TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

PART 1—WASHINGTON, D.C.

JULY 30, 1969

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

41-304 WASHINGTON : 1970

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TRENDS IN LONG-TERM CARE

WEDNESDAY, JULY 30, 1969

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

The subcommittee met at 10:15 a.m., pursuant to call, in room 3110, New Senate Office Building, Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Miller, and Fannin.

Committee staff members present: William Oriol, staff director; John Guy Miller, minority staff director; and Margaret M. Fink, assistant clerk.

Senator MOSS. The subcommittee will come to order.

I am pleased to see so many here which indicates interest in this subject that we have to discuss this morning. I am grateful for your presence.

OPENING STATEMENT OF THE CHAIRMAN

I had expected to begin these hearings on "Trends in Long-Term Care" later in the year, but it has become obvious that this subcommittee cannot ignore a current crisis while considering future trends.

That crisis is the recently issued interim regulations describing the standards for skilled nursing homes under medicaid issued by the Department of Health, Education, and Welfare.

The new regulations provide that, by July 1, 1970, licensed practical nurses in charge of nursing activities on all shifts must be qualified by graduation from a State-approved school of practical nursing or have background equivalent to such training.

But until then, nurses in charge on other than the day shift may be licensed practical nurses "waivered" by a State licensing agency. HEW's recent announcement also notes that the newly published standards match those in the handbook of public assistance administration that regulated services until January 1 of this year, with the exception of the waiver granted for the employment of nurses who are not qualified by formal training.

We are left, therefore, with regulations that say, in effect, that a single, untrained practical nurse on duty in a home with 200 or 300 patients or more constitutes "properly supervised nursing services" on the afternoon and night shifts.

It is also questionable whether the provision for what HEW calls background equivalent to such training will in fact provide properly

trained supervisory personnel. This language permits a State licensing authority to determine that an individual has "background considered to be equivalent" to graduation from a State-approved school of practical nursing. I fear this may mean serious State-to-State differences in supervisory quality.

I have become increasingly concerned with the reports on the quality of nursing care received in nursing homes across the country, whether the patient is a medicaid recipient, a private patient paying the fee out of his own pocket, or being cared for under medicare.

Some of the reports have to do with the fact that many nursing homes do not accept medicaid recipients because, in their own words, "they cannot afford to—and still offer good care to these people." Of those homes who do accept medicaid patients, a number are reported to have separate "medicaid beds." The implications here are obvious: the medicaid patient does not receive the quality of care that the other patients receive.

If the interim regulations are allowed to stand as they are, where will that place the medicaid patient who is on the low end of the pole as far as nursing services are concerned right now?

"Reality" and Standards

Much has also been said about the necessity to hold down standards because of shortages of skilled nursing homes and of nurses. This is known as being "realistic."

I would be very happy if we could introduce a little reality into these hearings in terms of factual information concerning the population of elderly persons residing in nursing homes today, the kind of care they are receiving, and the kind of care they should receive.

We know that the nursing home population is made up of what are called the older aged; that is, individuals 75 years of age and older and that this age group consumes much of our health, hospital, and nursing costs. In addition, the nursing home population is a heterogeneous group of individuals. Some patients need total care; some require help with medication only; others are terminal and have gone to the nursing home to die; while there are many who could be prepared for a return to the community or at least more independent living in a semiprotected environment. But there is one thing the nursing home population has in common—all of these individuals are sick; they need nursing services, medical services, and oftentimes they need psychiatric services.

It is obvious that the problem will not be solved by calling facilities skilled nursing homes when they offer little or no nursing services and are not homes. This will only obscure the problems.

We will be realistic when we stop labeling facilities skilled nursing homes when we know they are not, when we stop paying public funds for services which are not being delivered but we tell ourselves they are, and stop telling ourselves we are serving patients by placing them in institutions that are inappropriate to their needs.

Until we begin to be realistic in these terms, patients will suffer and public money will be wasted. With more than $1 billion every year of

Federal tax collections being spent on nursing homes, it is the duty of Congress and of HEW to see to it that the patients who use these facilities receive the quality of care we all pay for.

Because of the implications raised by the new standards, I have urged each of our witnesses to comment on the interim regulations.

However, our overall purpose here today is to begin to explore a broad range of subjects related to long-term care—the beginnings of a subcommittee study on "Trends in Long-Term Care"—which will take several months to complete.

Some of the subjects I would like to examine briefly today are: new techniques to improve care and to emphasize rehabilitation, advanced building methods to reduce costs and provide more attractive and functional surroundings, the place of the long-term care institution in the development of comprehensive health care facilities for communities and regions, the need for trained professionals and nonprofessionals, the effects of the development of chain facilities, methods of keeping costs to a minimum, and improvements in Federal programs related to nursing home construction or operation.

That is admittedly a large order, and we will go into much of this in depth during subsequent hearings to be held later this year.

No Industrywide Indictment

Before we begin, I would like to make clear that I do not mean to denigrate the nursing home industry. This subcommittee is aware that there are many homes across the country who are offering the finest care, along with some very innovative rehabilitative and therapeutic programs.

So with that we will begin today. Let me say that we have a long list of very competent witnesses who are going to appear before us today and I appreciate their coming, every one. Because of the number that we have and the problem that we are going to have on time, I would ask witnesses to be as brief as possible. All I think have filed a written statement and of course they may, if they wish, read the written statement.

If the witnesses would care to do so, it would be perfectly appropriate to put the full statement in the record and make a summarization of the statement pointing out the areas of emphasis that the witness wishes to make. If we do that, I would urge that it be done succinctly and not really lengthen the performance by having the comment longer than reading the text of the paper.

I appreciate the great work and thought that have gone into all of these statements that have been prepared and certainly we want them fully in the record for the full committee to study and the staff to analyze for us. If the witness wants to make a summary and point out to the Chair things that he wants to emphasize, it might be helpful and might move us along a little bit more quickly.

I see that we have 12 or 13 witnesses—well, more than that because some of them consist of two or three people on the panel. We have appearances of at least 13 different groups here today. We want to hear as fully as we can all that we can get into the record.

STATEMENTS OF THOMAS LAUGHLIN, DEPUTY COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; AND JOSEPH HUNT, COMMISSIONER, REHABILITATION SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY STERLING B. BRINKLEY, M.D., CHIEF MEDICAL OFFICER

Our first witness then will be Mr. Thomas Laughlin, Deputy Commissioner, Medical Services Administration; and Mr. Joseph Hunt, the Commissioner of Rehabilitation Services Administration, U.S. Department of Health, Education, and Welfare.

I am very pleased to have the Commissioner and Deputy Commissioner with us. We look forward to hearing your testimony now.

Mr. LAUGHLIN. Good morning, Mr. Chairman.

Senator MOSS. Commissioner Martin is here, too. I did not mean to overlook him.

STATEMENT OF MR. LAUGHLIN

Mr. LAUGHLIN. I am Thomas Laughlin, Jr., Acting Commissioner of Medical Services Administration since last Friday when Dr. Francis Land submitted his resignation as Commissioner. Before assuming this position I was Dr. Land's deputy. The statement I am about to read was prepared for Dr. Land. I will endeavor to the best of my ability to substitute for him and to answer any questions you may have.

I welcome this chance to appear before you to discuss some aspects of the medicaid program. It comes at a time when the Department is reviewing the program to improve it and I look forward to several helpful changes.

The Social and Rehabilitation Service received with wholeheartedness approval the 1967 social security amendments that required both the Federal Government and the States to provide closer supervision of long-range care institutions that are home for an increasing number or our aged citizens at one time or another. I need not review these amendments now. Those who wrote them reviewed many aspects of nursing home care and throughtfully set standards for their physical characteristics; for the quality and amount of the nursing care required; for the suitability and adequacy of the food served; for the completeness and continuity of medical records; for the availability of more comprehensive medical care when needed; and for the need to know who owns them; and to license their administrators.

As is a matter of record, interim policy implementing section 1902 (a)(28) of the Social Security Act was published in the Federal Register on June 24, 1969. That section of the 1967 amendments requires that skilled nursing homes receiving payments under a State's medicaid plan must meet standards of fire and safety protection, sanitation, environment, and personal and medical services.

Another amendment that requires the licensing of nursing home administrators has also been implemented. The Social and Rehabilitation Service has developed and distributed a model licensing law and 19 States have already established licensing programs. Before passage of

the amendments only two States had licensure laws. We are confident that all States with medicaid programs will fulfill their obligations in this regard by the deadline date of July 1, 1970.

Three Categories of Care

The 1967 amendments also broadened the range of federally supported care available to the elderly by recognizing intermediate care facilities. Many standards for all three long-range care facilities—intermediate care facilities, skilled nursing homes, and extended care facilities—must be equally comprehensive and protective. High standards for conditions relating to fire protection, safety, environment, and sanitation apply to all. But the personal and medical care required by the people in each of these institutions must dictate the essential characteristics that make them differ—that make one institution an intermediate care facility and not an extended care facility, and make another a skilled nursing home and not an intermediate care facility.

Just as an individual's needs determine which home he should live in, it is the kind of care given that distinguishes one facility from another.

Thus, in thinking about the care to be given in a skilled nursing home, we were guided by the idea that there should be distinctions in service between a less medically oriented facility and a more medically oriented facility. We were guided by the comment of the Senate Committee on Finance:

> It is understood that, in general, the type of care rendered by skilled nursing homes under title XIX is not identical to the extended care provided under title XVIII. Title XIX care tends to be long term care, while title XVIII is designed for care of a more intensive and relatively short-term nature. In this context, therefore, the committee expects that the Secretary and the states will not seek to impose unrealistic requirements upon title XIX skilled nursing homes.

The definition of a skilled nursing home in supplement D of the Public Assistance Handbook, issued in 1967, required that the nursing service be in charge of a registered nurse and that charge nurses on other shifts be at least licensed practical nurses qualified by training at a State-approved school of practical nursing or by experience plus another type and amount of training approved by the State agency.

At the time this definition was issued in 1967, it was realized that there was a shortage of licensed practical nurses fully qualified by training and that many practical nurses were licensed by waiver. It was also clear that training opportunities for practical nurses licensed by waiver were very rare and that there was need to mount a full-scale training program.

1967 Training Effort Fails

But, the training program envisaged in 1967 never materialized. In the first place, the Department never provided the ingredient essential to the development of such a program—money. In addition, other aspects of a training program were never clarified. There was little agreement, for example, about the curriculum to be covered. There was great disagreement about the number of hours of training it should take to bring a licensed practical nurse who is not fully trained up to the level of a licensed practical nurse qualified by

graduation from a State approved school. Estimates for the time required for such training ranged from 60 hours to 1,600 hours. Thus, for a variety of reasons, it is now no easier for a practical nurse licensed by waiver to upgrade her training than it was in 1967.

The interim regulation on standards for skilled nursing homes published in the Federal Register on June 24, 1969, extends the deadline for the employment of practical nurses licensed by waiver as charge nurses until July 1, 1970. The regulation also provides that after July 1, 1970, practical nurses in charge of the nursing services during all shifts must meet, at least, the minimum requirements previously specified.

I am aware of the disappointment felt in many quarters that the Social and Rehabilitation Service found it necessary to extend the period during which a practical nurse licensed by waiver may function as a charge nurse. I am aware also that many people believe that an extension granted once is easier granted again.

The effort to establish a training program in 1967 to upgrade practical nurses licensed by waiver did not make a dent on the problem. With the knowledge born of experience though, we envisage a greater thrust from now on. The press release issued on June 24, 1969, when the interim regulations describing the standards to be met by skilled nursing homes were published in the Federal Register, said:

> With all the resources at the command of the Health Services and Mental Health Administration, the Department is launching a program to accomplish this.

At this time, the Health Services and Mental Health Association is investigating the many aspects of the implementation of a supplemental training program for practical nurses that will provide the States with a supply of fully qualified practical nurses by the July 1, 1970, deadline. The source of necessary funds is, of course, one facet being looked into.

Deadline on "Waivered" Nurses

Our decision to extend the deadline for nurses licensed by waiver was primarily based on the delay in a training program but it had other roots as well. You are all aware that the country suffers from shortages of health personnel of all kinds—physical therapists, practical nurses, registered nurses, physicians. Secretary Finch has on many occasions underscored the urgent need to retain the services of every individual now in the health professions and to attract new people to it. Others urge us to develop new careers to encourage people on the lower rungs of the professional ladder, to provide job mobility for individuals by arranging opportunities for inservice training and educational leave.

The importance of making allowances for equivalent training is being particularly stressed. In the absence of opportunities for training that would allow practical nurses licensed by waiver to qualify for responsible positions, we are negating our instructions and responsibilities, and aggravating the shortage of health personnel if we declare individuals who have filled responsible positions ineligible for those positions.

I would like now to turn to the problem of the ratio of charge nurses to patients. In early drafts of our regulations we had included a requirement that established such a ratio. Discussions with other government agencies revealed that the ratio we set could have resulted in more stringent staffing requirements for skilled nursing homes than for extended care facilities and that this was not supportable.

Further research disclosed that the Joint Commission on Accreditation of Hospitals does not recommend ratios for extended care facilities, nursing homes, or resident care facilities. It has become clear to us that no practicable way has yet been found to establish a ratio as a national standard. We have, therefore, published our regulation without a ratio of supervising nurses to patients and believe it wiser to do this until such time as staffing experts can find a basis for a recommendation.

In concluding my statement, I want to point out that, as is customary with all regulations that cross the lines of interest and responsibility of several public and private agencies, the interim regulation governing skilled nursing homes was discussed with many people. The American Nursing Home Association and the American Association of Homes for the Aging were consulted at several stages. Comments received from State departments of health and welfare were considered.

Opinion Sought on Regulations

Since publication in the Register several weeks ago, and here again I digress from the prepared statement because in the past few days we received more comment. We now have 29 letters that have been received with comments about the regulation. They reflect differences of opinion on the new regulation. Organizations polled by the Advisory Commission on Intergovernmental Relations, with one exception, approved or had no comment on the policy.

I will be happy to attempt to respond to your questions.

Senator Moss. Thank you, Mr. Laughlin, for your statement. I do have two or three questions I would like to ask.

On page 6 you say that:

> We have therefore published our regulation without a ratio of supervising nurses to patients and believe it wiser to do this until such time as staffing experts can find a basis for a recommendation.

Who are the staffing experts?

Mr. Laughlin. Frankly I don't know, Senator Moss. Perhaps this committee can give us some aid in this regard.

Senator Moss. Well, the thrust of your statement was that there just was not any way to fix a ratio, and yet if there are such things as staffing experts I wondered why they were not consulted earlier rather than later.

"Greater Thrust" for Training?

Your statement seems to suggest that the Department of Health, Education, and Welfare will provide "greater thrust from now on"—I think those were the terms you used—on programs to help waivered nurses to increase training opportunities. Exactly what do you propose to do?

Mr. LAUGHLIN. The responsibility for mounting a training program for the upgrading of the practical nurses licensed by waiver has been assigned by the Secretary to the Health Services and Mental Health Administration, and as I said in the statement they are studying the aspects of getting this thing mounted. We are trying to determine the parameters of the problem, exactly how many of these licensed nurses require this training, but to date our data is incomplete.

Senator MOSS. Is this just a broad proposal that has not been implemented yet? You have not set up any training centers or anything of that sort.

Mr. LAUGHLIN. That is correct.

Senator MOSS. How long is the study going to take to know what to do?

Mr. LAUGHLIN. I don't know, sir.

Senator MOSS. According to the press, the Social and Rehabilitation Service established an ad hoc committee to review the interim regulations published in the Federal Register for June 24. When will this committee offer its recommendation and what will the Social and Rehabilitation Service do if they find deficiencies in the regulation?

Mr. LAUGHLIN. Senator, the committee has not met. We had planned an early meeting of the committee but in view of the present hearings being held by this committee we have deferred the meeting until such time as we can get the results growing out of this hearing today. Tentatively the first meeting of the first committee is scheduled for August 14.

Senator MOSS. The 14th of August is the tentative date for the committee to meet.

Mr. LAUGHLIN. That is correct, sir.

Senator MOSS. You are hoping that the hearings will bring forth information and comment that will aid that committee.

Mr. LAUGHLIN. That is exactly correct, yes, sir.

Senator MOSS. Now what about the other part? Suppose the committee then does find serious deficiencies in the regulations, what will be the procedure?

Mr. LAUGHLIN. The committee will recommend changes in the policy to Miss Switzer and to the Secretary.

Senator MOSS. But the committee, of course, has only power of recommendation, it does not have any final vote on the problem.

Mr. LAUGHLIN. That is correct.

MEDICARE AND MEDICAID DIFFERENCES

Senator MOSS. Now, you pointed out that the Finance Committee, in its report, indicated that skilled nursing homes under title XIX were not identical to the extended care provided under title XVIII. I am sure you know that many people in the field dispute the contention that skilled nursing home care under XVIII is different from that under XIX. When skilled nursing home care is needed by a sick person, it must be of high quality and rendered by a competent staff. What differences do you see in treatment afforded by medicare and medicaid in skilled nursing homes?

Mr. LAUGHLIN. Well, as I stated in the statement, Senator, we look upon the title XIX as long-term care for patients who come to us and

stay for extended periods, sometimes several years. The thrust of the extended care facility provision is to provide a posthospital convalescent benefit. Normal length of stay in these facilities is somewhat less than 30 days, I understand.

Senator MOSS. Well, is there really any difference then in the type of care these people need? Every patient has some difference, I know, but they are all people who were ill in some degree and need some nursing care and supervision, isn't that right?

Mr. LAUGHLIN. That is correct. We do see some differences, granted that the level of care in both instances must be of high quality. The care in an extended care facility we would think would be of a more intense, short-term nature than the care given in a skilled nursing facility.

Senator MOSS. Do you think that the title under which they happen to fall can make that distinction in the type of nursing care?

Mr. LAUGHLIN. Perhaps not.

Senator MOSS. How often have you consulted with the Medical Assistance Advisory Council about the June 24 regulations and what is the council's position on the regulation?

Mr. LAUGHLIN. The Medical Assistance Advisory Council has not met since these regulations have been published.

Senator MOSS. You have not had any opportunity to consult with them?

Mr. LAUGHLIN. We have not.

Senator MOSS. You have no knowledge whether they have a position or an opinion?

Mr. LAUGHLIN. I do not.

INDUSTRY AIDE "CONSULTED" ON REGULATIONS

Senator MOSS. A statement by another witness here that will be heard today quotes the newspaper account which asserts that, "A paid representative of the nursing home industry actually participated in the revising of these standards to their liking."

I have seen the same clippings and I wonder if you would like to comment on that.

Mr. LAUGHLIN. There has been quite a controversy on this matter in the press over the development of these policies. I would say so far back as last year and this year, too. We did consult with a gentleman who was a consultant to our administration and also a consultant to the American Nursing Home Association. He did consult with us, yes, sir.

Senator MOSS. Did he assist in the revising of the regulations?

Mr. LAUGHLIN. We consulted with him on it, sir. The revising and the writing of the document was done by our staff.

Senator MOSS. But after consultation and advice from this representative?

Mr. LAUGHLIN. Well, we received advice from him as we did from many, many other people, sir.

Senator MOSS. Was he simultaneously consultant to the Department and also to the Nursing Home Association?

Mr. LAUGHLIN. He was.

Senator MOSS. You have undoubtedly heard assertions that the establishment of an intermediate category of nursing homes will

result in a tendency on the part of the skilled nursing home administrators to dump certain patients, including those whose medicaid payments have been exhausted, into the intermediate care facility. Do you share this concern?

Mr. LAUGHLIN. I certainly hope that this does not occur.

Senator MOSS. Well, we all hope it does not occur, but are you concerned that it is likely to occur?

Mr. LAUGHLIN. Well, I would not say so. No, sir.

Senator MOSS. Is there any way to be assured that it will not?

Mr. LAUGHLIN. The regulations that we are about to issue with respect to medical review of the quality of care given in the skilled nursing home and also the medical evaluation of the patient that is to be done for those persons in the intermediate care facility, both of these responsibilities will be that of a single State agency. We would expect that they would take the necessary steps to assure that this does not happen.

Senator MOSS. You depend on the States to take appropriate steps to prevent this dumping?

Mr. LAUGHLIN. Yes, sir.

Senator MOSS. Senator Fannin, do you have any questions or comments?

Senator FANNIN. Mr. Chairman, I do.

STEPS TOWARD IMPLEMENTATION

Mr. Laughlin, we have experienced considerable difficulty and I think on the finance committee we have had many problems brought to our attention. Now with the new interim regulations do you feel that the plan for implementation is in proper order? I am concerned about this. Although we have had a change in the regulations, are we going to have proper implementation?

Mr. LAUGHLIN. We expect so, yes, sir.

Senator FANNIN. Do you want to outline just how this will be accomplished?

Mr. LAUGHLIN. I don't follow your question.

Senator FANNIN. How will this be accomplished? In other words, you are setting this up and you say that it is the responsibility of HEW to go forward with the implementation of these new regulations and the complete overall program.

Mr. LAUGHLIN. Yes.

Senator FANNIN. What change has been made as far as the supervision and the implementation, as I said before?

Mr. LAUGHLIN. By the nature of our program, Senator, we have a State-administered program. These regulations when once published become the responsibility of the State agency to implement them. Our Department follows up and monitors the operations of the State to assure that they are indeed implementing the regulations.

Senator FANNIN. That is why I asked the question, because in the case of the intermediate carriers we had this problem. I realize that this does not pertain to the exact question at hand, but that has been our great problem so far as our overall program is concerned. We have not had a followup, we have not had the necessary close supervision in that field. Now that is why I am concerned as to just what is going to happen.

Here you have your new provisions and requirements that perhaps are going to assist a great deal if they are administered properly, but if they are administered as loosely as some of the other programs in which we have been involved, and especially on which we have had our hearings, then I am vitally concerned because we just have not followed through, the proper authorities did not follow through as intended.

ADDITIONAL SURVEILLANCE FORESEEN

Mr. LAUGHLIN. The Secretary has made several statements to the effect that he plans to augment the staff of the Medical Services Administration both in the central office and in the field in the regional offices so that this additional surveillance effort can be made and so that we can indeed followup on many of these regulations which are being implemented.

Senator FANNIN. But the staffing needs still present quite a problem, do they not?

Mr. LAUGHLIN. They do, indeed.

Senator FANNIN. What do you need most to increase opportunity for more professionally trained personnel?

Mr. LAUGHLIN. What do we need most?

Senator FANNIN. Yes. I am not just talking about money alone. Do you need some program that would assist in this regard?

