructively in California, to describe a high level of care (as later defined). Such care being somewhat less than nursing and convalescent care and more than nominal residential care, Homes and facilities in California serving the aging would be encouraged to include this level of services and, by virtue of such arrangements, would defer, for many of its residents, the use of the costlier nursing and convalescent care.

With this approach, intermediate care becomes one phase of care in a Home for the aging; its residents, whose problems are of a social and health nature, require and will benefit from the complex of professional services available. Intermediate Care serves the generally feeble or mildly confused older persons who may require some assistance in ambulation, dressing, bathing, distribution of medications, and who need continuous observation. However, such residents often are capable of participating in activities outside their own residential area. Consequently, a resident, if he can be served in an "intermediate" way, may feel better than those who require "skilled nursing care;" the resident in "intermediate care" may be able to mingle with those not so infirm as he is. The intermediate care arrangement can be an inducement to a resident temporarily under "skilled nursing care" to improve so he can move back with those less in need of nursing care.

PROPOSAL

Under the broadest construction of the federal enabling legislation, every licensed residential (board and) care facility in California could be considered an intermediate care facility; however, in view of the likely more stringent federal rules and regulations, *it is recommended* that the intermediate care facility program

be instituted in California on a selective basis. Such a new program, *it is recommended*, should be confined to those residents requiring such care, including those on public assistance, and only to those Homes and facilities as are certified to provide such care.

FACILITIES TO BE INCLUDED IN THE PROGRAM

It is recommended that the following facilities be eligible for certification as Intermediate Care Facilities, providing they are able to render the special out-of-home care services required of an Intermediate Care Facility:

(*a*) any facility which is licensed by both the State Department of Social Welfare and the State Department of Public Health, or by the Department of Public Health only;

(*b*) any two facilities in a given geographic area which are operated by one owner, providing one facility is licensed by the State Department of Social Welfare and the other by the State Department of Public Health;

(*c*) any facility licensed by the State Department of Public Health as a nursing or convalescent home, or by the State Department of Mental Hygiene as a mental hygiene unit, either of which is unable to meet the increased requirements under Title XIX; and,

(*d*) facilities for sixteen or more residents, licensed by the Social Welfare Department for residential case.

CONDITIONS WARRANTING INTERMEDIATE CARE

The intermediate care program would be for those residents:

(*a*) who, because of their physical or mental condition (or both) require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities;

(*b*) who do not have such an illness, disease, injury or other condition as to require the degree of care and treatment which a hospital or skilled nursing unit is designed to provide;

(*c*) who need assistance with routine activities of daily living, such as help in bathing, dressing, grooming, shopping, trips for medical and rehabilitation services, etc.; and/or

(*d*) who need continuous supervision when their mental condition is such that their personal safety requires such care and supervision.

The program for Intermediate Care shall apply only to those persons who are certified by a County Welfare Department as having one or more of the following disabilities requiring out-of-home attendance and care:

(*a*) require help with medications because of forgetfulness, poor eyesight, lack of motor control, inability to read the directions on a prescription, etc.;

(*b*) under special circumstances require extra care and special services due to poor eyesight or poor hearing or due to the use of a mechanical walking aid, and therefore require a room specially approved by the Fire Inspector for technically non-ambulatory occupancy;

(*c*) require a modified diet and/or help with eating;

(*d*) require personal supervision in or away from the Home because of general feebleness, tendency to wander, unsteadiness or mild confusion;

(*e*) require restorative and/or maintenance services to sustain regular living functions; and,

(*f*) require regular assistance in bathing, dressing and personal hygiene, or in caring for their own rooms.

CERTIFICATION OF QUALIFIED FACILITIES

No new licensing program should be required for a Home or a facility, in order to be qualified as an Intermediate Care Facility.

The State Agency or Department given the responsibility should ascertain whether or not a Home or a facility is properly staffed and organized to provide all of the services enumerated in the section on "Conditions Warranting Intermediate Care," before any Home or facility, as suggested in the section on "Facilities to be Included in the Program," is certified as an Intermediate Care Facility and may be reimbursed for rendering such out-of-home care protection in addition to regular residential care services.

In order to be certified, every Intermediate Care Facility must have:

(*a*) At least one registered or licensed vocational nurse on duty forty hours a week, plus access to a licensed nurse at all other hours in the week, for consultation. In case of a dually-licensed facility, qualified personnel on duty in other distinct units but available to the Intermediate Care unit shall be considered as meeting the requirements for the Intermediate Care unit.