Mr. LAUGHLIN. Not especially. I don't really understand your question.

Senator FANNIN. What is your plan to obtain more professional personnel?

Mr. LAUGHLIN. First, of course, we must obtain the proper authority from the Bureau of the Budget and from the Congress to hire the additional people and then we must go out and search for the trained medical care administrators and other medically oriented people who can work with the State agencies to help them improve the administration of their programs.

Senator FANNIN. What is there provided in this program that that will give greater incentive, for instance, at the nursing home level? We know that that is where the breakdown exists. Of course it breaks down just because there has not been a liaison, as I understand it, from the top level to supervisor spot. So I think many of our difficulties are the result of lack of supervision or lack of any check on what is actually being done.

Mr. LAUGHLIN. Yes, sir. We feel that with the additional staff which is planned for our offices, both here in Washington and in the regions, we can accomplish this.

Senator FANNIN. And you feel that the provisions that you now have where new standards have been set, or temporary standards have been set for newer intermediate regulations, that we would rescind the former regulations that are insufficient to carry out this program?

Mr. LAUGHLIN. If you take these new standards that we have established in their entirety, Senator, we feel that they are a great step forward, that there are many items contained within the new regulations that were not covered in the previous handbook definition of a skilled nursing home and that if these items specified in the new regulations are indeed carried out that this will greatly improve the quality of care in skilled nursing homes.

Senator FANNIN. Of course we are concerned about the quality of care. Then, of course, there is a vital concern about the cost involved because we have a great problem as far as the State is concerned. Of course as far as the Federal Government is concerned, we want to implement the most adequate program that we can possibly have and still keep it within the budget that would be available. We all realize that many of the States are having the great problem of keeping the programs underway and properly administered, properly financed. So I just hope that we can take into consideration all of these problems that have been brought about previously by the lack of proper administration.

No further questions, Mr. Chairman.

Senator MOSS. Thank you, Senator Fannin.

Mr. Laughlin, in your statement you quoted from the report of the Finance Committee about the difference between requirements under title XIX and title XVIII, and I have looked that up in the report. I think that to make the record complete we perhaps should have part of the following paragraph which reads as follows:

> In particular, requirements relating to nursing personnel other than the requirement of a full-time registered nurse on the staff of the institution should give due recognition to shortages of such personnel where such shortages exist and determine needs for other nursing and auxillary personnel on a realistic basis consistent with the actual needs of the types of patients in a particular institution. Such an approach is not intended, however, to excuse or permit continued understaffing.

That last sentence, it seems to me, is the key here, that this should not be used as an excuse for understaffing.

Mr. Oriol of the staff, do you have any questions?

Mr. ORIOL. Just one question, Mr. Chairman.

SURVEY STATISTICS SOUGHT

In the preparations for this hearing committee staff met with representatives of the Medical Services Administration to discuss ways of getting statistical information about nursing homes of the United States and we were told that you recently conducted a very extensive survey to get the most comprehensive information we have yet had on nursing homes. I find no reference to the survey in your testimony. I believe there is going to be an attempt for this hearing to give us data on at least selected States.

Mr. LAUGHLIN. Mr. Oriol, the reason this was not put in the testimony is that the information that we received so far is incomplete, it is inconclusive, it is not comparable between States; it is very rough, it is raw. We are going to have to go back to the States and define it and get it in better shape. Once we have done that, we will be happy to provide that to the committee.

Mr. ORIOL. Actually your administration has very little comprehensive data related to the nursing home industry of the United States.

Mr. LAUGHLIN. Yes, sir.

Mr. ORIOL. What has the survey already shown you about the ownership of nursing homes? Have you detected any trends there?

Well, what do you find that the State agencies responsible for licensing nursing homes now know about the ownership of nursing homes?

Mr. LAUGHLIN. I cannot respond to that question, Mr. Oriol. I will have to give you a statement on this at a later date if I may.

Mr. ORIOL. I think we would like to have that.

Senator MOSS. Yes, I would like to have that furnished for the record, please.

Mr. LAUGHLIN. Be happy to do so.

(The material referred to follows:)

You asked what we have learned thus far from the survey on ownership of skilled nursing homes, requested by the Senate Finance Committee.

The survey asked for the name of every person having an ownership interest of 10 percent or more in each skilled nursing home, the names of all officers and directors for homes organized as corporations, and the names of all partners in homes owned in partnership. We have completed tabulating, to date, the returns from 30 States reporting on 2,122 skilled nursing homes. Here is the ownership breakdown:

	Percent
Corporations organized for profit	58
Individual ownership	13
Nonprofit corporations	9
Church affiliated	7
Government owned	7
Partnerships	6

The 58 percent of homes organized as corporations for profit do not necessarily involve multiple ownerships. Many of the smaller homes in this category doubtless are individually owned, and the officers of these corporations do not necessarily participate in the ownership.

Returns from 29 States, reporting on 1,903 skilled nursing homes, show that approximately 10 percent of the homes list one or more physicians among the owners and officers. The actual number of physicians who are owners or officers of nursing homes may be greater than our tabulation shows. The only indication on the ownership lists that an owner or officer of a home is a physician is the degree after his name. Since the inclusion of the degree is not a requirement, it may well be that the number of physician owners and officers is understated in this tabulation.

You asked whether State agencies responsible for licensing nursing homes are informed regarding the ownership of the homes in their State. From the lists submitted it is clear that the States are well informed as to the owners of homes and the officers of corporations. Our information does not indicate, however, whether the States have in their files any additional data on the owners and officers listed.

You inquired, also, whether we detected any trends in nursing home ownership. Since the survey was limited to eliciting the information mentioned above, it is not possible to project any trends from the data on hand.

PROBLEMS IN RURAL AREAS

Senator FANNIN. Mr. Chairman.

Senator MOSS. Senator Fannin.

Senator FANNIN. We have had continuous complaints from the rural communities, the isolated communities, that they have a very difficult time abiding by some of these regulations. Naturally we want to keep the quality of the staff as high as possible, and at the same time we want to be sure that service is available for the people that are in need. Do you have any ideas as to what could be done in that regard? Without going into the quality of the service, do there tend to be any changes made and stipulations pertaining to these nursing homes in isolated areas?

Mr. LAUGHLIN. Senator, we feel that the regulations we have issued here are the minimal regulations that you can issue and still provide skilled nursing care.

Senator FANNIN. Well, in some instances we find that the nursing homes will be closed if they do not have some time or at least some consideration. I realize the time in the area that we have, the inner period involved, and some of these regulations are not applicable for some period of time.

Mr. LAUGHLIN. Yes, sir, but also in the accompanying legislation was the provision that homes of this type could qualify as intermediate care facilities in all probability and continue to provide needed service in these communities of a level somewhat less than that of a skilled nursing home.

Senator FANNIN. I think that is important because we certainly want to provide the services. At the same time we naturally want to keep the standards as high as possible, but to make the same requirements on some of these homes in isolated areas of rural communities makes it extremely difficult.

Thank you, Mr. Chairman.

Senator MOSS. Thank you.

Just one more question about the genesis of these regulations and the general question about consultations with the official who was also a consultant to the nursing homes. I have here a copy of the minutes of the meeting of the Committee of State Officials which I understand was participating in the development of these standards. The meeting was on January 13 and 14 of this year.

These minutes would indicate that on January 13 the committee reviewed the standards which they had helped to develop in earlier meetings and were under the impression that your agency was considering.

Then the next day the committee was told the draft they were working on was withdrawn and they were presented with an entirely new draft which, according to these minutes, was written the night before.

Could you tell us just what happened during this period where apparently there was this very abrupt and unexplained change in your agency's thinking on the standards?

CHRONOLOGY ON STANDARDS

Mr. LAUGHLIN. Yes, sir. In the early part of January this document to which you allude was reviewed by the deputy administrator of the Social and Rehabilitation Service who advised Dr. Land, the commissioner, that they were too detailed, too lengthy, and we would have to revise them and tighten up the language and made the document more concise and precise.

On Monday, I believe it was January 13, we got a group of our staff together and did work late into the night and produced another draft which was considerably less lengthy in its scope. This is how this came about.

Senator MOSS. And they were drafted overnight between the two dates then, the 13th and the 14th?

Mr. LAUGHLIN. That is correct, yes, sir. It was done on a Monday and Monday night.

Senator MOSS. And was this conference the one that was participated in by the man who was a consultant to the Nursing Home Association?

Mr. LAUGHLIN. We did discuss the matter with him. I cannot recall the exact date, Senator, sometime during that week. He did not write the document.

Senator MOSS. How much before? Would that be around the 9th or the 10th that you consulted with him?

Mr. LAUGHLIN. No, sir. He was not consulted until the week of the 13th, the exact days I cannot recall.

Senator MOSS. Now who were the staff people present at the meeting when this redrafting was done?

Mr. LAUGHLIN. The staff people present during the redrafting were Dr. Kerr, Mr. Milton DeZube, Mr. Charles Cubbler, and myself.

Senator MOSS. Just four of you working on the draft?

Mr. LAUGHLIN. That is correct. We did consult with Mr. Harold Smith later in the week.

Senator MOSS. Well, you said that the regulation was in much detail before. Was there a considerable or major change made then in this redrafting?

Mr. LAUGHLIN. Yes, sir. I think the document was changed something on the order of about 40 pages down to something of about 13.

Senator MOSS. Did you tell me that this came in part or wholly on the recommendations of this official, the consultant of the American Nursing Home Association?

Mr. LAUGHLIN. I did not say so.

Senator MOSS. Where did the recommendation come from?

Mr. LAUGHLIN. What recommendation is this?

Senator MOSS. To redraft it between the 13th and the 14th.

Mr. LAUGHLIN. The order to redraft it came from the deputy administrator of the Social and Rehabilitation Service, Mr. Joseph Myers.

Senator MOSS. This was not communicated to the group meeting on the 13th, was it?

Mr. LAUGHLIN. I don't know whether it was or not.

Senator MOSS. Thank you, Mr. Laughlin. We appreciate your testimony.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Senator MOSS. We will turn now to Mr. Joseph Hunt, Commissioner of Rehabilitation Services Administration. Mr. Hunt, if you would proceed.

STATEMENT OF MR. HUNT

Mr. HUNT. Thank you, Mr. Chairman.

My name is Joseph Hunt and I am the commissioner of the Rehabilitation Services Administration within the Social and Rehabilitation Service, an agency of the Department of Health, Education, and Welfare. Broadly speaking, our mission is to provide leadership and administer programs to assist the physically and mentally disabled to be restored to work and useful functioning within the community. Services are provided through a variety of programs authorized by the Congress in the Vocational Rehabilitation Act. These are mentioned in my prepared statement.

With the permission of the chairman, I will make available for the record if he wishes a more detailed summary.

My testimony this morning is given from the viewpoint of the special interests of the Rehabilitation Services Administration and of course all the cooperating State and voluntary agencies.

I must say that we find in the present situation a rapidly changing pattern of long-term care for the chronically ill and disabled due in large measure to the impact of medicare and medicaid. Home care programs, both hospital and community based, are developing in an increasing number.

Mr. Oriol. Commissioner, could you tell us what that increase is?

Mr. Hunt. Statistically?

Mr. Oriol. Yes.

Mr. Hunt. No, I cannot. In the rehabilitation program our statistical system does not report on nursing homes and the reason for this is, of course, a great deal of our work is done in hospitals and rehabilitation centers. Some of the things that are done in nursing homes are done in the rehabilitation centers, that of in-patient service, and there is quite a network of them although naturally not enough so there is need for good nursing homes for a number of the disabled people we treat.

Mr. Oriol. The reason I ask, you have greater emphasis in your statement later as to nursing home care programs, so I think it is important that we have as full a statistical description as is available.

Mr. Hunt. Mr. Oriol, we could on a test basis, I think, get some satisfactory estimates of these that would help the committee and I would be happy to do that.

(The following was supplied:)

In 1962, there were about 9,700 "homes" with 338,700 beds having the major purpose of providing skilled nursing care.

In 1968 there were 10,816 skilled nursing homes with 618,045 beds.

In 1962 there were less than 500 general hospitals with long-term or extended care units, in 1968 there were 1,208 of these units.

In 1968 there were over 2,500 home-care programs in the United States of which about 300 were hospital based. This development has for the most part occurred since 1962.

Mr. Hunt. Home care programs, both hospital and community based, are developing in an increasing number. In metropolitan areas these programs are becoming more comprehensive, including at their best the services of doctors, diagnostic services—laboratory and X-ray—visiting nurses, therapists, homemakers, health aides, home economists, and volunteers

Under our program there are a great number of facilities—of which 878 are listed as rehabilitation hospitals—that just would not tend to be referred to as nursing homes but the service that we would like to see in these homes are performed in these places. Of course we have a special problem that is different from the one that faces Deputy Commissioner Laughlin.

Use of the Rehabilitation Act

Extended care facilities offering more active and personalized services with professional supervision and staffing are also being constructed in greater numbers. This is being done under the authority of the Rehabilitation Act for a variety of facilities, by and large for taking care of the disabled. They are not for the long-term disabled but for persons that must be kept for the rest of their lives because the

rehabilitation program itself has a certain cutoff point even though it could be distant. For seriously disabled persons there is a point at which a decision has to be made.

Included are those facilities which are developing functional affiliations with general hospitals in order to encourage the appropriate placement of individuals according to their medical needs.

Mr. ORIOL. Commissioner, here again you mentioned great numbers of facilities having the functional affiliation with general hospitals. Could you give us an idea of the percentage?

Mr. HUNT. I think that I can probably give you for the record a reasonably accurate figure because there has become a fairly widespread use of this kind of affiliation in a variety of the States.

(The following was supplied:)

Virtually all skilled nursing homes (10,816) have transfer agreements with general hospitals to implement the flow of patients according to their need for care. Further investigation shows that relatively few nursing homes have fully developed formal affiliations with general hospitals or medical centers, but that the majority of free-standing rehabilitation hospitals either have or are developing such affiliations.

Mr. HUNT. I meant to mention before that I have with me Dr. Sterling Brinkley who is our chief medical officer and who has opportunity to go about the country and see some of these programs in action. Maybe later you might want to have some discussion with him on some of that.

Despite this long overdue and welcome activity, the quality of life for the great majority of persons in need of long-term care reflects poorly on the attention given to those afflicted by our society.

SRS RESEARCH PROJECTS

Research projects sponsored by the Social and Rehabilitation Service have identified a number of factors which bear on the utilization of nursing homes in the rehabilitation process:

Implementation of standards of facilities and staffing;

Clear description of the services provided;

Clinical supervision of patients;

Architectural barriers which restrict independent activities of patients;

Architectural barriers which decrease efficiency and economy of operation;

Safety factors relating to fire and injury hazards;

Programs which stimulate and motivate;

Social and recreational activities;

Continuity of care;

Involvement of families;

Involvement of community;

Long-range planning with each patient for optimum adjustment;

Disproportionate lack of facilities for minority groups;

More appropriate location of facilities.

Illustrative of these points are the following examples from three selected projects.

The first is Maine, a project of the Thayer Hospital to demonstrate the rehabilitation potential of patients on home care or in nursing homes found that there was a need for more careful clinical supervision of patients in nursing homes.

A study of 81 patients showed that 12 were incorrectly diagnosed. A patient in the nursing home for 2 years with a diagnosis of cancer of the nose was found to have nasal polyps. Fifteen had significant clinical episodes not reported to their managing physician—coronary infarct—21 were in need of more intensive care to regain abilities, 21 needed a change of prescriptions—a patient with mental confusion due to medications, relieved when drugs were discontinued—and 12 had unrecognized rehabilitation potential.

The following suggest some of the practices prevalent in this study: Steps in "old renovated" homes were difficult for the weakened, and the wheelchair patient to master. Sometimes the most orderly and clean homes had removed all personal memorabilia of the patient—family pictures, clothes, et cetera. The more passive and quiet the patient, or more regressed, the less attention given. Communal dining was nonexistent. Some nursing home administrators gave drugs on their own initiative to keep patients quiet. Lighting was poor for reading. No music was seen or heard. Relatives or other visitors were not welcome.

Second, in New England the Center for Continuing Education, North Eastern University, Boston, which made a study of the care of stroke patients in nursing homes, found that:

Patient motivation for improvement was apparently lacking in part due to passive acceptance and lack of expectation on the part of others. Only 50 percent of the homes were easily accessible; 64 percent had provision for privacy when visitors came; 27 percent had "OT," primarily games and crafts; 80 percent had no provision for physical therapy.

Third, the Illinois Public Aid Commission reported in a study of 1,674 patients in nursing homes that only 6 percent were under 60 years of age. The primary disabilities were heart disease, 15.6 percent; hemiplegia, 9.1 percent; arthritis, 7.6 percent; fractures, 8 percent; mental disorders and senility, 4.2 percent. Additional findings indicated that:

A lack of motivation toward independence was a major deterrent to improved functioning; too often the patient's family was not interested in having him return home, since this necessitated coping with his problems.

Discharges for the previous year showed that 50.9 percent died, 20.7 percent were transferred to hospitals, 5 percent were transferred to other nursing homes, and 19 percent returned to their homes. Nearly half of all persons now served in skilled nursing homes could be at home if they had welcoming families, or in boarding homes if minimum additional care were provided.

It is our belief that skilled nursing homes could have more significance in the rehabilitation process. Rehabilitation begins in the hospital, continues in the nursing home, if necessary, or in a less sheltered environment, and then follows the patient until he has achieved a satisfactory level of adjustment. We believe that all facilities and services involved in the care of long-term illness should be coordinated by functional associations and practices to ascertain that the patient is in the right place at the right time to receive what he needs.

For example, there are many of these associates, and Dr. Brinkley here I think was a party to a very fine association, Gaylord Farms,

an institution in Connecticut, with Yale University. If the chairman would like, Dr. Brinkley could describe that in some detail.

Expert Specialists Available

Nursing homes would enhance their usefulness if they called upon the expert resources from established service agencies of the State government, if they specialized in certain types of management. In so doing they could, through training programs and staff recruitment, including vocational counselors, develop the expertise needed to serve patients with conditions requiring special programs and do so on an economic basis. Examples of such specialization are:

Chronic hemodialysis, one to three times per week, 6 to 12 hours treatment, for patients with end-stage renal disease;

Detoxification and orientation of alcoholics;

Training and supervision of certain types of mental retardation;

Improvement of self-help skills;

Recreational and maintenance services for quadriplegics;

Nursing rehabilitation for adolescents;

Nursing rehabilitation for young adults.

Too often patients in nursing homes with long-term illnesses do not receive intellectual stimulation, thereby regress mentally, or unnecessarily develop contractures of joints, or decubiti thereby prolonging or limiting the degree of their recovery. This is, of course, a deterrent to any hope for successful rehabilitation.

While, as Senator Fannin pointed out, there is great need for nursing homes in the rural setting, many times these nursing homes are too often located there when they do not have to be located there. They are not located there always in order to take care of the rural population, they are there because of a variety of circumstances and they are too often located there, we think. It makes family participation from the cities, and so forth, inconvenient and they manage with difficulty or impossibility.

More facilities should be located in urban centers, hopefully ghettoes, individualizing their programs to the social characteristics of the persons served and utilizing the resources of the ghetto for manpower. Such resources could be utilized for health manpower training for training for services at nonghetto centers as well.

The location of nursing homes should also reflect the primary need of the patients. If the need is primarily medical, they should be located at or near hospitals or group practice clinics; if work evaluation, training, et cetera, at or near rehabilitation workshops; if education, at or near universities or community colleges.

20-Bed Minimum

Although small nursing homes, less than 20 beds, are said to have a "home-like atmosphere," there is a critical size with increments which is essential for quality of care and comprehensiveness and economy of operations. Therefore, Federal support from all sources—Small Business Administration, HUD, HEW—probably should limit support to facilities of 20 beds or more—increments of approximately 20 beds.

In the use of Federal funds for new construction, approval should depend upon compliance with State plans developed by health departments and vocational rehabilitation agencies. An overall plan

should be established and all official activities should be consonant with this plan. Facilities planning under Vocational Rehabilitation should be a prototype for this kind of activity.

Since most studies indicate that persons are deposited in nursing homes as often for social—situational—reasons as they are for medical reasons, social services with social adjustment plans for all patients, which became effective July 1, 1969, should be implemented. Such social services must include activities which reinvolve the family with the patient and other activities which would assure outward mobility.

Innovation should be encouraged by grant support: to develop a system for the care of the long-term illness, to test new approaches within the system once developed; to study alternatives to nursing homes, such as group housing, on a more organized, integrated basis, and community based services which would permit patients to live satisfactorily upon discharge from the nursing home.

The regional medical program, Office of Economic Opportunity, HUD, Small Business Administration, the various Regional Commissions, in addition to SRS have vital interests in this area. It is essential that their innovative programs supplement and complement each other to provide cohesive programs.

Thank you.

Senator Moss. Thank you, Mr. Hunt.

I certainly agree that we need programs which supplement and complement each other to provide cohesive programs.

Incorrect Diagnoses

On page 3 you describe the study in Maine of the Thayer Hospital and told of the patients that were incorrectly diagnosed and many other factors. Is this fairly typical or do you think this is unusual?

Mr. Hunt. My estimate would be that it is not too unusual because when you consider the situation in many of the homes you can have this kind of thing happen. Dr. Brinkley is somewhat familiar with what happened there and I am sure he is familiar with the institution itself. Dr. Brinkley here is our chief medical officer.

Senator Moss. Dr. Brinkley, could you answer that? Is this fairly typical?

STATEMENT OF DR. BRINKLEY

Dr. Brinkley. I could only say, sir, that I think it was typical of that area of Maine that was studied. I don't believe a great number of studies of this intensity have been done throughout the country.

Senator Moss. It is pretty shocking.

Dr. Brinkley. It is disturbing.

Senator Moss. On this study that was made in Illinois which concludes by saying, "Nearly half of all persons now served in skilled nursing homes could be at home if they had welcoming families, or in boarding homes if minimum additional care were provided," do you think that is fairly typical?

Dr. Brinkley. I think, sir, that if the families are accepting, a great number of patients in nursing homes could be handled at home with inconveniences to the family but nevertheless not any detriment to the patient.

Senator Moss. If the family would provide the essential needs, the person would be a lot better off at home than in any nursing home, would he not?

Dr. Brinkley. Well, it depends on the home, I am afraid.

Senator Moss. I say if they would provide the essential needs. Of course it would be more of a burden on the family and they would have to provide some additional services perhaps, but if we give them that why certainly he would be better off, would he not?

Dr. Brinkley. I think so.

Mr. Hunt. Several years ago Dr. Howard Rusk had made a study and I remember his saying a number of times that one of the things that came out of that study was that the recovery was much better when they went to the home where they were loved and accepted and encouraged to go ahead rather than those that continue to be institutionalized.

Senator Moss. Mr. Hunt, I am concerned about constructional barriers which restrict activities of patients. What do you mean, and please tell me more about your reference to "safety factors relating to fire and injury hazards."

Architectural Barriers

Mr. Hunt. Well, as the members of the committee know, last year there was an Architectural Barriers Act passed by the Congress to provide that architectural barriers had to be removed from Federal buildings and in all buildings that used Federal funds. We found throughout the country in the older institutions and even some of the newer ones an amazing amount of architectural barriers for wheelchair cases, for persons who cannot lift their legs very high with serious arthritis and serious back problems.

Senator Moss. This means steps instead of ramps?

Mr. Hunt. That is right. When you get inside these older homes you will find that there is a long hallway first and then the patient has to go up to another level to get to the back part of the home or the institution.

Senator Moss. So even if it is a single step, it is an architectural barrier for older people.

Mr. Hunt. It is tremendous. Let me tell you this. We put on a performance for NBC on architectural barriers. We brought over for the show the famous basketball player Junius Kellog, who is now a paraplegic, and was one of the Globetrotters. He said when Senator Robert Kennedy's body was lying in state at St. Patrick's Cathedral he tried to get in. He could not get up the front steps. There was a side step but he could not make it. He never got inside and he told the audience about his great disappointment.

We see this everywhere. The older the homes, the more you run into this. It is true that they can take care of some of these things with ramps, but as he explained even ramps have to be designed in a certain way because some ramps will not take the chair up. Architectural barriers are a very serious thing for the handicapped in this country. The American Institute of Architects has done a lot of work with us on this. Standard specifications have been issued, but despite this new buildings get put up with these barriers which are so difficult for heart cases and wheelchair cases and many others who are severely disabled.

Senator Moss. Particularly serious in an emergency situation, too.

Mr. Hunt. Yes, and with elderly people.

Senator Moss. Your statement says that too often patients in nursing homes develop bed sores. How prevalent is this and how is this avoided?

Mr. Hunt. I have my expert with me. I am sure he will be happy to describe it for you, Mr. Chairman, if you like.

Causes of Bed Sores

Dr. Brinkley. I cannot give you any sound figures on this but bed sores are a reflection of the amount of staff time per patient. In other words, to avoid a bed sore, a patient who cannot move himself, the patient has to be moved at regular intervals. If you have the nursing staff to do it, you avoid bed sores; if you don't, you get bed sores. It is as simple as that. I am afraid they are rather prevalent.

Senator Moss. You are afraid they are rather prevalent. You don't have any exact estimate on it?

Dr. Brinkley. I don't, no.

Senator Moss. Are these very painful and annoying?

Dr. Brinkley. On a paraplegic, for example, they are not painful because he has no sensation of pain below the level of the injury. But they are usually infected and may go down to the bone and cause infection of the bone as well and actually are one of the most frequent causes of death in this type of disability.

Senator Moss. Mr. Hunt, your statement says, "Extended care facilities offering more active and personalized services with professional supervision and staffing are also being constructed in greater numbers." I would like a few more details, if you could give them to me, on this trend. I especially would like information about the services offered in so-called chains of extended care facilities that are now causing so much excitement in the stock market and elsewhere.

Dr. Brinkley. On the chains themselves we have seen how the chains are fitting in very effectively in some areas. For example, at Boston University the Medicenters of America system is fitting into the medical complex there and apparently doing an excellent job. It looks to me as though the concept of chain development is a good, sound development and one where there is competition which is always good.

"Chain" Operation

Senator Moss. Do you think that this is really a movement toward getting a better type of services for the long-term care patient?

Dr. Brinkley. Yes; I do.

Senator Moss. And is this based on the theory of better centralized management to put into effect various progressive types of improvement?

Dr. Brinkley. It is the supermarket approach compared to the corner grocery store type.

Senator Moss. Is this because our nursing homes just sort of grew up like Topsy? When a person had a large house and did not know how to utilize it, one of the ways he determined to utilize it often was to make a nursing home out of it?

Dr. BRINKLEY. I think that has happened; yes.

Senator MOSS. And you think that the chain approach is now moving away from that and producing a more functional type building with proper facilities?

Dr. BRINKLEY. That is right, where they are needed. And they will, of course, be the kind of place to which doctors will wish to refer their patients.

Senator MOSS. That is the competitive factor.

Dr. BRINKLEY. Right.

(The following was supplied:)

Medicenters of America now operate 31 facilities (soon to be increased to about 100) for pre- and post-operative care, while a related program known as Manor Care presently operates 8 facilities for extended care and rehabilitation staffed with registered nurses on a 24-hour basis, registered physical therapists and licensed practical nurses.

Senator MOSS. Senator Miller, do you have any questions or comments?

Senator MILLER. Thank you, Mr. Chairman.

Mr. Hunt, two questions. On page 2 you list a number of factors which have been identified. You do not list the factor of State legislative action. Would that be regarded as a major factor in this?

Mr. HUNT. State legislative action?

Senator MILLER. Yes.

Mr. HUNT. I would think so.

Senator MILLER. Have you done any research?

Mr. HUNT. I could not speak definitely on it. I would think so as a personal opinion.

Senator MILLER. Because if the State legislatures do not respond appropriately to the regulations we could have lack of facilities, lack of care, could we not?

Mr. HUNT. You could. Of course you could have unsupervised standards and unmonitored standards. It depends upon the strength of the monitoring agency in the State and also depends upon the strength of the authority in the statutes. For example, in architectural barriers we now have a fine Federal law. We have a number of States that have passed a barriers law but the enforecment sometimes is mild.

STATE MATCHING MONEY

Senator MILLER. In the same connection I was thinking of State money needed to finance or to match Federal funds for title XIX coverage. If the State does not appropriate adequate money, then we are not going to get the services we wish either, are we?

Mr. HUNT. That is right.

Senator MILLER. So perhaps equal to or greater than the program is the money side?

Mr. HUNT. It is a very important part of it. Very important, very significant.

Senator MILLER. Yes. Do you have any observations on how the State legislatures are coming along on appropriating the moneys needed to enable us to attain the objectives that we envision in this basic law?

Mr. HUNT. This has to do with title XIX?

Senator MILLER. Yes.

Mr. HUNT. Yes. My responsibility does not go to title XIX. I am the Commissioner of the Rehabilitation Services Administration. Mr. Laughlin here testified for title XIX.

Senator MILLER. I am just interested in what other factors there might be. It seemed to me that the factor of State legislative action regarding money would be an important factor. Now if we can get a later witness to go into that aspect of it, I would not want to take up your time.

Mr. HUNT. I would not be able to answer on that.

Senator MILLER. Now on staffing, do you have any comments regarding the need for training more personnel, especially nurses, in order to accommodate the staff you need?

Mr. HUNT. My view is there are a great number needed but the testimony on that has been given or would be given by another witness who represents the medicaid program.

Senator MILLER. You have an example in your testimony on page 3 and that example indicated that there was a lack of appropriate staffing.

Mr. HUNT. That is right.

OPTIMUM STAFFING REQUIREMENTS

Senator MILLER. I do not believe that the kind of staffing by category was held up; for example, whether you needed more registered nurses, licensed practical nurses, or technicians—just why there was not the adequate staffing there. You have actually presented the need for staffing. The question is, what could be done about it?

Mr. HUNT. We have a copy of that study here. If you will permit me to ask Dr. Brinkley whether or not he recalls from the study of this as to whether or not it makes recommendation with regard to the appropriate staffing of nursing homes. I suspect it would.

Senator MILLER. I do not wish to belabor this point and delay the committee any longer. If you would pull that out and supply it for the record at this point, I would ask that you do it, Mr. Chairman.

Senator MOSS. Without objection.

Mr. HUNT. We would be happy to do that, Senator.

(The material referred to follows:)

Among the suggestions for more adequate care in skilled nursing homes are the following items:

1. Size of nursing units—most efficient units permitting optimum staffing have from 20 to 30 beds.
2. The optimum numbers of nurses to patients varies according to the requirements for care—the range being from 0.2 to 0.7 nurses per patient.
3. Special duty nurses can be utilized to care for more than one patient under usual circumstances (contrary to practice).
4. Family members can substitute for nursing personnel in many situations.
5. Volunteers can enhance the quality of life in nursing homes, reading to patients, playing cards with them, fixing hair, writing letters, etc.
6. Where there is a nursing shortage, day care centers would permit many nurses or aids to work if their children were well cared for.
7. On the job training should be provided for unemployed or unskilled persons.
8. Homes should be located in areas which can be reached by public transportation or homes should provide transportation for those employees who need it.

Mr. ORIOL. In this Illinois Public Aid Commission study it said that 8 percent of the elderly in the institution had mental disorders and

senility. There are two questions. Is senility used interchangeably here with chronic brain syndrome? The second point, according to an NINH study in 1968, about 55 percent of the patients in such homes have mental impairment of some kind. Can you comment on that?

Dr. BRINKLEY. I cannot speak in great detail on the report of the Illinois Public Aid Commission as to their findings except to say that these were no doubt the diagnoses listed by the various nursing homes they contacted, and I think you do have a matter of terminology. I would assume that senility and chronic brain syndrome are essentially the same thing.

OPPORTUNITIES FOR REHABILITATION

Mr. ORIOL. Commissioner, I wonder if we might have a supplementary report on the areas in which you see the greatest opportunities for rehabilitation in nursing homes? I think this would be very helpful.

Mr. HUNT. We would be delighted to prepare that for the committee.

Senator MOSS. Thank you. Without objection that will be supplied.

(The material referred to follows:)

Opportunities for rehabilitation in nursing homes include the following:

1. Social services related to ways and means of resolving problems of living upon discharge from a nursing home are of primary importance. These may include the provision or arrangements for the provision of home care services such as visiting nurses, occupational therapists, physical therapists, housekeeper, meals on wheels, arrangements for transportation to and from hospital clinics, treatment centers, counseling with respect to budgeting and other home living problems via home economists, family counseling via home services, etc. Arrangements may also be made for home visitors. For those with a potential for work, referrals should be made to the State vocational rehabilitation agency.
2. By developing special programs for selected categories of disability uniquely valuable services may be developed for persons with end-stage renal disease (hemodialysis), adolescents with severe neurological impairments (milieu therapy), for alcoholics (detoxification and reorientation), senile aged, (milieu therapy).
3. By serving as a "way station" for other categories of disability, orthopedic disabilities, post-operative or between operations, a more home-like, relaxed environment at less cost may be provided in nursing homes.

Mr. MILLER. I have just one question about the Thayer project and the two studies referred to on pages 2 and 3 of your statement. What were the dates of those, respectively?

Dr. BRINKLEY. The Thayer study went from 1959 to 1963. The New England study went from 1960 to 1963. The Illinois Public Aid Commission, the final report was dated February 1960.

Senator MOSS. Do you know of any studies since medicare and medicaid became effective?

Dr. BRINKLEY. Not that I know of.

Senator MOSS. So, we cannot measure whether there has been a change or not?

Dr. BRINKLEY. No.

Senator MOSS. Well, thank you very much. We appreciate that, gentlemen.

We will turn now to Commissioner John B. Martin of the Administration on Aging. We are pleased to have you, Commissioner Martin, and we will ask you to proceed now.

STATEMENT OF HON. JOHN B. MARTIN, JR., COMMISSIONER, ADMINISTRATION ON AGING

Mr. MARTIN. Thank you very much, Senator Moss.

I am appearing here not as a technical expert on medical care but as a representative of the millions of older persons who are going to be affected by whatever program is developed in this Nation for the provision of long-term care. This is an area which has not been fully explored and which we are very happy to work on with you because the need is urgent.

At the present time the fastest growing portion of our population is the portion over 100 years of age, of whom we have between 10,000 and 13,000. The next highest percentage of growth is in the group from 75 to 85. In view of the fact that many of these people, if not most of them, have chronic difficulties of one kind or another, the need for long-term care is most urgent.

What I have to say relating specifically to long-term care is supplemental to the statement by Secretary Finch and Dr. Egeberg on July 10.

I will try to be brief. You have heard the statistics before. We know that our older people are ill more often and for longer periods of time than the general population. We estimate that the proportion of the aged population resident in nursing homes and related facilities increased more than threefold from 1954 to 1967; that is, from 1.1 percent to 3.6 percent. This, of course, is because there are more facilities and there are more funds available for such older persons to get such care.

We estimate that total national expenditures for nursing care services, which for fiscal year 1968 were about $2 billion, have increased an average of approximately 15 percent per year since 1950. We expect that the rapid increase in charges for nursing home care will continue. Aside from inflation, the effects of including nursing homes under the Fair Labor Standards Act and of imporvements in service required under the 1967 Social Security Act Amendments will increase the cost of care.

The fact that the aged are the major users and beneficiaries of nursing care services over long periods of time makes the subject of this hearing a matter of major concern to us in the Administration on Aging.

A SOCIAL POLICY FOR LONG-TERM CARE

I believe that the Nation must develop a rational social policy for long-term care of the aged. I believe that the absence of such a policy is tantamount to a decision to have no adequate policy. I would illustrate that briefly by these three points: manpower shortages; the absense of alternatives to acute care; and the necessity to rely on mental hospitals.

In examining your call for this hearing, I noted your interest in the proposed medicaid standards for skilled nursing home care. We might all agree that these standards are only a floor caused by our current meager resources of trained personnel; that is what I think has caused it. Yet without a policy which insures an adequate continuing supply of trained personnel, any standards—strong or weak—will leave much to be desired, because older persons will not receive the kind of care you or I would want for our parents or ourselves.

In this connection the Administration on Aging wishes to submit to the staff of your committee and to yourselves a research memorandum on "Trends in the Nursing Home and Related Facilities Industry; Implications for Health Services Needed by the Aged and for Paramedical Manpower Requirements,"[1] for which we contracted with the Surveys and Research Corp. We think it has pertinent material in it.

Senator Moss. That will be placed in the committee files and incorporated by reference.

Mr. Martin. Thank you, sir.

I am discouraged by a continuing situation in which older persons with chronic illness not requiring acute care occupy acute care hospital beds. This is brought about by a shortage of nonacute care beds. We might all agree that many of these older persons would benefit from another form of adequate alternative care, but out agreement will prove meaningless, unless the alternative care exists and is made available to them.

What is needed is a comprehensive system of care running all the way from acute care in hospitals right through to home care and including various forms of care in skilled nursing homes and intermediate care and extended care facilities. Because we do not have a comprehensive system, we get log jams, particularly in our hospitals, which prevent us from providing the kind of care that these older people are particularly in need of. In some cases this is acute care; in some cases it is ambulatory care and so on.

A Continuum of Care

What we are looking for is a continuum of care that covers all of their needs. Short of that, as Secretary Finch pointed out, it leads to overuse of high cost acute care facilities while the need is increasingly for lower cost alternatives to wasteful utilization of the facilities that we are using.

Of course, the plight of older persons confined in mental hospitals even though they are not in need of such hospitalization is not only heart-rending but wrong. Yet, even more wrenching are the problems which confront such older persons when they are suddenly discharged by institutions seeking to cut costs to the State and to the community.

We believe that a sufficient number of studies upon which a policy on long-term nursing care for the aged must be based has been made. Mechanisms, such as the comprehensive health planning program, for executing a policy exist. The time has come to pull together the many diverse components of our long-term nursing care system, including: (1) the individuals and population groups whose health is of concern, (2) the personnel who perform direct health services, and (3) the institutions organized to provide services. The time has come to coordinate all of the Federal programs which have impact on long-term care, including: Hill-Burton, medicare and medicaid.

That is a big order but it is an order that has got to be carried out if we are going to have the kind of service that we ought to have instead of the fractionated and fragmented service that we have today.

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[1] The "Technical Memorandum" was later submitted to the committee for its files. It is a supplement to the study entitled "The Demand for Personnel and Training in the Field of Aging," authorized by the Older Americans Act Amendments of 1967 (Public Law 90-42).

Policy Recommendations

I propose to urge the Advisory Committee on Older Americans, the President's Council on Aging, and the White House Conference on Aging to help me articulate the dimensions of the kind of policy I have in mind. That policy would address itself to five specific elements.

(1) The supply of facilities must be expanded and their quality improved, and I stress again the broad range of facilities that we need. Since the public share of the cost of long-term care was already more than 75 percent in fiscal year 1968 and it may continue to rise, we must be prepared to ask ourselves whether and to what extent our present supply of nursing homes available for long-term care is adequate to our needs. If not, we must decide what we are going to do about it. Are we prepared, for example, to tolerate a contunuing shortage of quality facilities in low income and rural areas? These are areas where there are acute shortages of all kinds. To what extent can and should the Hill-Burton program be used to meet such a shortage?

(2) The supply of nurses and paraprofessional personnel must be increased. The study which we are submitting to the committee shows the effect of the shortage of such personnel. This shortage can be remedied. In that regard, I particularly call attention to Secretary Finch's intention to develop programs for returning Vietnam medical corpsmen through an Office of New Careers. This is a source of supply that ought to be used, of course, but which won't be used unless such men are adequately paid for what they are asked to do. I am also hopeful that the proposed retired senior volunteer program will provide an additional manpower resource.

(3) The skills of managerial personnel must be improved. As I understand it, training in hospital administration has been placed by universities in their graduate curriculums. Should we expect older persons to be cared for in institutions administered by individuals with any less training than that? For this reason I am pleased to report that at North Texas State University the Administration on Aging is supporting the first graduate program anywhere in the United States directed exclusively at training the administrators of personal care facilities. Upgrading skills is an important area where we can improve.

(4) A full range of care which represents an alternative to long-term institutionalization must be incrementally developed and made available. Such care would include: home-maker and home-health aid services; home maintenance, friendly visiting and telephone reassurance services; foster home placements; meals on wheels; specialized transportation; and outpatient health and rehabilitation services available in an older person's neighborhood. Attention should also be directed at the development of day care services through which an older person may receive the benefit during the day of the services an institution delivers to its 24-hour residents.

(5) Alternative care services to older persons at the local level must be delivered comprehensively and in a coordinated fashion. Even more important than plugging gaps in services is the establishment of a coordinating mechanism at the local level for organizing and delivering services. Without such a coordinating mechanism the older person too often will continue to confront the duplication of services on the one hand and the absence of essential services on the other.

Mr. Chairman, the problems inherent in the task of framing an expression of national will to meet the long-term care needs of the elderly are great. But it is increasingly clear that these needs will only be met by setting a long-range target and then moving determinedly to meet it.

Thank you, sir.

Senator Moss. Thank you, Mr. Martin, for a very fine statement. Your proposals here as to what must be done are similar to some of the suggestions that were made by Mr. Hunt in his statement.

As Special Assistant to the President on the Aged, what specifically can you do at this point to get us moving in this direction?

Mr. MARTIN. Well, I hope I can do a good deal to bring together the several portions of the Federal Government which are working on fragments of this problem. The problem is that we have not faced it as a total problem. Each is working in a separate category, separate niche. I am going to work to bring together the representatives of these various programs. I think there is an opportunity to treat this problem as a whole instead of in isolated chunks without too much relation to other pieces of the problem.

Senator Moss. Would that include in part recommendation for legislation if it is needed to bring about this coordination?

Mr. MARTIN. It could include such recommendations. Perhaps we might be permitted to present our conclusions to the Urban Affairs Council out of which might come suggestions for legislation.

Senator Moss. I applaud your discussion of the problem. I agree we certainly need coordination among the Federal agencies, many of which have a part of the administration's program in their hands.

AoA ROLE IN STANDARD-SETTING

We were talking earlier about the issuing of the nursing home standards under title XIX. Was the Administration on Aging consulted on those regulations and, if so, what was its position?

Mr. MARTIN. We were not in on the drafting procedure that you discussed earlier. Exactly what standards you use to provide adequate care is a fairly technical area and we did not expect to be consulted on the technical aspects of the problem. On more general aspects, we would.

Senator Moss. You did not expect to be consulted then on these standards?

Mr. MARTIN. Not necessarily, although the clearance procedure usually brings those things to our attention for an expression of opinion if we are dissatisfied. It seems to me that these regulations were simply facing on an interim basis the problem that we know exists and that is the shortage of qualified personnel. I do not regard the setting of the date here as being damaging to the long-range picture. I think it is a reflection of the fact that we simply do not have enough qualified or registered and trained licensed practical nurses at the moment and that a little longer time will give us an opportunity to make sure that they are fully qualified. So I do not think that the regulations should be condemned merely because they do allow a little longer time to accomplish that purpose.

Senator Moss. Senator Miller.

Senator MILLER. On about the same subject, the report that you are furnishing to the committee, which will be in the file as I understand it, goes into the acute shortage of personnel. Does it give any estimated timetables by which certain qualified categories of personnel will be available?

Mr. MARTIN. Senator, I don't think it does give any timetable but this, of course, is what is urgently needed.

Senator MILLER. Could you give any estimate of what can be done? For example, recently I was at a hospital dedication and they are doing some research on the subject. I call attention to the fact that that even with the program you now have that will increase medical school graduates, that it would be 1980 or beyond before we would be able to have enough medical doctors to meet the needs to handle the programs that are on the books right now. I suspect that the same thing is true with respect to paramedical personnel and nurses. One thing that is troubling me is that if we have a regulation which requires a certain category of personnel and you cannot find personnel to meet this requirement, then you are not going to meet the regulation.

Mr. MARTIN. It is not possible.

Senator MILLER. Or possibly you meet the regulation by going out and pirating that person from a hospital, for example, paying him a much higher salary, but this leaves the hospital deficient. The next thing you have is an overall increase in the cost of care. I am wondering if we are putting the cart before the horse a little bit if we are promising or requiring what we cannot efficiently and effectively meet.

TRAINING NEEDS

Mr. MARTIN. There is not any question, Senator, but that the additional facilities are not going to be any good without adequately trained personnel. What I really believe is needed is a crash program especially in these areas where training can be done in a relatively short space of time. Training paramedical personnel doesn't take forever; it does not take 8 years to prepare them for their function. There are shortages in these hospitals and there are registered nurses doing things they should not have to be doing and under tremendous pressure.

Senator MILLER. Do we get to the point, Mr. Martin, that it is a matter of timing?

Mr. MARTIN. Yes.

Senator MILLER. And working on a crash basis to keep the timing down to a minimum?

Mr. MARTIN. The time has to be synchronized with training and development of your facilities, there is no question about that.