(*b*) Proper arrangements to ensure that every resident shall have available as needed, a doctor of medicine for evaluation, therapy and handling of any emergencies.

(*c*) Proper arrangements to ensure that skilled nursing care of general hospital care shall be available to every resident as needed.

(*d*) A functioning admissions policy which requires evaluation by a doctor of medicine, of the individual's physical and mental condition, the kinds and amounts of care required and a determination that the individual needs one of the services enumerated in the section on "Conditions Warranting Intermediate Care," but does not require skilled nursing care nor acute hospital care; and a program for re-evaluation of the individual's physical and mental condition as indicated by changes in his condition, and in no case at intervals longer than quarterly.

(*e*) Appropriate personnel who are assigned and work regularly in the unit under immediate supervision of qualified personnel. A responsible staff member should be on duty at all times in the facility and should be accessible to all residents immediately.

(*f*) Social services to assist residents with their social and related problems.

(*g*) Activities which regularly are available for all residents, including social and recreational activities which involve active participation by the residents, of appropriate frequency and character, and opportunities for participation in community activities as are possible and appropriate.

(*h*) Individual health records for each resident, which should include:

1. the name and address and telephone number of his physician;

2. a record of the physician's findings and recommendations in the preadmission evaluation of the individual's condition and in subsequent reevaluations, and all orders and recommendations of the physician concerning the care of the resident; and,

3. all symptoms and other indications of illness or injuries brought to the attention of the staff, by the resident or from other sources, including the date, time and action taken regarding each.

PHYSICAL FACILITIES

The same standards of safety and sanitation should be required for Homes and facilities certified for Intermediate Care as currently are required in California for licensure of a Home for the aging for residential care.

If necessary, California must point out to the federal authorities that nationally the term "nursing home" has been used to describe both the "skilled nursing home" and the "unskilled nursing home" which provides personal care. In California, the unskilled nursing home is licensed for board and care either as a smaller Home, through the accredited county agency, or as a Home for the aging (sixteen residents or more). Therefore, California's safety and sanitation standards for residential care, which are as high or higher than those in many other states, should be allowed to govern for Intermediate Care. It should be noted that California does have differences in the physical requirements for the nursing and convalescent home and the residential care Home, which are appropriate for their respective functions.

FLEXIBILITY OF APPLICATION

In an Intermediate Care Facility qualified to receive vendor payments for such services, a separate and distinct unit should not be required, although such a facility might, for administrative purposes, tend to congregate its residents who are receiving intermediate care.

In the interest of the residents, the setting should be as homelike as possible and there should be flexibility in utilizing existing facilities of presently licensed residential and/or nursing and convalescent facilities.

Similarly, flexibility should be employed in the use of staff.

RATES

It is recommended CAHA reaffirm its position that payments should be on a differential rate basis, related to the actual reasonable, reimbursable costs of care. To implement this concept, the facilities qualifying as Intermediate Care Facilities should provide appropriate financial reports to establish their costs. Such cost statements may follow any of the three accounting formats now approved for use in establishing reimbursements for nursing and convalescent care.

SUMMARY AND OTHER RECOMMENDATIONS

It is recommended that the California Association of Homes for the Aging recommend the establishment of the Intermediate Care Facility program in California, to ensure the high quality of care and level of services required by all those in need of such care and services. *Further it is recommended* that the Association declare it believes it not only is a sound public policy for all residents to be able to obtain intermediate care services, but it also is a program which would result in the most efficient use of public funds for those on public assistance who would require such care. This program would in itself be an incentive for all Homes and facilities for the aging to upgrade their services in order to qualify as Intermediate Care Facilities.

It is suggested this Intermediate Care program might be instituted in several stages:

(*a*) *an initial period,* limited to facilities licensed both by the Department of Social Welfare and the Department of Public Health, or by the Department of Public Health only, starting April 1, 1969;

(*b*) *an expanded program,* permitting all residential care Homes and facilities of sixteen or more residents, to qualify by January 1, 1970; and,

(*c*) *a total program,* which would upgrade a high quality of care, requiring all Homes and facilities for the aging, of fifty or more residents, to qualify as Intermediate Care Facilities on or before July 1, 1975, in order to continue to be licensed as residential care facilities.

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