Senator MILLER. This is what you are talking about really in terms of broad policy which we need?

Mr. MARTIN. That is right.

Senator MILLER. So it can be coordinated with what we are doing.

Mr. MARTIN. Exactly.

Senator MILLER. Thank you very much.

Senator Moss. Thank you, Commissioner Martin.

Any questions from the staff, Mr. Oriol?

Mr. ORIOL. Commissioner Martin, the Older Americans Act amendments as you said have a new program or would establish a new program which would be a very important volunteer program.

Mr. MARTIN. Yes.

Mr. ORIOL. Do you see ways in which this program could be helpful in providing the kind of manpower that could help make it more feasible for helping the people stay at home instead of going to nursing homes?

Mr. MARTIN. I think that it certainly could be helpful in this regard, and we look forward to opening up a huge volunteer pool in this new program that can do just that. Many older people can get along perfectly well if they have only one older person who can work with them a little bit and help them get a meal or do simple nonmedical things for them. Home care can be just as good as hospital care. It is even a little better in many cases for people. So we hope to be able to make people available for that purpose, yes, sir.

Senator MOSS. Thank you very much, gentlemen. We appreciate your testimony.

I think we will have time to hear one more witness before we must take our noon break.

Mr. Paul De Preaux, president of the Connecticut Association of Nonprofit Homes and Hospitals for the Aged.

We are very pleased to have you, Mr. De Preaux.

STATEMENT OF PAUL DE PREAUX, PRESIDENT, CONNECTICUT ASSOCIATION OF NONPROFIT HOMES AND HOSPITALS FOR THE AGED

Mr. DE PREAUX. Thank you, sir.

I wish to thank you for inviting me here today to present my opinions on a subject which I consider to be of tremendous import both to our elderly and those of us who attempt to serve their needs.

On June 27, 1969, we received copies of the Federal Register, volume 34, No. 120, dated June 24, 1969, containing the "Standards for Payment for Skilled Nursing Home Care." We were amazed that an agency of the Federal Government could promulgate standards such as these and still term the result a "Skilled Nursing Home." With the exception of the compliance date being moved forward a year, this appears to be the same "Interim Policy Statement" to which we have been objecting since February 14, 1969, when, to our knowledge, it first appeared on the scene.

"MORE STRINGENT STANDARDS . . . FOR POODLES"

In previous correspondence with a member of this committee, I made the statement that, "It is a sad day when the laws of States such as Connecticut require more stringent standards for the care of poodles than the Federal Government proposes requiring for nursing homes caring for people." I was asked to document this statement if I could, and I did.

Investigation of the veterinary laws of five States other than Connecticut revealed that their laws paralled those current in Connecticut and are definitely more stringent regarding the care of animals than the proposed nursing home standards are for the care of our aged ill.

Let us compare a few facts.

For example, section 2-vi-b-1-i-(a)(b)(c)(d) and section 2-vi-6-i-II and III on page 9789 of the Federal Register reads:

(1) Organized nursing service. The term "organized nursing service" means that:

(i) Nursing services are under the direction of a director of nursing service who is a professional registered nurse and who:

(a) Is employed full time in the facility, devotes her full time to supervising the nursing service, and is on duty during the day shift;

(b) Is qualified by education, training or experience for supervisory duties;

(c) Is responsible to the administrator for the selection, assignment, and direction of the activities of nursing service personnel;

(d) Is responsible to the administrator for development of standards, policies, and procedures governing skilled nursing care and for assuring that such standards, policies and procedures are observed;

(ii) There is at least one professional registered nurse or licensed practical (or vocational) nurse on duty at all times and in charge of the nursing activities during each tour of duty;

(iii) (a) No later than July 1, 1970, there is on duty at all times and in charge of nursing activities at least one professional registered nurse or licensed practical (or vocational) nurse who is a graduate of a State-approved school of practical nursing, or who is found by the appropriate State licensing authority on the basis of the individual's education and formal training to have background considered to be equivalent to graduation from a State-approved school of practical nursing; . . .

These paragraphs contain many points which we feel do not constitute skilled nursing care.

One registered nurse, licensed practical nurse or vocational nurse on duty at all times, without regard for the number of patients in the facility. This requirement becomes all the more ridiculous when the following paragraph states that this requirement need not be met until January 1, 1970. It necessarily follows that for one more year the Department of Health, Education, and Welfare will allow nursing service personnel, such as ward clerks, nurses' aides, attendants, and orderlies to supervise the second and third shifts and of necessity dispense medications since their dispensing is not limited to the first shift.

RN Supervisor Standards

Let us consider the most stringent proposal listed in this section, the presence of the registered nurse on the 7 a.m. to 3 p.m. shift to act both as the registered nurse on duty and the nursing supervisor. The patients in our nursing home receive an average of five medications and treatments on the 7 a.m. to 3 p.m. shift. In a nursing home of 120 patients receiving an average of only four medications and treatments, this would total 480 medications and treatments. At the rate of one medication dispensed or treatment rendered every 2 minutes, it would only take the registered nurse 16 hours. And in her spare time she must supervise her skilled nursing home.

As you can see, the premise is illogical and absurd. In fact, if we double the number of patients, this stringent requirement becomes chaos.

In Connecticut, our nursing home regulations list what we consider minimum standards for nursing personnel coverage commensurate with good patient care. They are:

One director of nurses and one RN or LPN for each 30 patients or fraction thereof—7 a.m. to 3 p.m. shift.

One supervisor of nurses for an extended care facility of 61 beds or more and one RN or LPN for each 45 patients or fraction thereof—3 p.m. to 11 p.m. shift.

One RN or LPN for each 60 patients or fraction thereof—11 p.m. to 7 a.m. shift; plus

One nurses' aide for each 10 patients or fraction thereof—7 a.m. to 3 p.m. shift.

One nurses' aide for each 15 patients or fraction thereof—3 p.m. to 11 p.m. shift.

One nurses' aide for each 20 patients or fraction thereof—11 p.m. to 7 a.m. shift.

And we consider these, as I said, minimums.

Gentlemen, please compare these standards to the standards proposed by the Department of Health, Education, and Welfare. I find a divergence of opinion between what our State and the Department of Health, Education, and Welfare considers a skilled nursing home.

There are other areas with which we disagree, but let us return to the comparison of the required care for poodles and people. Our State laws require that the Board of Veterinary Registration license no person as a veterinarian until he has passed an examination before the State examining board; has presented a certificate of good moral character signed by two respectable citizens; and has proved to the board that he is a graduate of a school of veterinary medicine, dentistry, or surgery approved by the board.

Once he is licensed, then he may "diagnose, administer biologics for, treat, operate or prescribe for any animal or bird." With this training and approval by his peers he may now administer biologics to our poodles; but until July 1, 1970, the Department of Health, Education, and Welfare presumably allows a nurses' aid, orderly, attendant, or ward clerk with minimum training to administer drugs to people.

I have here copies of our State laws regarding the care of animals of all categories, and I am sure you would find them unbelievably more detailed and precise in their requirements than this "Standards for Payment for Skilled Nursing Home Care." In addition, I invite your comparison of the "Standards for Payment for Skilled Nursing Home Care" and the "Regulations and Standards for Laboratory Animal Welfare" printed in volume 32, No. 37, of the Federal Register dated February 24, 1967.

Disagreement With Standards

There are other areas of these "Standards for Payment for Skilled Nursing Home Care" with which we disagree, but we can speak of them later because I do not wish to take too much of your time.

Two years ago when the Department of Health, Education, and Welfare published its regulations for skilled nursing homes we considered them low. However, we knew it was impossible at that time to commence any standards at too high a level, for it would work a hardship on some nursing homes and on the title XIX patient. We believed that periodically these standards would be raised with time periods allowed for compliance.

Why are they now being lowered? There are only two premises. Is it because some States have failed to meet even these minimum standards or is it to lure into the title XIX fold the 13 to 16 States which do not now participate in the title XIX program? If it is the former, then we are allowing expediency to replace concern. Not all long-term facilities are perfect, but the majority are trying. To lower standards for this reason would be a serious blow to those who have fought for years to raise standards and result in the legitimization and further Federal subsidization of substandard homes to the detriment of the patient for whom we avow concern.

If the reason for lowered standards is the latter, will it accomplish its end? We do not believe so. With standards now set so low, what happens if, say, 11 States still refuse to participate in the title XIX program? Do we then lower standards again? Does this go on ad absurdum? It is ridiculous to seek the lowest possible level of care.

It is my opinion that standards should be raised and a specific time period given for compliance. If the new standards are not met, then noncomplying homes should be dropped from the program.

This may sound cruel to those who ask, "What happens to the hundreds of thousands of our aged ill in States with low or no standards who cannot participate in the title XIX program because of their standards or because of lack of sufficient funds?"

I say to this, our national goal should be the best possible care for all our aged ill, but I believe that we cannot attain this objective by legitimization of substandard care for all. After all, why shouldn't we demand good nursing care, thereby guaranteeing this care for many rather than lowering our standards to the point where we can guarantee it to none. If it were not for the various State regulations, imagine the care our aged would now be receiving.

Our standards are high in Connecticut, and we are proud of this. These regulations do not affect us, but we must consider the aged ill in other States whose standards are either low or nonexistent. How can the Federal Government condemn them to substandard care? This is what will happen if the State regulatory bodies accept the Federal standards as maximum and promulgate these standards using the waivers authorized in this document. The intent of this document, then, becomes ridiculous and the result extremely expensive.

Suggestions for a Solution

In conclusion, let me suggest a possible solution for your consideration.

1. The Department of Health, Education, and Welfare should raise the present standards for nursing coverage under title XVIII and combine title XVIII and XIX requirements.
2. The State regulatory bodies would then submit to the Department of Health, Education, and Welfare a list of complying homes.
3. A single reimbursement rate be established for both categories using the cost reimbursement formula established by medicare.
4. Reimbursement could be forwarded through the third party intermediary presently handling medicare in each State.
5. Qualifications for participation by the patient in this program would remain as they are at present or should be standardized nationally.

This would accomplish two things. It would place the title XVIII and the title XIX patients on an equal basis, and it would assure good nursing care for our aged ill regardless of their State residence.

Properly supervised and conducted, I feel this could result in a savings to the Federal Government for the medicare machinery is there and could be utilized for both programs. There would be no need for duplication by either Federal or State agencies.

Gentlemen, I thank you. I hope that these standards can be raised for we sometimes speak of our aged ill as though they were an ephemeral group, forgetting that the aged ill will be us in 15 or 20 years and we are, therefore, setting standards for ourselves. I hope that if I ever do require nursing care under title XIX I will receive the same care that it is now required I give any dog.

Thank you, gentlemen.

Senator MOSS. Thank you, Mr. De Preaux, for a very fine and direct statement and one that comes from long experience in dealing with this matter in your home State of Connecticut.

I wonder if the new requirements to eliminate some of the deficiences, described on page 5, is companion to your veterinary versus medicare and medicaid statement.

Mr. DE PREAUX. I didn't get that question, sir. You mean am I asking that the two be——

Senator MOSS. Would these new requirements eliminate this disparity you say we have now between veterinary services and medicare?

Mr. DE PREAUX. I do not think it would quite match it, sir, but I would hope that it would at least get a lot closer.

CUT-OFFS FOR CARE

The other thing I might say, if I have your permission, is that the question was asked of Mr. Laughlin as to the difference between title XVIII and title XIX, and the only difference that I have been able to find is that a title XVIII patient has been on the sicklist 100 days and a title XIX patient has been on the sicklist 101 days.

Under title XVIII the patient is under intensive medical care, but this intensive medical care may require 150 days. Do we then refer him to an intermediate care facility or do we stop this care just because he is no longer a title XVIII? I think this rather strange, sir.

Senator MOSS. The difference there is really meaningless because it is an arbitrary dateline which may mean something and it may mean nothing. It usually does not mean anything.

Mr. DE PREAUX. Very true, sir.

Senator MOSS. We appreciate your statement.

Senator Miller, do you have any questions of Mr. De Preaux?

Senator MILLER. Thank you, Mr. Chairman.

Mr. De Preaux, I realize that you can make a line appear absurd by talking about the 100 and 101 days. However, I invite your attention to the fact that the Senate Finance Committee in its Report on Social Security Amendments Act of 1967 said this:

> The committee amendment also specifies the proper conditions relating to meal planning, nursing staff, medical recordkeeping, and, to the extent feasible, appropriate arrangements with hospitals for transfer of patients be met. It is understood that in general the type of care rendered by skilled nursing homes under title XIX is not identical to the extended care provided under title XVIII.

Title XIX care tends to be long-term care while title XVIII is designed for care of a more intensive and relatively short-term nature. In this context, therefore, the Committee expects that the Secretary and the States will not seek to impose unrealistic requirements upon title XIX skilled nursing home.

Now I think the rationality behind that statement, although I was not a member of the committee at that time, was to recognize that there are degrees of nursing home care required. It may be that the 100-arbitrary-day guideline is not realistic, and perhaps it ought to be changed. In view of that statement and in view of Mr. Martin's statement indicating that what we need is complex levels of service, I find it hard to go along with your suggestion that title XIX and title XVIII be combined.

Mr. De Preaux. Well, sir, if I may answer that question I would say this. We have at Avery a complex of the type you are talking about. For example, we have 58 apartments, we have 61 people living in the congregate living area. We have a 90-bed nursing wing and we are now preparing to construct a 60-bed resthome with nursing supervision. Now that is what I believe you are talking about. However, I find it rather strange when they start differentiating between our patients and placing them in a category which is actually only a financial numbers game.

We are talking about a patient, for example, who is not young. You can talk about short-term care for children, you can talk about short-term care for people our age, but when you get up into the 80 to 100 class, this decade, you are not talking about people who recover quickly. You are talking about people who tend to recover more slowly. Therefore, you will find that the days on the sicklist are necessarily longer than short-term patients.

Of course it is nice to say that an ECF is aimed at the short-term care and a nursing home is aimed at the long term but let's be realistic and say that both of them should be able to handle either. There is no question about the fact, for example, that in ours alone of the 150 patients that we have discharged, 62 percent have gone home. I can send you figures on this and I could also tell you the number of days that they spent in the hospital.

Many of them are far over 100 days but you get a far greater pleasure out of sending somebody that age home who has been given up because you have the rehabilitation services in a skilled nursing home.

Senator Miller. I do not think any Senator would dispute that. I invite your attention to the fact that the Finance Committee was very careful in its choice of words when it used the phrase "tends to be this, tends to be longer, tends to be shorter," and this was based upon expert testimony before the committee from medical doctors and other people.

I must say that if you have a person who has a need for a certain level of care, whether it is 100 days, 50 days, or 500 days, and then because of the change needs a lesser level of care for 30 days, 100 days, or 5 days, it just does not make sense to me to have them in the same facility or give them the same level of care. It seems to me that it would be a horrible waste of manpower. We already have abundant testimony indicating that we have a horrible shortage of trained personnel.

Mr. DE PREAUX. Yes, sir; I agree with you. I would say this: This is the reason we have a utilization review board and this is the reason in our State—I don't know but I think for some reason or other we are talking about two separate terms. In our State the majority of your ECF's are skilled nursing homes, and those with nursing home supervision are considered in the intermediate care class.

Therefore, if they no longer require the intensive care that a skilled nursing home gives them, then they are transferred to a rest home with nursing supervision which has as its staffing, staffing which is now similar to what the Federal Government is requiring in a skilled nursing home. Our staffing is much higher in our skilled nursing homes.

Senator MILLER. You do not have any custodial homes?

Mr. DE PREAUX. Yes, sir; they are called homes for the aged.

Senator MILLER. Then what you have are three categories?

Mr. DE PREAUX. Yes, sir.

LEVELS OF CARE

Senator MILLER. Do you disagree with Mr. Martin who seems to imply that we need more levels of care than just the three?

Mr. DE PREAUX. No, sir; in fact, if you had asked me to speak about this today, I would have loved to have come down and talked to you about the fact that I believe that nursing homes, ECF's if you wish to call them that, homes for the aged, and rest homes with nursing supervision, and, in fact, congregate living and apartment-type dwellings should all be set up in complexes because I feel that one of the silliest things that I have ever seen in my life is the fact that you take a person 65 or 70 years old and you put him in an area which is so-called public housing for the elderly where he has his apartment type living, you give him four walls and a ceiling and say, "I have done my Christian duty," and you have done nothing.

You have taken them from a known environment and put them in an unknown environment. They have no custodial care. If they are sick, they are transferred to the hospital and after a specified time they must give up this apartment. Then they require nursing home care so they go to an ECF or, as you say, a skilled nursing home. Then they require another type of care and go to a rest home with nursing supervision. When they are well they have to go home and they have no apartment.

Senator MILLER. What you just described is the general pattern today, isn't it?

Mr. DE PREAUX. Yes, sir.

Senator MILLER. And the complex which you are advocating is rather unique as of now?

Mr. DE PREAUX. Yes, sir.

Senator MILLER. I would guess that most people would agree with you on the objective of that complex. I happen to be familiar with one and it is the only one I know of within a radius of 300 miles all around; there are many other types of facilities but only one like you are talking about. It is great but it is going to take a long, long time to attain the objective because you have got to give time for these things to materialize.

I think we made a lot of progress in the last few years. If anybody had asked me about such a complex 5 years ago, I would have said I

never heard of such a thing. It is there and there are others coming along, but it takes time to move from a unique situation to a general situation. I do not say we should not try it, I think it is a great idea. But it is going to take time.

Now one other thing. I was very interested in your comparison of nursing home care and veterinarian services. I just suggest to you that one possible flaw in the example is that while only veterinarians can give the treatment, maybe an awful lot of those family pets and animals die because they do not have the service. To me it is better to have some service than none at all unless you are just flooded with veterinarians up there in Connecticut.

Now this gets us down to a practical problem that the Congress has to confront. I do not know how it is up in Connecticut but I know how it is out in Iowa and I know how it is in some other States. Mr. Martin has already furnished us with the report showing us the acute shortage of personnel.

"Condemned" to Substandard Care?

I do not think the fact of life that there is an acute shortage of personnel which we have to overcome is a proper basis for you to say, How can the Federal Government condemn them to substandard care? The Federal Government is not condemning anybody to substandard care. We are bending every effort to achieve the objectives that you have outlined and which we all share, but you have to face the fact of life.

Now I went through the same thing in Iowa in the legislature with the schoolteacher certification. When we started out back in 1955, we could have schoolteachers who only had a high school education if they had a little supplemental training. Of course the education association and the PTA's and all those people wanted to have a teacher with a degree.

Now if we had come along and said that every school has to have a teacher with a degree, we would have a lot of schools without teachers. I think it would have been horrible for somebody to have come along and said to the members of the Iowa Legislature, the State of Iowa is condemning our children to substandard education because you have not put that law on the books.

What did we do? We used the phase program so by certain dates they had to have increased education in order to get a teacher's certificate, and today they all have to have a degree. I do not think that anybody could say that our State of Iowa is condemning our people to a substandard education. What we were doing, we were recognizing the facts as they were and we were building toward our goal. I think that is really what your attitude is.

Mr. De Preaux. All right, sir. May I answer that?

Senator Miller. Surely.

Mr. De Preaux. Let us go back to the fact that standards were set 2 years ago. There was a time given for compliance. At the present time we are lowering standards far below what they were 2 years ago.

Now I would ask this question. Can someone show me a list of the States that are unable to meet the requirements that were set 2 years ago and therefore we must of necessity lower the standards so that they can comply? This would be a very serious question to ask for if

there are 10 or 12 or 14 States which are not able to meet those standards, then, No. 1, why didn't the Federal Government institute the training program about which we hear so much today? Why didn't they institute it 2 years ago?

Senator MILLER. We did.

Mr. DE PREAUX. Yes, sir, but it seems to be not working.

Senator MILLER. In fact, we went back, I think, to 1964 when we started that program to help the health professions train more people. I must tell you that it takes time.

Mr. DE PREAUX. Yes, sir.

Senator MILLER. A lot of time. I do not know how many States would come in this cateogry. I would be surprised if it were considerably more than 12 or 14, because there is a shortage of these people.

Now we are trying to do something about it, and I have been around in my State where they have tried to fill the gap with practical nursing training and they are coming along. The estimate I get is that it is going to be quite some time yet.

Now with respect to the standards of 2 years ago which you say are now lower, I do not have any trouble with that as a matter of precedent. If those standards were set too high 2 years ago, to be realistic they ought to be lowered, but that does not mean that they should not go back up as we can phase in the personnel needed to meet those standards just like out in the Iowa Legislature.

Suppose that a lot of people come around and say, "Now if you pass this bill you are going to condemn our little people in Iowa to substandard education." You put it on the books right now that each teacher is going to have to have a degree. Two years later we found that we fell flat on our face because we found that we could not do it and so we lowered it back to provide that every teacher had to have 2 years of college. I do not think that you can say that was being unrealistic. We would have only rolled with the punch of the facts of life and then later on we came up with the college degree. What we did, we phased up so that after a certain period of time every teacher had to have 2 years of college and then we went up to a full degree.

It may be that we have moved a little bit too fast. I think this is one of the problems with medicare. We have promised a lot of people a lot of things but we do not have the medical personnel to deliver. That means that we ought to get realistic from these things, put in a good time phase consistent with a policy for training personnel and I think we will all be happy.

Mr. DE PREAUX. Yes, sir. Now you talk about nursing personnel. Are you talking strictly about registered nurses?

Senator MILLER. I am not talking about necessarily registered nurses, I am talking about licensed practical nurses, especially those we need in our hospitals.

TRAINING REQUIREMENTS FOR NURSES

Mr. DE PREAUX. It takes approximately 10 to 12 months to train a licensed practical nurse, a good training program. It takes approximately 6 to 12 weeks to train a nurses' aide. If the people who have been living under the title XIX requirements of 2 years ago had not taken any steps to see that the licensed practical nurses that were

necessary and the nurses' aides that were necessary to supplement the registered nurses on duty, then I would question the thrust that we are talking about in our so-called training programs.

Senator MILLER. If we have taken no steps at all and have just sat there and let the world go by, I would agree with you but I do not think that it will be found to have occurred. I know my own State has done a lot of work on this; a lot of people are involved in it. I think we are probably coming along pretty well. I think we probably have fewer problems in our State than most other States, but we have problems. These are serious problems, not the least of which is the cost. One of the reasons for the cost problem is because it was found that some people were receiving skilled nursing home care who did not need it and that is the reason for trying to develop the complex. Now until we can get the complex built all over the State, we are going to have to have these various levels; otherwise, we are just going to throw the taxpayers money down the drain. You may even find people who need service and can't get it because the nursing homes cannot qualify.

I would not want to indict any State; there may be some States who are just sitting on their haunches and forgetting about trying to do something about this. If there are, then they ought to suffer the consequences. I do find a lot of concern about the fact that there are too many theoreticians down here in the Washington empire and especially over on the administration side who are not recognizing the practical facts that we have to deal with. I just want to emphasize that to you because I do think that your objectives are good, I think we all share them. I think maybe you overstated your case a little bit.

REQUIREMENTS IN CONNECTICUT

Mr. DE PREAUX. Well, sir, as I stated, in Connecticut we have our requirements and these are minimums. Now we are able to meet these; in fact, some of our homes are far above them. For example on the 7 to 3 shift alone I had one RN for every 20 patients—sorry—one for every 15 on the 7 to 3, one for every 20 on the 3 to 11 and one for every 15 on the 11 to 7. I do not think they can match this.

Senator MILLER. You are talking about "we."

Mr. DE PREAUX. My facility, Avery Heights.

Senator MILLER. Your own facility?

Mr. DE PREAUX. Yes.

Senator MILLER. What about the State facilities as a whole?

Mr. DE PREAUX. The State facilities as a whole meet the minimum standards that are listed here. In fact, to meet that minimum standard they must meet this minimum standard even to be licensed.

Senator MILLER. When I said State maybe I misspoke myself. I am talking about all the nursing homes in the State of Connecticut.

Mr. DE PREAUX. That is exactly what I am saying. Every nursing home in the State of Connecticut has to meet the standards that I read earlier before they can even be licensed. This year 117 of our 254 nursing homes became A–1—that is, the A–1 category.

Senator MILLER. You say 117 out of how many?

Mr. DE PREAUX. Out of about 251.

Senator MILLER. What was the picture 3 years ago?

Mr. DE PREAUX. Well, the picture last year was 17 of them were in that class.

Senator MILLER. So there were 17 in No. 1 and 231 in No. 2?

Mr. DE PREAUX. Yes, sir.

Senator MILLER. So in one year 100 got moved——

Mr. DE PREAUX. No, sir; I am talking about only A–1. We have a category A–1, 2, 3, B, C, D, and E. I would say over 225 of ours are now in the A–1, 2, and 3 class.

Senator MILLER. I wonder if you could furnish for the record a little picture of how Connecticut has moved along on this, all your nursing homes over let's say the last 5 years.

Mr. DE PREAUX. I will try.

Senator MILLER. It could be that this could serve as a good model for other States to follow. If the chairman agrees, I would like to have this put in the record.

Senator MOSS. It will be included in the record if you will supply it.

Mr. DE PREAUX. Thank you.

(The material referred to follows):

CONNECTICUT ASSOCIATION OF
NONPROFIT HOMES AND HOSPITALS FOR THE AGED,
August 14, 1969.

DEAR SENATOR MOSS: As per your request at the Committee hearing on 30 July 1969, I am forwarding you the enclosed information which was so graciously supplied by the Connecticut State Department of Health. You will note the increase in the upgrading of homes to the "A" category in the last seven years.

Further, since I mentioned the Avery Heights Complex, I am forwarding information which may be of interest to you.

Again, I thank you for your consideration to me personally and your concern for the elderly.

Sincerely,

PAUL DEPREAUX, *President.*

STATE OF CONNECTICUT,
STATE DEPARTMENT OF HEALTH,
Hartford, Conn., August 12, 1969.

Mr. PAUL DEPREAUX,
Administrator, Avery Nursing Home,
Hartford, Conn.

DEAR PAUL: Listed below is the information your equested concerning the progress of nursing home classifications in this state since it's conception in 1962:

Year	Number of beds	Number of homes	Classification breakdown				
			A	B	C	D	E
1969	14,908	245	172	32	35	5	1
1968	13,769	243	171	30	35	6	1
1967	13,729	256	172	35	42	6	1
1966	10,906	242	103	62	62	11	4
1965	10,194	234	92	60	68	10	4
1964	8,142	223	60	72	72	14	5
1963	9,022	221	38	71	79	21	12
1962	8,530	226	31	61	89	37	8

Per your request, I am also enclosing a copy of the Licensure Code for nursing homes, the applicable Physical Standards for nursing homes, and a copy of the Classification System.

Further, be advised that as of January 1967, of the 257 licensed nursing homes in this state, 185 were certified as extended care facilities.

Yours truly,

ARTHUR J. JARVIS,
Director, Division of Hospital and Medical Care.

Enclosures.[1]

[1] See pp. 115–135.

Senator Moss. Senator Fannin.

Senator FANNIN. Yes, Mr. Chairman.

Mr. De Preaux, I commend you for what is happening and what you feel is happening in Connecticut. I think we would all agree that that is a good goal.

Is it your opinion that nursing homes have not been upgraded in the last 2 years?

Mr. DE PREAUX. No, sir. The majority of nursing homes have.

Senator FANNIN. Tremendously?

Mr. DE PREAUX. Yes, tremendously.

You see, Senator Fannin, this is the area I questioned, the lowering of the standards, for the simple reason that so many nursing home administrators—and I include every type known; proprietary, nonprofit, what have you—they have all tried and tried hard to raise these standards. I would say that by far the greater majority have matched them and I find it just a little bit unbelievable that we would lower the standards in the face of these people trying so hard to raise them.

Senator FANNIN. Well, here is the thing. I think you are being a little unrealistic. Now on page 2 you outline the requirement as far as personnel is concerned, as far as nurses are concerned. How many nurses would be required if this were made nationwide, this program that you have listed on page 2?

Mr. DE PREAUX. Page 2, sir, comes from the Federal Register.

Senator FANNIN. Now if we followed that and could implement it as rapidly as you think it could be implemented, how many nurses would be required? Would it be unrealistic?

Mr. DE PREAUX. No. This is far below. This is below what it was 2 years ago.

Senator FANNIN. This is Connecticut. Connecticut lists what they consider minimum standards.

Mr. DE PREAUX. That is not page 2, sir. That is page 4.

Senator FANNIN. Page 2.

Mr. DE PREAUX. I am sorry.

Senator FANNIN. Page 2 on what I have here.

Mr. DE PREAUX. I would agree, as I said to Senator Miller earlier, this would be unrealistic. I do not think that you could possibly match in the next 5 to 7 years, the standards that we have in Connecticut. Again, I do not say that this is what we should be aiming at in these present standards.

Senator FANNIN. That is what I am talking about. Now I do not know what it lists, this is on your page 2. I am just talking about being realistic as to what we can have as goals and I certainly believe we all want to do everything possible to upgrade. But when we start making comparison of an animal hospital, if you take the staff with an animal hospital you would not compare with that the staff that you have in a nursing hospital.

Mr. DE PREAUX. I should hope not.

Senator FANNIN. The laws of the State of Connecticut require those stringent rules for the care of poodles. The Federal Government requires certain rules for nursing homes. Now most of the work that is done in animal hospitals is not done perhaps by the veterinarian so I think it is a false premise.

Mr. DE PREAUX. The only comparison there, sir, is the Department of Health, Education, and Welfare is going to allow nurses' aides, ward clerks, orderlies and attendants to dispense medication whereas I could not find in any of the six State laws that a veterinarian was not required to dispense the medications or administer the biologics.

My question would be: What knowledge, what training, does a nurses' aide or an attendant or a ward clerk or an orderly have to allow her to differentiate between drugs? I don't think they know the difference.

STANDARDS FOR HOSPITALS

Senator FANNIN. By June 1970 what are the requirements for hospitals?

Mr. DE PREAUX. That there be one RN on each shift, and this is fine. But again you have the point I made that in a skilled nursing home—and this is the point that rather touches us—is the fact that if you have 120 beds as the average nursing home of today and if you have four medications per patient on one shift alone, if she gave a medication every 2 minutes—and I would find this rather unbelievable myself—she would take 16 hours just to dispense medications. How could she possibly supervise a skilled nursing home? It would be impractical, sir.

Senator FANNIN. Well, of course we can talk about specifics or we can talk about generalities, but you and I both know that there are many of the nursing homes, especially that I know of in my State, in isolated areas where it would be very difficult to set down the same rules and regulations and have them as stringent as you state they should be and still be practical.

Mr. DE PREAUX. No, sir. I firmly believe that if the rules were set at one RN or LPN on duty for say 90 patients, this could be met. I have a feeling this could be met. Our figures I cannot give you but I believe that they could be met and I think this would be a starting point.

Senator FANNIN. What we are trying to do is to have legislation that will accomplish an objective. We all have the same objective. I do not differ with you on that. I do know that we have the financing problem and we also have the personnel problem and neither are simple to resolve.

Senator MILLER. Would the gentleman yield?

I am wondering if what you are getting at is whether the regulation should be according to the number of patients.

Mr. DE PREAUX. Yes, sir.

Senator MILLER. In the nursing home?

Mr. DE PREAUX. Absolutely, sir.

Senator MILLER. Here is one nursing home with only 20 beds; here is another one with 300. Both are treated alike under the regulations?

Mr. DE PREAUX. Yes.

Senator MILLER. Will you agree we could have a small nursing home where they might well not need to have an LPN or a registered nurse on duty at all times?

Mr. DE PREAUX. No, sir. You are giving nursing care. If you are giving nursing care, sir, and you have five patients you should have an RN or an LPN there if you are giving intensive skilled nursing care.

Senator MILLER. Do you have any idea about what kind of a ratio of patients you have on that? Will you make it one LPN for each 50 or one LPN for each 100, or what do you have in mind?

Mr. DE PREAUX. Let me make one thing very clear, sir. I am not an expert on the care of the aged and I want this understood because as beauty is in the eyes of the beholder, so is expertise usually in the mind of the speaker.

I can merely forward what I consider to be my opinion, and of course, it is opinion from long experience. Again, it is just an opinion.

I would say that if the regulations started at one RN or one LPN for every 90 patients, this could be a start. I do not say that this is perfect because it is far from perfect. I say that if you require in the new Federal regulations one RN or one LPN for every 90 patients, then this would be a start to what we hope some day will be much higher standards.

Senator MILLER. How much higher would you be aiming for?

Mr. DE PREAUX. Pardon?

Senator MILLER. How much higher or lower a ratio would you be aiming for?

Mr. DE PREAUX. Well, sir, again——

Senator MILLER. You say this 90 would be a start. Looking down the road, what would be the ideal objective?

Mr. DE PREAUX. I think the ideal objective would be what we have in Connecticut, one for every 30.

Senator FANNIN. I just have the problem of satisfying myself that we carry through some of the suggestions that you have in some of these isolated hospitals. That is my concern because we do want the best care possible. We do not want those nursing homes to close because they cannot meet these requirements, and we have already had that result in some instances. I am just concerned that we may be so stringent in the requirements that we just eliminate the nursing homes.

ONE RN OR LPN FOR EVERY 90

Mr. DE PREAUX. No, sir. My answer to that would be if—and again I mention this quite a few times in the statement—if we set the standards, I mean just using a premise, say one RN or LPN for every 90, give every nursing home in the country a specific time period for compliance. Now if it takes 1 year to train an LPN, all right. Give them 2 years, give them a year and a half. This is the decision you will have to make, but give them a specific time period for compliance.

Then if they do not meet these requirements within that time, if there has not been this great thrust to take care of our elderly, then drop them from the program because I feel that you have already given them 2 years. If the training programs have not accomplished this in 2 years and it does not accomplish it in 4 years, or if they have not tried to accomplish it in 4 years, then, sir, something is wrong.

Senator FANNIN. You say try to accomplish. There is a great deal of difference between trying to accomplish and having the regulations apply that they are not going to be able to be in a position where that they can take advantage of the program. That is a different story.

Mr. DE PREAUX. Yes, sir.
Senator FANNIN. Thank you.
Mr. DE PREAUX. Thank you, sir.
Senator MOSS. Does the staff have any questions?
Mr. ORIOL. No, Mr. Chairman.
Senator MOSS. Thank you, Mr. De Preaux. I do appreciate your testimony. Let me tell you that I am with you, I do not think we ought to retreat on this matter. I think we ought to be moving forward rather than stepping back and lowering our requirements for nursing home care.
Mr. DE PREAUX. Yes, sir. We have a lot of elderly people and they need help.
Senator MOSS. Now Mr. Hutton had indicated he might not be able to come this afternoon. However, we have run now to a quarter of one and we are going to try to reassemble this afternoon to finish this long list of witnesses. You can see the problem we are up against.
Mr. Hutton, if you are unable to return this afternoon, we would accept your written statement and permit you to say a word if you like. If you can come back this afternoon, we would appreciate it.
Mr. HUTTON. I am trying to rearrange my schedule to come back this afternoon.
Senator MOSS. All right.
We will then be in recess until 2 o'clock.
(Whereupon, at 12:46 p.m., the subcommittee recessed, to reconvene at 2 p.m.)

AFTERNOON SESSION

Senator MOSS. The hearings will come to order.
We will continue with our hearing on trends in long term care.
We do have something of a problem. This morning we heard from four witnesses and consumed nearly 3 hours in doing it. This afternoon we have seven witnesses and we must get them in before the end of the day. I would, therefore, urge the witnesses, rather than reading their statements in full, to submit the statement for the record and to condense orally the statement, the points they wish to stress. We will try to be a little more sparing, perhaps, in the number of questions we have because, obviously, the Senators contributed to the length of the hearing by questioning. But it is just one of those practical problems we have to meet.
This is really an informational type of hearing, in any event, and we are going to have additional hearings in the future. So, for that reason, I think it is not unreasonable to ask the witnesses to do their best to condense their testimony down. Even if we only took 15 minutes apiece it would probably push us beyond the time we have.
I will ask your cooperation. I will try not to cut any witness off as long as he has something that he feels needs to be said. But I will make the general rule that all of the prepared statements will be in the record in full and will be available to the committee. We will see how we can get along now in the time we have remaining to us today.
Our first witness this afternoon is Mr. William R. Hutton, who is the executive director of the National Council of Senior Citizens.
We certainly appreciate your being here to appear before the committee, Mr. Hutton, and we will ask you to proceed.

41-304—70——4

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Thank you very much, Mr. Chairman.

If I may, because of the shortage of time, I would like to submit my complete statement for the record together with the various appendixes, which are appendix 1, Washington Report on Medicine and Health, dated January 27, 1969; appendix 2, a report from the Washington Daily News of February 14, 1969; appendix 3, a report from the Washington Post of Sunday, February 16, 1969; appendix D, or 4, a resolution on Nursing Home Standards, which was unanimously enacted by the National Council of Senior Citizens at its annual convention on June 6; and, finally, one which I did not presubmit to the committee but a copy of the letter submitted by myself as the executive director of the National Council of Senior Citizens to Miss Mary Switzer, the Administrator of the Social and Rehabilitation Service, on the subject of the interim regulations.

Senator MOSS. They will all be appended to your statement and will be part of the record.

(The prepared statement of Mr. Hutton follows; the additional material referred to appears in appendix 1, p. 135:)

PREPARED STATEMENT OF WILLIAM R. HUTTON

Mr. Chairman and members of the subcommittee, during the past several years the National Council of Senior Citizens has received in its headquarters offices letters numbering in the thousands from members reporting and protesting the plight of a relative or friend confined in a nursing home. Expressions of concern over scandalous conditions reported in nursing homes have been transmitted to us by many of our affiliated clubs. There are few issues affecting the senior citizens of this nation about which our two and one-half million members feel more strongly.

The National Council vigorously supported the amendments to the Social Security Act proposed by the Chairman of this Subcommittee in 1967. When these were enacted and signed into law, we permitted ourselves to hope that the Department of Health, Education and Welfare, knowing the conditions that exist and the helpless plight of so many aged welfare patients in nursing homes, would take full advantage of its new legal authorities and that we would see the beginning of real progress toward assuring the aged sick the humane and professional care they so desperately need. Today, we are bitterly disappointed.

The National Council of Senior Citizens pretends to no special expertise in medical care, but simply by comparing the provisions of the interim regulations which were published by the Department last June 24, with the provisions of the law and with the Department's past requirements, and by use of common sense we can see clearly that the interests of the nursing home industry have been accommodated and the aged have been sold short.

The crucial element in skilled nursing home care is skilled nursing service. It is in this section, paragraphs (1) through (3) under "*Definition of terms*" that the Department fails to respect the law and fails to meet its responsibilities to Medicaid patients.

Such nursing care standards as these interim regulations contain are found under the heading "organized nursing service." These standards provide for nothing more than the Department required of skilled nursing homes before the Moss amendment was enacted. In fact, the issuance of regulations under the Moss amendment was used as an excuse to postpone the qualification requirement for charge nurses already in effect. Under these proposed standards, a single, untrained practical nurse caring for 500 patients on the afternoon or night shift would meet all specific requirements. It is not necessary to be expert in medical care to evaluate this standard. Any layman can see its absurdity. Can this honestly be called implementation of the law? The National Council of Senior Citizens protests this flouting of the will of Congress.

Mr. Chairman, the report of this Committee—the Special Committee on Aging—entitled "Developments in Aging 1965" (Senate Report 1073, 89th Congress) had this to say about the setting of standards for care under the then new Medicare program:

"Substandard and marginal facilities and programs cannot be tolerated—even for a so-called interim period. Experience has shown that, all too often, interims are extended, extended again, and eventually provisional acceptance becomes permanent. If we meet demand by permitting substandard institutions and organizations to participate, we will be building in a deterrent to the establishment, expansion, and construction of programs and facilities capable of meeting high professional standards."

The truth and wisdom of your Committee's warning, uttered more than three years ago, is amply demonstrated by the events which have finally brought us to this hearing.

Let us take for example the qualification requirements for charge nurses in extended care facilities and skilled nursing homes. The conditions of participation for extended care facilities under Medicare required that the nurse in charge on a shift, if not a registered nurse, must be a graduate of an approved school of practical nursing. The nursing home industry loudly protested this requirement, invoking a bleak picture of wholesale disqualification of facilities and denial of care to beneficiaries. This issue was confronted by the Health Insurance Benefits Advisory Council and an alternative proposal which would have weakened the standard was offered. HIBAC members decided that the problem was exaggerated and that even a few bad situations arising from allowing a charge nurse without proper training could not be justified. HIBAC voted down the proposal to weaken this standard. This can be found in the HIBAC minutes of January 30, 1966.

Did this firm stand produce the chaos predicted? Not at all. In a report to Congress in December 1968, former Secretary Cohen stated:

"Despite the number of complaints received about the charge nurse standard, which would seem to indicate that many extended care facilities had practical nurses licensed by waiver serving in this position, only 254 extended care facilities, when initially certified for participation in the Medicare program, had to be certified conditionally because they did not have qualified charge nurses. When these conditional certifications were withdrawn in April 1968, only 17 had to be terminated for failing to qualify."

Standard-Setting Under Medicaid

Contrast this record with that of standard setting for skilled nursing homes under Medicaid.

(I might say parenthetically, Mr. Chairman, that the National Council believes these are similar facilities and should have similar standards. No one has satisfactorily explained to us why a skilled nursing home patient who may have several mutually aggravating chronic illnesses needs less skilled care than an extended care patient who is recovering from an acute illness after hospitalization.)

In June 1966, the Department of Health, Education, and Welfare issued a statement that a skilled nursing home qualified to participate in Medicaid would be one which could meet the Conditions of Participation for Medicare. Nursing homes had a year and a half—until January 1, 1968—to comply. Immediately there was a hue and cry from the American Nursing Home Association and the Department retreated.

The next time the Department poked its head above the bushes was in March 1967. Somewhat lower and much less detailed standards were issued, and the time for compliance was extended another year until January 1, 1969. Nursing homes which did not meet the requirements by January 1, 1968, were required to have filed a plan for meeting them within the remaining year of the grace period.

January 1, 1968, came and went and noncomplying homes apparently had not filed plans for upgrading since the Department postponed the deadline until July 1, 1968. January 1, 1969, came and went. Many nursing homes still had not complied and many had not filed plans in the interim. But, never fear, HEW was equal to the occasion. On the same day the new nursing home standards were published, another regulation was issued which rescinded all previous nursing requirements retroactively.

". . . The predecessor condition relating to nursing service staff as stated in Interim Policy Statement No. 19, paragraph B.(4)(a)(viii), published in the

Federal Register on November 5, 1968 (33 F.R. 16165), and in the Handbook of Public Assistance, Supplement D, section D-5141.4.1(h), is revoked as of July 1, 1968."

The new nursing home standards just issued, purporting to implement the Moss amendment, freeze into place the meager nursing care standards of March 1967 but again postpone until July 1, 1970, the qualifications requirements for charge nurses. This is coupled with a fierce admonition that in States in which homes do not have qualified charge nurses by December 31, 1969, they must have a plan! Mr. Chairman, if we could clear from our mind's eye the image of the sick and helpless people who are the victims of this ludicrous game, it would be comical. But we can't, and it is not.

RECOMMENDATIONS

Mr. Chairman, the National Council of Senior Citizens has specific recommendations for the improvement of the nursing home standards which have just been published in interim form. We have submitted these recommendations formally to the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, and we would like to submit them now as an appendix to our statement for the information of this Committee. We will be glad to answer any questions you may have about our recommendations, but we would like to devote the remainder of our statement to some broader aspects of the problem.

Why do we have such difficult problems in trying to assure good care for nursing home patients under our Federal programs? What is the explanation for this chronicle of timidity and retreat by a Federal Department that I have recounted earlier? Why did the Moss amendment, which was intended to strengthen the Department's position by giving it a mandate and added legal authorities, meet the ignominious fate of serving as an excuse to perpetuate low standards of nursing home care and to further postpone the most minimal requirements?

We in Washington grow accustomed, perhaps too accustomed, to the fact that nearly all commercial and industrial groups have representatives here who pursue the interests of their members. Working relationships are established with Federal officials, and those officials sometimes come to rely on the special interest representatives for information and advice.

There is not necessarily anything wrong with this system. The problems arise because the consumers of products and services and the general public which foots the bill for many programs do not have representation in the same channels.

One of the functions of the National Council of Senior Citizens is to represent the public in the councils of government, especially that substantial part of the public which is our constituency. We see it as our duty to raise questions when we see what appears to be a questionable degree of special interest influence being brought to bear at the expense of the public, and to protest in their behalf.

"SERIOUS QUESTIONS . . . RAISED BY EVENTS"

We raise some of these questions now. They are based on stories which appeared in the press earlier in the year concerning the development of these regulations. I have here a copy of the January 27, 1969, issue of the Washington Report on Medicine and Health, and I ask that the relevant news item be printed at this point in my remarks. It reports that standards developed within the Department, which were considered by representatives of the nursing home industry to be unfavorable to their members' interests, were radically changed almost overnight at their behest. I have here also a news article which appeared in the Washington Daily News of February 14, 1969, which also reports the same situation and gives confirmation of the report that a paid representative of the nursing home industry actually participated in the revising of these standards to their liking. I ask that this may appear in the record at this point. I wish to submit also an article from the Washington Post, dated February 20, 1969, which raises still more questions by suggesting that the abrupt change in the Department's thinking on nursing home standards may have been related to the personal fortunes of some of its officials.

Mr. Chairman, the National Council of Senior Citizens is not leveling accusations, but we submit that very serious questions are raised by these events and the reports of them which should be answered for the sake both of the Medicaid program and the public. The National Council of Senior Citizens in its Convention on June 6, 1969, expressed its concern and apprehension about these matters in a resolution adopted by the Convention calling attention to the apparent weakness

of Medicaid administration in the area of nursing home care and to the apparent excessive influence of industry representatives with Medicaid administrators. I request your indulgence once more to ask that this resolution be printed as a part of my remarks.

The last paragraph of our resolution calls upon the Congress to follow-up on its enactment of the nursing home amendments of 1967 and exercise its oversight responsibility. You are doing that today, Mr. Chairman. We are grateful to you for it, and we hope that your efforts may shed some much needed light in the dark corners of this affair.

Mr. HUTTON. I would like to go through some of the highlights.

I want to point out, in addition to being the executive director of the National Council of Senior Citizens, I am a member of the Statutory Committee known as HIBAC, the Health Insurance and Benefits Advisory Council, and I am advised I am to be a member of the ad hoc committee which is to study the comments on the regulations. I now know the date of the first meeting, which is August 14. I had not known that previously.

If I may, Mr. Chairman, I do want to say that during the past years the National Council of Senior Citizens has received at its headquarters thousands, not hundreds, but thousands of letters from members, individual members, reporting and protesting the plight of a relative or a friend confined in a nursing home. The expression of concern about these scandalous conditions reported in nursing homes not only have come from members and have come from our affiliated clubs, the leaders of our clubs, but they have also come from many members of the general public, who know of the national council's interest in the welfare of our elderly people. And they say, "Please, won't the national council try to do something about this?"

My appearance today is in response to those many letters we have received from the general public asking us to take a real interest.

We have over the past 2 or 3 years sought to get some 2,500 affiliated clubs around the Nation interested in conditions in their local nursing homes. We are hopeful that in the not too distant future we will be able to provide you another report, one strictly from an outside source, about some of the conditions which our local club leaders have found when they have gone into the kind of nursing homes which exist in their areas.

Some homes, I hasten to add, are very good, but far and away too many of them are terrible places in which to die and, really, warehouses for the soon-to-die. That is about all they are.

We vigorously supported the amendments to the National Social Security Act proposed by you, sir, in 1967. Now, when these amendments were enacted and signed into law, we all hoped that the Department of Health, Education, and Welfare, knowing the conditions that existed—at least I hope they know of the helpless plight of these older people—would take full advantage of the new legal authority which was given them in these regulations. We thought perhaps we might see the beginning of real progress.

Today we are just as disappointed as the last witness you heard just before lunch.

WARNING GIVEN 3 YEARS BEFORE

I want to highlight some of the areas where this morning's testimony might, I think, have clouded the issue. The fact is the truth and wisdom of your committee warning uttered more than 3 years

ago is amply demonstrated by the events which have brought us to this hearing. The conditions of participation for extended care facilities under medicare require that a nurse in charge on a shift if not a registered nurse, must be a graduate of an approved school of practical nursing. The nursing home industry loudly protested this requirement, invoking a bleak picture of wholesale disqualification of facilities and denial of care to beneficiaries.

This issue was confronted by the Health Insurance Benefits Advisory Council and at this time a proposal which would have weakened this situation was offered in HIBAC. But the HIBAC members, which, as you know, are brought from all walks of life, experts and nonexperts—I happen to be one of the public representatives—decided that this problem, the problem of wholesale disqualification and nursing homes unable to continue, was exaggerated and that even a few bad situations arising from allowing a charge nurse without proper training could not be justified. HIBAC voted down the proposal to weaken this standard. This can be found in the HIBAC minutes, sir, of January 30, 1966, which have now been released.

Now, did this firm stand produce the chaos which the nursing home industry predicted? Not at all.

In a report to Congress in December 1968, Secretary Cohen said this:

> Despite the number of complaints received about the charge nurse standard, which would seem to indicate that many extended care facilities had practical nurses licensed by waiver serving in this position, only 254 extended care facilities, when initially certified for participation in the Medicare program, had to be certified conditionally because they did not have qualified charge nurses. When these conditional certifications were withdrawn in April 1968, only 17, sir, out of several thousand, had to be terminated for failing to qualify.

Now, contrast this record with that of standard setting for skilled nursing homes under medicaid.

I might say, parenthetically, Mr. Chairman, that the national council believes these are similar facilities and should have similar standards. No one, not even this morning, sir, has satisfactorily explained to us why a skilled nursing home patient who may have several mutually aggravating chronic illnesses needs less skilled care than an extended care patient who is recovering from an acute illness after hospitalization.

Statement of June 1966

Now, in June 1966, the Department of Health, Education, and Welfare issued a statement that a skilled nursing home qualified to participate in medicaid would be one which could meet the conditions of participation for medicare. Nursing homes had a year and a half, until January 1, 1968, to comply. Immediately there was a hue and cry from the American Nursing Association and the Department retreated.

The next time the Department poked its head above the bushes was in March 1967. Somewhat lower and much less detailed standards were issued, and the time for compliance was extended another year, until January 1, 1969. Nursing homes which did not meet the requirements by January 1, 1968, were required to have filed a plan for meeting them within the remaining year of the grace period.

Now, January 1, 1968 came and went and noncomplying homes apparently had not filed plans for upgrading since the Department postponed the deadline until July 1, 1968, another 6 months. January 1, 1969, came and went. Many nursing homes still had not complied and many had not filed plans in the interim. But, never fear, HEW was equal to the occasion. On the same day the new nursing home standards were published, another regulation was issued which rescinded all previous nursing requirements retroactively. That is B(4)(a), published in the Federal Register of November 5.

I just wanted to hit the points here, sir. But we have specific recommendations for the improvement of nursing home standards and they are in that letter [1] to Miss Switzer.

We want to know why do we have such difficult problems in trying to assure good care for nursing home patients under the Federal program? What is the explanation for this chronicle of timidity and retreat by a Federal department time after time after time?

Mobilizing for Training

Even this morning, despite the fact that we have been hearing for years of the shortage, the shortage, the shortage, they have not yet discussed real plans for training people. They certainly have not discussed the money because money is in short supply. But it doesn't take as long to mobilize the Nation to the moon and we made it. Can't we mobilize the Nation now for training of adequate personnel for nursing homes?

The comparison I heard this morning about the situation regarding alleviating or lessening the standards of education in one particular State as a comparable example, kind of made me shiver. We are dealing with a life-and-death affair when you are dealing with nursing homes.

It does seem to me, sir, that we in Washington grow perhaps too accustomed to the fact that nearly all commercial and industrial groups have representatives here who pursue the interests of their members.

Working relationships are established with Federal officials and those officials sometimes come to rely on a special interest representative for information and advice. We had no denial this morning of your question; in fact ready agreement that the Department of HEW used as its consultant a man who was opposing the regulations on behalf of his organization. They used him to help them write the the regulations which they wanted.

There is not necessarily anything wrong with a system of working together with special technicians. The problems arise, sir, because the consumers of products and services and the general public which foot the bill for any programs do not have representation in the same channels.

One of the functions of the national council, sir, which I represent, is to come and try and present their case. I am here not for me, I am no expert in medicare. I am trying to help the older people to a better life through the National Council of Senior Citizens working on their behalf.

[1] See appendix 1, p. 139.

I am to report the things which our club leaders, 2,500 of them, tell me. Each one of them has been asked to set up a committee on nursing homes in their areas. But what we hear from the people out there is very, very bad and it is high time that this Congress, this administration took notice.

I sympathize with you, sir, because I know how difficult it is to get legislation through Congress, but when you get it through, when it is enacted and then it is frittered away by useless administrators then you are doubly sad.

Senator Moss. Thank you, Mr. Hutton. I appreciate your testimony. That, with the appendixes, gives us a very full picture. Did you indicate that there are 2,500 clubs in the national association?

Mr. Hutton. In my national council, sir, yes, sir, more than a combined membership of more than 2½ million people.

Senator Moss. We certainly appreciate receiving from you the comments that have been gathered from all of these areas because it seems to me this would be as good a grassroots survey as we could make. Nobody is more concerned about this problem than senior citizens because they are the candidates for admission to nursing homes and extended care facilities. They are the ones who need the services and what they report, I am sure, will be very candid and I think very accurate as to what they find in their own local communities.

I also appreciate what you had to say. The reason for having these hearings is that in adopting the amendments to the Social Security Act, we thought we had set up standards that were going to be met and that we were going to move forward rather than take steps backward. It has given us great concern.

As you indicated, rather than require compliance where it was shown that actually we could get compliance—what was it, only 17 that did not comply under medicare?

Mr. Hutton. That is right, only 17 eventually.

Senator Moss. Yes, 17 had to be terminated and that would indicate that with very few exceptions they could all meet the standards if given a year's time or 2 years' time to do so, rather than constant procrastinating and now, stepping backward.

Senator Miller, do you have a question? Thank you, your cooperation in helping us move along is appreciated, too.

STATEMENT OF PIERRE SALMON, M.D., AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BERNARD P. HARRISON, DIRECTOR, DEPARTMENT OF LEGISLATION

Senator Moss. I am going to ask Dr. Salmon if he would testify next. I understand he has a time problem. He represents the American Medical Association. Dr. Salmon comes from San Mateo, Calif. He is a member of the AMA Committee on Aging. We appreciate your being here, Dr. Salmon, and you have come a long way to testify before the committee.

STATEMENT OF DR. SALMON

Dr. Salmon. Thank you, Senator Moss. I am Dr. Pierre Salmon, physician specialist at the Crystal Springs Rehabilitation Center, a division in the San Mateo County Department of Public Health and

Welfare in California. I serve also as a member of the Committee on Aging of the Council on Medical Services of the American Medical Association. With me is Mr. Bernard P. Harrison, the director of the association's department of legislation.

We appreciate your invitation to appear. I have a 6½-page formal statement which I would like to have put into the record, Mr. Chairman. I will highlight the first four pages and I would like then to read the last two-plus pages in detail.

Senator Moss. Thank you, Dr. Salmon. That will be done and you read from it or excerpt from it the parts you would like to emphasize here today.

Dr. Salmon. As your subcommittee well knows, the long-term patient is not defined or delimited by any particular disease entity, age group or type of impairment. He is quite simply an individual, of whatever age, diagnosis or type of impairment, who is significantly incapacitated or hindered in life's activities over what is for him a considerable period of time.

These long-term patients may live at home or be patients in different kinds of medical facilities. There has been confusion among physicians as well as in the public mind about the definitions of long-term care facilities. Many attempts have been made to describe the variety of services available but labels have tended to be used inexactly and inappropriately by the majority of physicians and practically all lay persons. These distinctions have not been precise. In the past, the short-term hospital has been the medical facility used by physicians during tht acute state of illness, plus a reasonable period of convalescence. The presumption now is that the patients will be transferred from the hospital to the extended care facility immediately after the acute stage of illness has passed, since the ECF is presumed to have the means and the staff to follow the acute therapy given in a hospital with proper convalescent care. The physician who follows his patient through the convalescent period in the ECF has responsibilities as an attending physician similar to those in the acute hospital, including the treatment regimen, an adequate medical record and the observance of formalized procedures as developed by patient care policies.

A possible effect of recent legislation has been to stimulate general hospitals to expand their services to include extended care by construction or by designating a distinct part of the hospital as an ECF. Hospitals may be better prepared than nursing homes with personnel and facilities to give care immediately subsequent to the acute phase of an illness. Post hospital care appears to be a logical extension of the general hospital progressive patient care concept. If such expansion occurs to a substantial degree it might be expected that nursing homes would most likely offer primarily the longer term personal and custodial care in which they are expert. For the present, however, all indications are that hospital operated ECF's and skilled nursing home ECF's are both needed to satisfy the demand for extended care.

"Community Coordinating Committees"

We believe that the medical profession should take the lead in organizing "community coordinating committees" to assume overall responsibility in coordinating available health facility services in the community.

This we have demonstrated. The evolution of progressive patient care from intensive short-term care to domiciliary or home care, influenced by medical specialization and hastened by legislation, appears to be moving toward a formalization of the various levels and types of long-term care facilities. Attention is now being focused on the care of chronically ill patients and the rehabilitative aspects of long-term care, both in institutions and in the home. This is in marked contrast to the earlier broad application of the "nursing home" category to many levels of care.

What then will be the function of the long-term care facility in the future? Concern with both quality and cost of patient care is at the root of all ongoing efforts to define the functions of the various types of patient care facilities. Since costs vary greatly with the degree of skill and the intensity of care, the length of stay at various levels of the progression becomes an important consideration in patient management.

From the point of view of the medical profession, there seems to be real significance in the fact that experience is being developed as to both medical and ancillary questions on the patient care progression. Utilization review in ECF's is one example. In the general hospital, the utilization review function is based on knowledge of the precise character of the hospital services, and the time requirements for diagnosis and treatment of the usually definitive ailments of its acute patients. In contrast, the utilization review function in the EFC is handicapped by lack of similar knowledge and experience. Elderly patients admitted to the ECF will often present a complex network of personal problems—emotional, social, behavioral, cultural—as adjuncts to their physical illnesses. There are few precedents on which a utilization review committee can judge the necessity for admission, the applicability of services, proper length of stay, et cetera, for the elderly ECF patients.

Home Health Care Services

In addition to its concern with the ECF and other long-term care facilities, the medical profession also is involved in the growing utilization of home health care services. The wide-range medical and institutional care for large segments of the population, as provided in Public Law 89–97, indicates the magnitude and complexity of medical decisions yet to come, and the new challenges yet to be met.

Before concluding, Mr. Chairman, I would like to respond to three specific questions contained in your letter of invitation. The first requested our comment on the proposed HEW standards for payment for skilled nursing home care under title XIX, the second asked for AMA recommendations for increasing the number of licensed nurses and other key personnel required for long-term care, and the third requested a report on any AMA research or conference relating to trends in long-term care.

As to the first question, we note that the proposed regulations for skilled nursing homes require them to maintain an organized nursing service under the direction of a full-time registered professional nurse on duty during the day shift and either a registered professional nurse or licensed practical nurse on all other shifts. The proposed

requirement is essentially the same as that required for nursing care facilities under the standards of the Joint Commission on Accreditation of Hospitals and for extended-care facilities under medicare.

We believe that this staffing regulation is sound in view of available funds and current shortages of manpower. We recognize, of course, that when the manpower supply improves and more funds become available for skilled nursing home care, more and better qualified nursing staff might be required.

Concerning the second question, in recent years the AMA has recognized the existence of an acute shortage of trained nursing personnel throughout the country. Many hospital nursing schools have been closed in recent years because hospitals can no longer afford the heavy costs of nursing education. We have urged increased subsidies to hospital nursing schools and have encouraged State and local medical societies to seek all available sources of financial support for hospital nursing schools.

We have commended those hospitals that conduct diploma schools of nursing for the great contribution being made by these institutions to the health needs of the Nation and have urged that such hospitals continue their schools and increase enrollment. Lest these remarks be misinterpreted, we hasten to reaffirm our support of all forms of nursing education including baccalaureate, diploma, associate, and practical nurse education programs.

AMA Conferences

With respect to AMA conferences relating to trends in long-term care, over the past 10 years, the AMA Committee on Aging has sponsored nearly 20 regional conferences on aging and long-term care in different parts of the country, with attendance ranging from 300 to 1,100 persons. These meetings have attempted to stimulate joint action at State and local levels between medicine and other concerned groups in improving long-term care. With the American Nursing Home Association, through the Joint Council To Improve Health Care of the Aging we held 15 institutes on care of the long-term patient in nursing homes. These were directed to nursing home administrators, and were also attended by hospital administrators, State and local public health and welfare officials, and others. We are currently involved in exploring with long-term care facility administrators and others, the development of educational seminars and resource material for physicians who care for patients in nursing homes.

Major projects and publications of the AMA Committee on Aging include several policy position papers, a guide for medical society committees on aging, special studies into such areas as home care programs and chronic illness information centers, a suggested outline for periodic health appraisals and an exhibit on this subject for physicians, and periodic presentation of scientific programs on aging and long-term care at AMA annual and clinical sessions.

We will make these available to the committee if it wishes.

Senator Moss. We would be pleased to have them in our files and if you could supply them we will be grateful.

Dr. Salmon. We will be happy to respond to any questions you and your committee members may have.

Senator MOSS. Thank you very much, Doctor, that is a very fine statement. You indicated that you approved of the requirements in the regulation that there be a RN on duty in charge during the day period and at least a licensed practical nurse for the other two shifts.

Nothing in the regulations governs the number of nurses per patient. What is your opinion on that?

Dr. SALMON. I think perhaps we have had too little experience up to this point to attempt to prepare specific guidelines or sound ratios. I think perhaps this will be necessary within the relatively near future, by that I mean perhaps the next several years. But I think it would be premature now to attempt to establish ratios which would be looked upon as definitive.

I think there would be more freedom of action if this were deferred for the next 2 or 3 years.

Senator MOSS. But if the trend were, whether it is a trend or not, if the optimum size of a nursing home is, say, 120 patients, the supervisory nurse, if she were the only trained person there, would be overtaxed really, wouldn't she?

Dr. SALMON. Oh, there is no question about that. I think when one enters into an activity of this sort, one has to use reason and I don't think that a reasonable individual who invests his money in a nursing home would consider that this would be at all possible.

I think that the type of individual who would go into this sort of an endeavor would be guided by ordinary business principles as well as by guidelines coming from other authorities.

MODELS FOR STANDARD-SETTING

Senator MOSS. Do you think that it would be desirable to have a model or demonstration project attempting to establish a ratio that would be a minimum nursing home standard?

Dr. SALMON. I think perhaps we have several models. We have heard about one in some detail this morning. I think experience gained in those areas on an experimental basis, perhaps varying the factors that enter into the experiment in various locations, culminating in culling out the data on this, will provide a much sounder footing on which to make these decisions.

At present you are subject to an expression of many opinions without a solid basis for them.

Senator MOSS. Is this something that your committee on aging in the American Medical Association would be interested in undertaking?

Dr. SALMON. I think I can't speak for them around the specific question, but I think we are not qualified to undertake this thing itself. However, we would be in favor, I believe, of urging some better qualified group, the joint commission perhaps, to undertake such a project.

Senator MOSS. Thank you, Dr. Salmon.

Senator Miller?

Senator MILLER. You say that you believe that the staffing regulations are adequate in view of the available funds and current shortages of manpower. What do you have in mind when you refer to available funds?

Dr. SALMON. The funds that come out, perhaps the first thought, that come out of the governmental system on medicare and medicaid, also from the private sector of medicine.

It seems to me that with the emphasis now being placed on the skyrocketing costs of total health care, the public perhaps is somewhat reluctant to pay for the maximum staffing patterns that might be required, let's say, if the ideal situation were to be met. Mr. Harrison would like to comment.

STATEMENT OF MR. HARRISON

Mr. HARRISON. The American Medical Association has testified recently on two occasions with respect to seeking and urging the Congress to fully appropriate funds for education, medical education and the ancillary and allied health purposes through those programs which provide for Government support of education and training.

We are all aware that in current times there is a shortage of available Federal funds or at least that there are many pressures for the use of those funds which are available. We have urged that high priority be given to this aspect of health care and this aspect of Government interest because of the needs with respect to health manpower, including the people who would staff nursing homes, the nursing personnel.

Senator MILLER. I thought possibly one thing you had in mind would be the fact that if you had a relatively small nursing home that the cost of meeting the regulation requirements for having a registered nurse and licensed practical nurse full time might cause the costs to go up in that small nursing home to an almost prohibitive degree.

For example, let's take a nursing home in a small town in a rural community with 15 beds. There might be no other facility available except the hospital. To have a full-time registered nurse or at least a part-time registered nurse and full-time LPN makes the cost of care very high, doesn't it?

Dr. SALMON. Yes, this would appear to be a factor. This is one of the unfortunate things, that the size of the long-term care facility is a direct factor in determining the unit cost of providing that care. I think the nursing home people would indicate a 15-bed nursing home is very uneconomical to operate.

Senator MILLER. What do we do in a situation like that if by the target date set forth in the regulations, July 1, 1970, this small nursing home simply can't afford to hire these people, in fact, they may not be available? They may not want to come to live in that little community, they may be in very sparsely settled area, perhaps out in Utah, or Nevada, or North Dakota, and so it can't qualify. Where are the medicaid patients going to go?

Dr. SALMON. The logical response that occurs to me, Senator Miller, is that where there are rules and regulations, there are always exceptions. It would seem to me that in a specific instance of this sort, which to me would be almost unique, it would not be a common type of situation, these would be relatively few in number, specific exceptions might be made in these instances.

Senator MILLER. In other words, you would advocate that there be discretion on the part of either the State or the Federal agency to relax those standards to meet the necessities of the situation?

Dr. SALMON. This would be under rather rigid criteria that might be set up for the guidance of the individual making the decision. Mr. Harrison, I think, would like to comment on that also, if he may?

Mr. HARRISON. I think that would be a possibility, Senator, and I am sure that care would have to be exercised so it is not an open door type of invitation for that kind of arrangement. But I am thinking of another thing. Under the medicare regulations there are provisions for arrangements with hospitals. For example, if I can assume that in this particular nursing home or extended care facility area there is also a hospital, which is very likely to be the case, I could see perhaps an exception which would allow for an arrangement between the extended care facility and the hospital to provide an overall coverage of personnel, staffing personnel, on a basis similar to that providing for a physician on call.

REGULATIONS FOR EXCEPTIONS

Perhaps regulations can be established to provide for those exceptions. Certainly there are two facets here that are involved. On the one hand, it is necessary to provide the needed extended-care facility care at whichever level we are speaking of. And we are speaking this morning on a number of different levels, from that which is the highest-of-care level immediately from the hospital under medicare within a very short period of time and after only 3 days of hospital care, to other kinds of care which are more commonly associated with that which we call custodial care.

One of the things we always have in mind is that it is necessary to provide nursing home care for these individuals. If we are, by regulations or otherwise, going to cut off that care entirely, perhaps we are not serving their interests best at this time. So, we have to balance that. We certainly don't want to cut off the care that is available. On the other hand, we want to insure that the maximum kinds of care are available to these people. Perhaps, then, there might be exceptions for other small nursing homes in sparse areas, perhaps with an arrangement with hospitals so that the maximum quality of care could be obtained under the circumstances.

Senator MILLER. Thank you very much.

Senator MOSS. Thank you very much, gentlemen, for your response to questions, for your testimony, Dr. Salmon. We are pleased to have had you.

(The prepared statement of Dr. Salmon follows:)

PREPARED STATEMENT OF DR. PIERRE SALMON

Mr. Chairman and members of the committee, I am Doctor Pierre Salmon, Superintendent of the Institutional Clinical Services Division in the San Mateo County Department of Public Health and Welfare in California. I serve as a member of the Committee on Aging of the Council on Medical Services of the American Medical Association. With me is Mr. Bernard P. Harrison, Director of the Association's Department of Legislation.

We appreciate your invitation to appear before this Subcommittee to present the views of the American Medical Association on the subject of long-term care.

As your Subcommittee well knows, the "long-term patient" is not defined or delimited by any particular disease entity, age group or type of impairment. He is quite simply an individual, of whatever age, diagnosis or type of impairment, who is significantly incapacitated or hindered in life's activities over what is for him a considerable period of time. As such, we are concerned with the child with a birth defect as well as the older person with arthritis, the individual paralyzed by an automobile accident as well as the person suffering from cancer.

In recent years, there has been an even further increase in the attention devoted to long-term disease and disability. The medical, social and economic problems posed by the individual who—whether because of acute or chronic disease, accident or genetic defect—is impaired over a long period of time are tremendous, and once again we would commend your Subcommittee for its continuing concern toward improving long-term care.

In previous appearances before the Senate Committee on Aging, other witnesses have testified for the American Medical Association expressing its overall concern and activities in the field of long-term care, and specifically on such areas as health maintenance programs and the prevention and detection of chronic conditions. In keeping with this hearing's major focus, I will direct my comments today primarily to the changing and evolving role of long-term care facilities.

Long-term patients may live at home or be patients in different kinds of medical facilities. There has been confusion among physicians as well as in the public mind about the definitions of long-term care facilities. Many attempts have been made to describe the variety of services available in the different categories, but labels have tended to be used inexactly and inappropriately by the majority of physicians and practically all lay persons. The distinctions have not been precise. There have been many areas of potential overlap. The development of accreditation programs by the Joint Commission on Accreditation of Hospitals for different kinds of nursing homes and the enactment of federal legislation have served to dispel some of the confusion.

In the past, the short-term hospital has been the medical facility used by physicians during both the acute stage of illness plus a portion of convalescence. Upon discharge from the hospital, the patient was able to convalesce further at home, or at a nursing home providing either a skilled or intermediate type of nursing care. Now, the presumption is that the patient will be transferred from the hospital to the extended-care facility immediately after the acute stage of the illness has passed, since the ECF is presumed to have the means and the staff to follow the acute therapy given in the hospital with proper convalescent care. The physician who follows his patient through the convalescent period in the ECF has responsibilities as attending physician similar to those in the acute hospital, including the treatment regimen, an adequate medical record, and the observance of formalized procedures as developed by a patient care policies committee. To a much greater extent, rehabilitation is now being incorporated as an integral part of medical care to be provided in the extended-care facility. This has important implications for prevention, rather than viewed as an isolated "action" to be tacked on at the end of definitive medical care. In many cases, deferring rehabilitation until the acute phase of illness has passed, rather than applying such procedures early in the onset of trouble, in a sense, has created disabilities which did not exist previously.

At long last, the potential of nursing homes as a link in the chain of medical facilities is now beginning to be realized in the extended-care facility. Of course the physician still has the problem of selecting other types of long-term care institutions when required for his patients. But with the development of various types and levels of long-term care, the physician will need a greater awareness of the character and availability of his community's facilities, and the range of alternative services, in placing or transferring his patient to the proper level of care within the patient care continuum.

Another possible effect of recent legislation has been to stimulate general hospitals to expand their services to include extended care, by construction or by designating a "distinct part" of the hospital as an ECF. Hospitals may be better prepared than nursing homes with personnel and facilities to give skilled restorative care immediately subsequent to the acute phase of an illness. Post-hospital care appears to be a logical extension of the general hospital progressive patient care concept. If such expansion occurs to a substantial degree, it might be expected that nursing homes would most likely offer primarily the long-term personal and custodial care in which they are expert. For the present, however, all indications are that hospital operated ECFs and skilled nursing home ECFs are both needed to satisfy the demand for extended care.

There is often a need for a cooperative approach to a critical evaluation of a community's health resources problems. This approach, by causing physicians and administrators to examine and identify jointly the type, quality, and level of care that can be provided by each facility in the area, affords the best chance for maximum effectiveness in the utilization of ECF and other health facilities

in the community, and for meaningful utilization review. Further, such a committee can work towards attaining a degree of standardization in procedures and terms of reference, and coordinating the services of at least the long-term care facilities in the area. In essence, this is comprehensive health planning.

We believe that the medical profession should take the lead in organizing "community coordinating committees" to assume overall responsibility in coordinating available health facility services in the community. We have suggested that local medical societies invite representatives of the other health agencies and professions in the area to discuss and consider jointly the community's particular problems with regard to long-term care—both convalescent and custodial care. Some local medical societies have taken this initiative. We have also suggested that such meetings include directors of hospitals, nursing homes, professional associations, and other local institutions; welfare and public health officials, social workers, and other interested professionals in the area.

The evolution of progressive patient care, from intensive short-term care to domiciliary or home care, influenced by medical specialization and hastened by legislation, appears to be moving towards a formalization of the various levels and types of long-term care facilities. Attention is now being focused on the care of chronically ill patients, and the rehabilitative aspects of long-term care, both in institutions and in the home. This is in marked contrast to the earlier broad application of the "nursing homes" category to many levels of care.

Long-Term Care of the Future

What will be the function of the long-term care facility in the future? Concern with both quality and cost of patient care is at the root of all ongoing efforts to define the functions of the various types of patient care facilities. Since costs vary greatly with the degree of skill and the intensity of care, the length of stay at the various levels of the progression becomes an important consideration in patient management. And, in order to insure the proper movement of the patient to effect his being in the "right place at the right time", the precise capabilities of each facility in a community must be established.

From the point of view of the medical profession, there seems to be real significance in the fact that experience is being developed as to both medical and ancillary questions on the patient care progression. Utilization review in ECFs is one example. In the general hospital, the utilization review function is based on knowledge of the precise character of the hospital services, and the time requirements for diagnosis and treatment of the usually definitive ailments of its acute patients. In contrast, the utilization review function in the ECF is handicapped by lack of similar knowledge and experience. Elderly patients admitted to the ECF will often present a complex network of personal problems—emotional, social, behavorial, cultural—as adjuncts to their physical illnesses. There are few precedents on which a utilization review committee can judge the necessity for admission, the applicability of services, proper length of stay, etc., for the elderly ECF patients.

In addition to its concern with the ECF and other long-term care facilities, the medical profession also is involved in the growing utilization of home health care services. The wide-range medical and institutional care for large segments of the population, as provided in Public Law 89–97, indicates the magnitude and complexity of medical decisions yet to come, and the new challenges yet to be met.

Before concluding, Mr. Chairman, I would like to respond to three specific questions contained in your letter of invitation. The first requested our comment on the proposed HEW standards for payment for skilled nursing home care under Title XIX, the second asked for AMA recommendations for increasing the number of licensed nurses and other key personnel required for long-term care, and the third requested a report on any AMA research or conferences relating to trends in long-term care.

As to the first question, we note that the proposed regulations for skilled nursing homes require them to maintain an organized nursing service under the direction of a full-time registered professional nurse on duty during the day shift and either a registered professional nurse or licensed practical nurse on all other shifts. The proposed requirement is essentially the same as that required for nursing care facilities under the standards of the Joint Commission on Accreditation of Hospitals and for extended-care facilities under Medicare.

We believe that this staffing regulation is sound in view of available funds and current shortages of manpower. We recognize, of course, that when the manpower supply improves and more funds become available for skilled nursing home care more and better qualified nursing staff might be required.

STAND ON PERSONNEL SHORTAGES

Concerning the second question, in recent years the AMA has recognized the existence of an acute shortage of trained nursing personnel throughout the country. Many hospital nursing schools have been closed in recent years because hospitals can no longer afford the heavy costs of nursing education. We have urged increased subsidies to hospital nursing schools and have encouraged state and local medical societies to seek all available sources of financial support for hospital nursing schools.

We have commended those hospitals that conduct diploma schools of nursing for the great contribution being made by these institutions to the health needs of the nation and have urged that such hospitals continue their schools and increase enrollment. Lest these remarks be misinterpreted, we hasten to reaffirm our support of all forms of nursing education including baccalaureate, diploma, associate, and practical nurse education programs.

Over the past 10 years, the AMA Committee on Aging has sponsored nearly 20 regional conferences on aging and long-term care in different parts of the country, with attendance ranging from 300 to 1,100 persons. These meetings have attempted to stimulate joint action at state and local levels between medicine and other concerned groups in improving long-term care. With the American Nursing Home Association, through the Joint Council to Improve Health Care of the Aging we held 15 institutes on care of the long-term patient in nursing homes. These were directed to nursing home administrators, and were also attended by hospital administrators, state and local public health and welfare officials, and others. We are currently involved in exploring with long-term care facility administrators and others, the development of educational seminars and resource material for physicians who care for patients in nursing homes.

Major projects and publications of the AMA Committee on Aging include several policy position papers, a guide for medical society committees on aging, special studies into such areas as home care programs and chronic illness information centers, a suggested outline for periodic health appraisals and an exhibit on this subject for physicians, and periodic presentation of scientific programs on aging and long-term care at AMA Annual and Clinical Sessions.

Senator MOSS. Our next witness will be Miss Mary Shaughnessy, member of the American Nurses' Association Commission on Nursing Services, herself a registered nurse. We will be very pleased to hear you, Miss Shaughnessy, representing the American Nurses' Association.

As I had announced before, your statement will be in the record in full and you may, as you care, present what you would like to emphasize for us.

STATEMENT OF MISS MARY E. SHAUGHNESSY, RN, M.S., MEMBER, ANA COMMISSION ON NURSING SERVICES

Miss SHAUGHNESSY. Thank you, Mr. Chairman.

I am Mary Shaughnessy. I am representing the American Nurses' Association. I would also like to add that for the past 8 years I have been involved in carrying out a series of studies to identify the nursing requirements of patients in nursing homes and to develop guidelines for staffing.

In addition to the statement that we have prepared, would you accept this copy of a report on 141 patients in two nursing homes which I think will describe in great detail the kinds of problems exhibited by these patients; the need they have for nursing care; and the ways in which we estimated staffing complements for the units studied.[1] There were a variety of patterns necessary in order to meet the needs of what is generally called a typical nursing home population.

Senator MOSS. The report will be received and be incorporated by reference in the record.

[1] Retained in committee files.

Miss SHAUGHNESSY. I would like to summarize briefly what I consider to be some of the important factors that need to be considered by this committee.

First of all, the complexity and intensity of problems presented by patients with long-term illnesses and disability require great expertise in planning and executing care with an appropriate specific goal(s) for each patient.

The nature of the nursing care can only be derived from the specific problems presented by the patient and therefore, requires a nurse director who has the necessary knowledge of physical-physiological and social-psychological factors required to assess accurately the nursing problems presented by a specific patient or a group of patients. Planning, implementing, and evaluating the outcomes of nursing action must rest with qualified professional nurses.

(2) By definition, nursing homes are limited in scope and the services available are supposed to be for patients with particular needs. In practice the population of most nursing homes throughout this country varies greatly including some patients who actually require the services of an acute hospital setting; many who ought to be in chronic hospitals; some who actually need nursing home care; and others who could be well cared for in the community if we had some of the supportive community services such as those available to elderly people in countries like England, Scotland, et cetera.

(3) If adequate nursing care is to be rendered in a nursing home the director of nursing service must have the authority necessary to carry out her responsibility to patients. In my judgment one of the most serious problems related to organizing and administering appropriate care in these facilities today rests with the failure to delegate appropriate authority to the director of nursing.

(4) The amount and kind of care, nursing care, that can be provided is influenced by the competence of the staff and by the nature of the patient population. Again, it requires the expertise of a prepared professional nurse to determine the extent to which the needs of a specific patient may be met in the institution. For this reason it is essential that nursing service have an integral part in determining admissions recommending transfers and discharges; and, in developing patient care policies within the facility.

(5) The problem of caring for long-term nursing home patients is complicated by the dearth of resources in many of the facilities today and it is also complicated by the isolation of these institutions from other health and welfare agencies in the community. Although it is theoretically possible to assist many patients to become more independent, the lack of specialized resources within the community places unrealistic burdens on nursing home facilities to meet the needs of a heterogeneous population. This results in less than adequate care for many patients.

100 DAYS INADEQUATE

(6) The problem of expecting 100 days to be adequate to meet the needs of most elderly people is most unrealistic. Experience has shown that the elderly respond at a much slower rate than other age groups. I would suggest that we need to do some studies to measure the amount of trauma experienced by patients who are being

shifted from one facility to the other due to the current policies in practice. I also would suggest that the move from one room to the other for many elderly patients is enough to cause them serious damage. Decisions to place patients in nursing homes should be made with consideration to the nursing problems as well as medical and social, economic factors. Unfortunately, most of the time little consideration is given to the nursing needs. The accurate assessment of the patients' nursing needs is not a part of current practice in most hospitals or long-term care facilities.

(7) Nursing requirements for patients appropriately placed in nursing homes differ from those in an acute hospital setting. However, up until recently, most nurses were prepared almost totally within an acute hospital setting. Therefore, we have a dearth of nurse practitioners in the country who are really skilled in meeting the needs of the aged with long-term illnesses and disabilities. It is necessary to supplement the education of most nurses in the country today in light of current needs of the aged with long-term illnesses and disabilitities. For too long we have delegated the care of persons with the most complex and intense long-term problems to the least qualified personnel. We have not yet defined nursing practice in a nursing home or a long-term case facility. Nursing is beginning to develop a group of effective leaders who can design appropriate patterns of care for long-term patients. However, at present, we cannot say specifically how many nurses or what kinds of nursing personnel are required in a skilled nursing home.

We must institute well-designed studies to answer these questions. Effective policies cannot be written until we have some of the answers that we lack today. Good care is a right, not a privilege, and the proposed standards, as they are written, in our judgment, do not reflect this but rather discriminate against segments of the population.

(8) While there is admittedly a shortage in some parts of the country, it is my belief that the problem of proper utilization of nurses is a far greater issue. There are, at the present time, 400,000 registered nurses who are not employed. There are over 69,000 licensed practical nurses who are not currently employed. There have been many attempts within the past few years to provide refresher course training for both licensed registered nurses and licensed practical nurses.

But time and time again, in talking to these people, they fail to continue in the work situation beyond 1 or 2 months because they find that the policies and practices in long-term care facilities are so difficult to work under that they retire again for the second time.

I would ask you again to refer to the report called "The Problem of Nursing Home Patients; Implications for Improving Nursing Home Care." This was a project funded by the Public Health Service and conducted in two cities in the United States over a 2-year period. In this study we elicited the wide variety of needs of patients being cared for in the study homes. We were able to point to some of the problems in executing even minimal safe nursing care. In both of these institutions they had more registered nurses and many more licensed practical nurses than one sees in many of the institutions in the country today. The staffing was much higher than the minimal standards required by medicare.

(9) In talking about recruiting nurses into this field of nursing, I think we have to look at both recruitment problems and staff turnover problems. I would just summarize some of the factors that I think influence our inability to get the kind of people that we need and/or to retain them after they are employed:

(*a*) Nursing homes do have a poor image as far as nurses are concerned. (*b*) The average nurse is ill prepared to meet the needs of elderly people with long-term complex medical problems, without supplementary training. (*c*) The difficulties of practicing safe nursing care according to accepted standards of practice are very great due to the restricted policies or lack of policies in many of these institutions. (*d*) The lack of authority vested in the nursing service department makes it very difficult to carry out the kind of care that is required. (*e*) The isolation of the nursing home from other health facilities makes it an unpopular place to practice. (*f*) The lack of stimulation and support from other nurses, physicians, and other health workers is another factor. (*g*) The poor administration, overall administration of many of the facilities prevents well prepared nurses from continuing to work in them.

(10) The nursing profession has engaged in many activities in the past few years to try to improve the quality of service available to patients with long-term problems. The plans and programs of the nursing profession are spelled out in some detail in our statement.

Some of the efforts to improve the quantity and quality of nursing services in long-term care facilities are spelled out on pages 7 to 10 in the testimony. The primary focus in on supplementing the basic educational preparation in the practical nurse and the registered nurse curricula. It stresses the need to include content relating to an understanding of the aged and an understanding of the nature and complexity of long-term care problems. Currently, we are beginning to develop clinical experience in long-term care institutions to introduce the student nurse to this area in the field of practice and this needs to be expanded to include care in community settings.

Continuing In-Service Education

There is also an interest in efforts to provide continuing in-service education and on-the-job training for two purposes; first, because technological practice is changing every day and nurses need to have some way to keep abreast of advances in health care; secondly, we are using the increasing need to provide on-the-job training and supervision for nonprofessional attendants, aides, and orderlies in light of the needs of the particular institution.

Educational offerings need to be carefully planned and carried out by the most expert practitioners and nurse-teachers if we are going to improve the interest and the skill of nurses in this field. Funds are necessary to implement programs and to support the research required in this field. Steps must be taken to improve the economic and general welfare of nurses working in nursing homes since today—particularly in urban areas—the demands for nurses in all health agencies require that nursing homes compete for personnel.

We hope to have the opportunity to discuss other aspects of the problem with you at future hearings.

Thank you for giving us the opportunity to speak to you today.

Senator MOSS. Thank you, Miss Shaughnessy for a very fine statement. We do anticipate calling on you at later hearings as we discuss this subject and others on which you can bring us viewpoints of the American Nurses Association and the experience that you have from that association.

Now, you indicated, I think, that there were 400,000 RN's who are not employed at the present time and 69,000 LPN's. This is a surprising number since we are all accustomed to believing that nurses are in such critically short supply.

I think that your statement also indicates that one of the reasons they may not be available to nursing homes is the rather poor image of the nursing home. Many of them just didn't choose to work there and retired voluntarily just because they didn't like it or it didn't suit them. In your opinion, does this arise largely from the failure to train nurses in geriatric fields, long-term care fields, that has been true, as you indicated, up until recently?

Miss SHAUGHNESSY. I think, Senator Moss, in great part it is due to this. It is overwhelming to walk into an institution filled with patients with such complex problems and to be able to deal in an effective manner with them without a very good kind of background preparation in this kind of care.

What we did, historically, was to dilute the kind of services that we provided to patients in an acute hospital, assuming that "two-thirds or one-half" of the care was going to meet the need of somebody whose status was less changeable and who required long-term but not as complicated care. This is not true. In my experience nurses who have become discouraged in nursing homes leave because they are unable to cope with the enormous problems due to a lack of the kind of assistance they need and, consequently, they leave the job.

The other major problem, of course, rests in the organization of many of the nursing home facilities which legislates against what most prepared nurses consider to be safe and good practice.

Senator MOSS. Is there a noticeable shortage of supportive personnel in nursing homes generally? Has that been a factor?

I think I gathered that somewhat in your statement. To turn it around the other way, you might say that nurses are confronted with large and complex problems in the nursing home without sufficient supportive personnel, such as orderlies and others that you might expect to have in an acute hospital?

Miss SHAUGHNESSY. By support, I mean the kind of professional support that nurses receive in a hospital from phsyicians and other health disciplines. In many nursing homes, it is only with great difficulty that one is able to get physicians to come to the institution at all. Seldom are physicians actively interested in the patient care problems. Often the nurse prepared with the help available to her in a general hospital setting suddenly finds herself, 3, 5, 8 miles away from the doctors or a hospital and she is overwhelmed with her responsibility.

CARE IN BRITAIN, SCANDINAVIA

I spent the fall and part of the winter studying the care of the elderly in Great Britain and Scandinavia. There, excellent quality care is provided to old people with long-term illnesses with a minimum number of registered nurse personnel, but with very well trained

licensed practical nurses or State-enrolled nurses, the scope and limitations of each type of institution is clearly defined and consequently properly utilized by patients and health professionals.

Another difference, in my view, was the fact that the nurse had clearly defined authority and responsibility and she was able to design a program of nursing service and to carry it out. She also had the interest and support of the community; of the medical groups; and all the other health and welfare disciplines.

Senator Moss. I suppose this is part of the problem that we thought we detected earlier; the lack of focus on this type of care in medical education. The exciting place to be is in surgery or in dealing with acute situations, and it is rather humdrum and discouraging to have long-term acute cases that stretch on and so many of them can not have a dramatic success in the end. For that reason, this part of medicine has been rather neglected. You are saying, I think, to me, that we have done the same thing on the nursing side.

Miss Shaughnessy. Yes.

Senator Moss. That is very revealing and would indicate where we need to place some emphasis on our education and motivation in the health field, if we are going to cope with the problem we have of our elderly in need of long-term care.

Thank you very much.

Senator Miller, do you have any questions?

Senator Miller. Thank you, Mr. Chairman.

Miss Shaughnessy, I appreciate your good statement, but I must say you leave me a little depressed. First of all, as I understand it, you think the regulations are all right but then you give us a picture of the difficulty in obtaining, let alone holding, nursing homes. It makes me wonder how soon we can attain the standards for all of our nursing homes that are set forth in that regulation or whether we will ever be able to.

Miss Shaughnessy. Senator Miller, I am sorry you are depressed. I did not mean to paint such a black picture. However, I do not agree that the regulations are as they should be. I stated that I can't come before you today and give documentation that there should be "*x*" number of registered nurses, licensed practical nurses and so forth. I said very honestly that we have failed to address ourselves to the problems to the extent that we can bring you this kind of information. This does not mean that I believe the regulations are all right.

I do know, on the basis of my experience, that you cannot equate an LPN and a registered nurse.

What is needed in a nursing home is someone with the discriminating judgment to make decisions about patients' care. The registered nurse is the only person prepared to undertake this responsibility. If you are interested in reading the report cited, you will see evidence that many of the decisions about patient care that were made by poorly prepared nurses resulted in longer institutionalization and in increased complications to those patients.

I don't agree with the regulations, but I can't come to you and give you a better answer except to ask that in some way we begin to institute some experimental programs to test out what patient mix and what staffing pattern is effective and suitable for a specific population of nursing home patients. I think that with these regulations we are trying to answer the question before we have done the necessary homework.

Senator MILLER. Are you implying that instead of having any absolute standards we ought to sort of feel our way along and see how fast we can move in these pilot projects and in our training programs? I am not suggesting that we just abolish all standards, but we have already had testimony today that the standards set forth are too low and they ought to be revised right away and if we don't revise them right away we are condemning people to improper care. The troublesome thing about it is the realism you have pointed out in trying to acquire and retain the quality-type people, but it is very difficult to figure out the timetable on it. I know we want to move as fast as we can, but everything I find is that we have quite a long way to go before we can obtain the personnel that we need. I am not talking about the 469,000 who are not working, because, as far as I know, unless there was a national emergency, it would be almost impossible to get them back. I am talking about those who are ready, willing, and very able to serve.

ALTERNATIVE STANDARDS

Miss SHAUGHNESSY. I believe, sir, that it isn't possible to have no standards because we have to have something to work toward. But I think it is essential to provide some guidelines and to provide for alternative approaches to meeting the standards. For example, if out in some rural State it is impossible to get a well-qualified registered nurse on full-time duty in a nursing home, then for the time being I would suggest that we find ways of supplementing this requirement by using consultant nurses from the State or county health departments, or consultants from the local hospitals or nurse-teachers who are prepared to give some supervision on a part-time basis to the nursing home. In order to provide minimal safe care for any patient who requires institutionalization there should be a registered nurse available and responsible for the organization and administration of nursing on a full-time basis. On an interim basis, it would be possible to meet this requirement with two part-time RN's.

I am afraid of having no standards; but I am equally afraid of having the wrong standards.

Senator MILLER. Thank you very much.

(The prepared statement of Mary E. Shaughnessy follows:)

PREPARED STATEMENT OF MISS MARY E. SHAUGHNESSY

Mr. Chairman, I am Mary E. Shaughnessy, Associate Professor, Department of Graduate Studies, Duke University School of Nursing. I am a member of the Commission on Nursing Services of the American Nurses' Association, and a member of the Interim Certification Board of the Division on Geriatric Nursing Practice. The American Nurses' Association is the professional organization of over 200,000 registered nurses in 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands and the Canal Zone.

The American Nurses' Association welcomes the opportunity to present a preliminary statement as part of its contribution to the study of Trends In Long-Term Care now being undertaken by this sub-committee. As the hearings progress, we will be speaking to the many concerns included in your letter of invitation dated July 2, 1969. We agree that the need for such a study is urgent.

The numbers of persons requiring long-term care are increasing each year. The nature and complexity of their health and social problems indicate a need for a wide gamut of institutional community services. Unfortunately, at this point in time we have developed few resources on a broad scale to meet the actual needs of this segment of the population. Rather, attempts have been made for the most part to place patients requiring continuing services into either chronic hospitals or nursing homes.

Advances in medical fields and technology have made it possible to prolong life for many persons. New techniques in restorative care have increased the possibility for many persons with chronic long-term illnesses and disabilities to become relatively independent and to compensate for many of their losses. In fact, theoretically, an increasing number of persons can be expected to return to the community provided their care is directed toward specific goals and continued beyond the initial period of the acute hospital stay in the appropriate facility, i.e., chronic hospital; rehabilitation center; nursing home; day hospital; etc.

The dearth of alternate resources for continuing health and social care for the long-term patient places an unrealistic burden on existing nursing home facilities to provide a wide range of services.

Our comments today will be confined to concerns which relate to the proposed standards for skilled nursing homes:

(1) The problems of organizing and administering nursing services.

(2) Ensuring the numbers and kinds of nursing service personnel required to meet patient needs.

(3) Factors influencing recruitment of nursing staff.

(4) Activities of the nursing profession to meet the needs of long-term patients.

THE PROBLEMS OF ORGANIZING AND ADMINISTERING NURSING SERVICES

The problems of organizing and administering effective nursing service in a typical nursing home in the United States today are complicated by the nature of the patient population. Although these institutions are primarily designed to offer continuing nursing care and intermittent medical and paramedical services there is great confusion about the scope and limitations of the nursing which can realistically be provided in these facilities. Decisions to place patients in nursing homes are based primarily on the medical status of the patient and on his social situation in terms of housing and the availability of family members to assist in his care.

In all too many instances, little consideration is given to the amount and kinds of nursing services required by the patient. Almost no consideration is given to the ability of a particular nursing home to provide the necessary nursing services. In too many cases the nursing home itself fails to provide the director of nursing service with the necessary authority to discharge her responsibility to patients under her care. It is our belief that the director of nursing service must have a voice in determining the kinds of patients that can be cared for in light of the personnel and resourses available to her within the institution. She can not provide adequate care for patients who require services available only in hospital settings. Nor can she provide effective service to patients whose social and psychological problems require assistance from other health workers.

Nursing services required in a nursing home differ from those required in an acute or chronic hospital setting. Nursing is still attempting to develop models of appropriate nursing care in these institutions. To successfully organize care based on the specific needs of patients requires that the best qualified nurses be encouraged to provide leadership in this field. Too long have we relegated the care of the long-term patient to persons least qualified to meet his needs. At this moment in time we do not know how many nurses or what kinds of nurses can best meet the needs of the long-term patient. We do know that effective nursing service can only be derived from the needs of patients and that the identification of nursing needs requires clinical knowledge and expertise.

There is an urgent need to spearhead well designed studies to answer these questions before we can write policy regarding staffing in nursing homes.

The proposed interim regulations issued in the Federal Register on June 24, 1969 concerning Standards for Skilled Nursing Homes ignore the need for adequately prepared personnel and propose to pay from taxpayer funds for care that cannot be forthcoming. Our comments regarding these Regulations are expressed in a letter to the Administrator of the Social and Rehabilitation Service. A copy of the letter is attached.[1] Our objections to the regulations will not be repeated here.

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[1] See appendix 1, p. 114.

ENSURING THE NUMBERS AND KINDS OF NURSING SERVICE PERSONNEL REQUIRED TO MEET PATIENT NEEDS

One of the reasons given for the lowered standards is the shortage of qualified nurses. The availability of qualified personnel should not be the factor which determines the standards for an establishment. Rather, the standards should be set according to the services that are to be provided. When the standards for Medicare were promulgated, there were many complaints that these could not be met. Your attention is called to the document *Personnel Qualifications for Medicare Personnel—A Report to the Congress, Department of Health, Education, and Welfare,* December 1968, where under *Manpower,* it states, "Despite the number of complaints received about the charge-nurse standard, which would seem to indicate that many extended care facilities had practical nurses licensed by waiver serving in this position, only 254 extended care facilities, when initially certified for participation in the Medicare program, had to be certified conditionally because they did not have qualified charge nurses. When these conditional certifications were withdrawn in April 1968, only 17 had to be terminated for failing to qualify. The others either had managed to employ charge nurses who were fully qualified to participate under Medicare, or had voluntarily terminated their Medicare agreement because of inability to comply. There were, of course, other facilities that could not be certified even conditionally because they had many deficiencies generally, including nursing deficiencies, representing an overall low standard of care." And the same Report states under *Conclusions,* "Following study of all available data concerning the functions, responsibilities, and qualifications of the charge nurse in a Medicare-certified extended care facility, it is concluded that the standard is minimal and should not be lowered. Therefore, no change is recommended in the Medicare conditions of participation for extended care facilities as related to the qualifications of the charge nurse." . . .

We believe that the same conditions should and could prevail for the skilled nursing homes which are considered equivalent to extended care facilities. We respectfully request that you consider the Report entitled *The Problems of Nursing Home Patients: Implications for Improving Nursing Care,* [PHS 108–66–276], Boston College, Chestnut Hill, Massachusetts, 1968, to further support the above and to demonstrate why we believe that much more study needs to be given to determining the staffing needs in a nursing home. As you can see in this Report the staffing requirements vary considerably from home to home and from floor to floor. It should be noted that the intent of this study was to determine the amount and kind of essential nursing services required by the patients in two nursing homes.

FACTORS INFLUENCING RECRUITMENT OF NURSING STAFF

Problems associated with nurse recruitment are given as further reason for lowering the proposed standards.

There is general agreement that registered nurses and qualified practical nurses have not been attracted, in sufficient numbers, to work in nursing homes. In our view there are many reasons which need to be considered in modifying this attitude.

In the past little attention was given to nursing of long-term patients in the curriculum of schools of nursing. Secondly, until very recently the personnel policies in most nursing homes were much less attractive than those of other health agencies. Thirdly, and most important, the safeguards to ensure good practice have not been present in most nursing homes. The lack of authority delegated to the nursing service department; the isolation of the facility from the mainstream of other health facilities; and the lack of stimulation and professional support all contribute to the reluctance of nurses to work in these settings.

Few attempts have been made to study the even greater problem of personnel turnover. This problem often stems from poor leadership, divided authority between the owner, administrator and nursing director; and, the lack of opportunity for nurses to provide the amount and kind of care patients require due to the restrictive policies of the institution.

There is a need to revise the administrative structure in many nursing homes in order to make it possible for nurses to practice according to the standards of the profession. Evaluation studies need to be done to measure the outcome of nursing care in order to make modification in existing services.

ACTIVITIES OF THE NURSING PROFESSION TO MEET THE NEEDS OF LONG-TERM PATIENTS

We have identified above certain problems of meeting the needs of long-term patients in nursing homes. Following is a brief account of some activities of the nursing profession to meet these needs.

The American Nurses' Association accepts as unquestionably sound the concept of comprehensive health planning as a means by which society may more adequately provide for community health care needs. Orderly planning and coordination of health care facilities will usually result in more efficient use of nursing and other health manpower. The Association has placed stress on the need for cooperation, coordination and planning in order that the social goals of improved health care for all citizens may be adequately met.

Planning activities for nursing services and nursing education continue to be conducted in numerous states and local areas. To date some fifty states have carried out or are in process of conducting surveys and/or studies to determine nursing needs and resources. Many of these studies have been initiated and sponsored by the state nurses' associations. Plans for recruitment, educational programs, and continuing education are recommended in the reports of these studies. The Division of Nursing, Bureau of Health Professions Education and Manpower Training, Department of Health, Education and Welfare, has furnished helpful consultation in many instances.

In addition, the Association is currently conducting with Federal funding, a pilot project here in the Washington, D.C. area. This project, called "You-In" seeks to identify, motivate and encourage disadvantaged youth to complete secondary school and pursue a career in nursing.

Schools of nursing in many parts of the country are developing theoretical courses and clinical practices in relation to care of the aging and long-term patient. Selected university schools of nursing are providing a major in long-term care and/or geriatrics.

There is an increasing concern in this area in relation to nursing practice, teaching and research. There are increasing numbers of professional nurses entering the field as clinical specialists, consultants, and nursing service administrators.

Short-term traineeship funds have been available to upgrade the competence of nurses employed in nursing homes. The quality of these programs has varied greatly. Further study must be done to determine the content most appropriate for this type of training.

The American Nurses' Association established a Division on Geriatric Nursing Practice in 1966 for members of the profession interested in this field. Membership in this Division has grown from under 5,000 to approximately 30,000. The primary functions of the Division are at present the development of standards for geriatric nursing practice and a program of certification for geriatric nursing practitioners. Certification will be a form of recognition of the nurse who is an excellent practitioner.

The state nurses' associations have kept pace with the activities at the national level. Twenty-four geriatric conferences and special interest groups have been formed by these state associations to assist nurses in upgrading their practice.

The ANA along with other groups is concerning itself with the problem of providing qualified staff for nursing homes. At present a project is being planned by the Division on Geriatirc Nursing Practice in cooperation with the Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education and Welfare, to develop a national conference for nurses interested in geriatric nursing, which will be a prototype for state or regional conferences.

A significant part of each American Nurses' Association convention are the clinical and scientific sessions many of which deal with aspects of long-term care. National clinical conferences are also conducted by the Association. The subject of geriatric nursing practice is always included.

The American Nurses' Foundation, the research organization sponsored by the American Nurses' Association is engaged in a program to support and conduct research in the area of nursing and long-term care with emphasis upon aged persons.

In recognition of the problems which derive from the utilization of nursing personnel the ANA Commission on Nursing Service is developing guidelines.

These will be the primary subject of discussion at three regional educational conferences and hearings for nurse administrators scheduled for December 1969.

Hopefully there will be nursing service administrators from nursing homes at these conferences.

Mindful of the need for sound utilization of the skills of professional nurses, the Association has been a strong supporter of programs for the recruitment, training and utilization of practical nurses and other assisting personnel. For many years the Association urged increasing financial support for training of nursing personnel in vocational and technical programs. We worked with the National Federation of Licensed Practical Nurses to delineate appropriate functions of the practical nurse and worked for licensing legislation that would define standards of training and the scope of the practice of this type of personnel.

In cooperation with the Office of Manpower, Automation and Training, and the Division of Nursing, Bureau of Health Professions Education and Manpower Training, Department of Health, Education and Welfare, the ANA has developed a suggested curriculum and promoted refresher courses for nurses not now practicing. About 6,500 have been returned to either part or full-time employment. This program is being continued in many local communities.

Provision must be made to ensure supplementary and continuing education for both registered and licensed practical nurses in light of the changing need of the long-term patient population. Very specific programs must be devised to efficiently prepare nursing aides on the job.

The ANA's continuing concern and active program to improve the economic position of the profession and the conditions under which nurses work is part of this entire effort. The ANA was a strong supporter of the legislation to amend the Fair Labor Standards Act to include hospitals and nursing homes under the minimum wage provisions of the Act.

In 1966, the Congress amended the Fair Labor Standards Act to include hospitals, nursing homes and related facilities. A follow-up survey was conducted by the Bureau of Labor Statistics, in 1968 to determine the effects of the amendments. A copy of the Report, Economic Effects Studies, Nursing Homes and Related Facilities is submitted with this statement. During the '67–'68 period, the hourly wages increased slightly: All non-supervisory personnel, $1.66; licensed practical nurses, $2.03 [a gain of 13¢]; registered nurses, $3.04 [a gain of 14¢].

There was an 8.5% increase in R.N. employment contrasted with 3.0 and 3.2% respectively for practical nurses and nurses' aides. Formal provisions for other conditions of employment such as paid holidays, vacation, sick leave, retirement plans, health insurance, especially in the small establishments [less than $25,000 a year revenue] are uneven and almost non-existent in some facilities.

The publications we have referred to, along with other materials exemplifying the Association's concern and activities are in a folder for Committee reference use. The American Nurses' Association stands ready and will welcome the opportunity to present other aspects of the Trends in Long-Term Care at subsequent hearings or upon request.

Thank you for the opportunity to appear before you today.

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

STATEMENT OF REV. WILLIAM T. EGGERS, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING; ACCOMPANIED BY REV. JOHN MASON, DIRECTOR OF SERVICES TO AGING, AMERICAN LUTHERAN CHURCH, MINNEAPOLIS, MINN., CHAIRMAN, COMMITTEE ON TITLE XIX; AND LESTER DAVIS, EXECUTIVE DIRECTOR

Senator Moss. We will now hear from the Reverend William T. Eggers, president of the American Association of Homes for the Aging. I understand he will be accompanied by the Reverend John Mason, director of Services for the Aging of the American Lutheran Church in Minneapolis, Minn., and chairman of the committee on title XIX; and Mr. Lester Davis, executive director of the American Association of Homes for the Aged.

We are glad to have all of you gentlemen with us and we will ask you, Reverend Eggers, if you will proceed.

Reverend Eggers. Thank you.

You are incorporating the full statement in the record?

Senator MOSS. The full statement is in the record and you may give us such parts or highlight such parts as you would like to do for us this afternoon.

(The prepared statement of Reverend Eggers follows:)

PREPARED STATEMENT OF REV. WILLIAM T. EGGERS

I am Rev. William T. Eggers, administrator of the Home for Aged Lutherans, Wauwatosa, Wisconsin, a suburb of Milwaukee. I am appearing on behalf of the American Association of Homes for the Aging, of which I am President.

The American Association of Homes for the Aging is the national membership organization of nonprofit voluntary and governmental Homes for the Aging across the country. The Association was founded in 1961 with a grant from the Ford Foundation. Since its inception it has dedicated itself to improving programs and standards of long-term care institutions serving older people. AAHA has been a prime mover in identifying and solving problems of common concern to its 1,000 member Homes as well as to all those dedicated to serving the institutional needs of our nation's elderly.

In offering the testimony on behalf of this Association I am also speaking out of deep personal convictions about the need for high standards in providing quality nursing care to people who, unfortunately must spend extended periods of time residing in skilled nursing facilities. Most of these people, moreover, find themselves doubly weighed with burdens: they are not only ill, they also carry the burden of aging.

While it is a privilege to appear here to speak on behalf of quality care in skilled nursing facilities, and while I am more than willing to make efforts like this repeatedly to improve the care in these facilities, I do feel some sense of unreality concerning this hearing. I believe my feeling is justified. I cannot understand why it is necessary once more to review materials which have in the past been thoroughly reviewed and to try once more to help reach a concensus which has already been reached and is even embodied in the law of our land.

That we also tend to lose ourselves in an approach to these materials, which supposedly is "realistic," moreover, holds its own measure of irony. Realism in this phase of the health field today is defined by some as facing the fact that this nation does not have the funds to support a program of quality care for its ill, nor the personnel to care for them nor the funds to train and educate the personnel their care requires.

Yet some ten days ago this nation left on the moon as expendable equipment what it did not want to bother returning to earth. This included a $250,000 television camera, two cameras for still pictures, a Kodak worth $50,000 and a Hasselblad which cost $11,176, two back packs for the astronauts who had been there, each worth $300,000, and tools which cost $45,000. The taxpayers of this nation have invested in these items and others which clutter up the Sea of Tranquillity more than a million dollars. It is now junk.

I do not regret this expenditure nor the billions of dollars spent to place the astronauts on the moon. I do assert, however, that the price of our little junk heap on the moon would buy a lot of improved care for a large number of older people for a good many years, and I do assert that the cost of our exciting but expensive leap into space would go a long way toward providing a superb health-care program for all the citizens of this nation, including its aging.

I do further assert that as long as we Americans can afford to indulge in fantastic explorations like the moon shot, we cannot argue that we lack the funds to provide the simple, elementary decencies of health care to our older people. The moon shot was a glorious adventure. Bringing competent staff to the bedsides to sick older people, nevertheless, somehow seems more human and more humane and more important and more glorious. To assert that we cannot afford this is to open oneself, under our circumstances, to ridicule as mere self-indulgent and selfish people entrapped in rationalizations and escapism.

When Medicare had just been created by Congress many people associated with the institutional health field believed and stated that the amount and intensity of care needed by patients under Title XIX program would prove to be essentially the same as the quantity and degree of care needed by Title XVII patients. I am aware of no knowledgeable person in the health field who questions this generalization. It is true in our Wauwatosa Home; it is true in all skilled nursing facilities.

On the basis of this generalization many were persuaded and still are persuaded that the standards for care under Titles XVII and XIX should be equivalent and that, moreover, the standards which the nation adopted for Title XVII were precisely what they had been advertised to be: minimum standards. The *Conditions for Participation* were not, at the time of their adoption, a description of an ideal care facility and they yet remain a far cry from that ideal.

The proposed standards for Title XIX facilities published in the *Federal Register* of June 24, 1968, in order to implement the Moss Amendment to the Social Security Amendments of 1967, Section 1902 (a) (28) not only do not provide for the elevation of standards which was the intent of the Amendment; they also fail to provide at this moment for the level of care which had previously been established.

These proposed standards permit the facility, on two of the three daily shifts, to place in charge of all nursing in the entire facility licensed practical nurses who have been "waivered" by the state licensing agency. Only after July 1, 1970 will all licensed practical nurses in charge of nursing activities have to be qualified by graduation from state-approved schools of practical nursing.

The American Association of Homes for the Aging deplores this postponement of the enforcement of standards which had previously been enunciated. In the past it has raides the question and again today raises the question as to the guarantee it can obtain that this postponement will be the last and that the dates set forth in the *Federal Register* are unequivocably firm dates.

At the time it raised this point it received no satisfactory answer; it was informed that theoretically none is possible. The Department of Health, Education, and Welfare might in theory regularize additional postponements of standards by the publication of new materials from time to time in the *Register*. While there currently exists no reason to doubt the Department's good faith, there can also now be no final assurance that additional postponements of the effective dates of standards will not take place.

The American Association of Homes for the Aging further underscores the materials developed by the American College of Nursing Home Administrators, which offer evidence that the problem of the waivered LPN proved to be a minor problem when the Bureau of Health Insruance determined that it would enforce a deadline concerning this category of personnel. It agrees with the judgment that but few Homes in remote, rural areas will be disqualified from immediate participation in Title XIX benefits and points out that the great bulk of skilled nursing home beds, like the great bulk of the American population, is found in urbanized settings, where professional and qualified personnel are more readily available.

The Association further favors a change in the language of paragraph (iii)(a), column 2, page 9789 of the *Register*. That paragraph now reads:

> "(iii)(a) No later than July 1, 1970, there is on duty at all times and in charge of nursing activities at least one professional registered nurse or licensed practical (or vocational) nurse who is a graduate of a State-approved school of practical nursing, or who is found by the appropriate State licensing authority on the basis of the individual's education and formal training to have background considered to be equivalent to graduation from a State-approved school of practical nursing;"

The Association recommends that the language referring to the state licensing authority be appropriately modified to indicate that the specific state agency which licenses nurses should be named to administer this activity.

The Association fully appreciates the difficulties all health-care facilities, including homes for the aging and skilled nursing homes, today encounter in recruiting qualified nursing staffs. It therefore recommends that current federal programs be utilized to the fullest and new agencies created if necessary, with adequate funds appropriated, to provide a national program to study national needs for health care personnel, to outline efficient and suitable methods for providing the training and education necessary to meet these needs under voluntary, nonprofit auspices, and to *implement* such a program.

It is further the position of the American Association of Homes for the Aging that those facilities which cannot qualify as skilled nursing homes because of personnel or other major deficiencies be designated by a name other than skilled nursing facilities, and that until the time at which they can qualify (under adequate standards) as skilled nursing facilities, they be reimbursed at a lower and more appropriate level of reimbursement. The Association believes that the creation and consistent use of such nomenclature and financial distinctions will

accomplish several worthwhile ends: it will reassure the public that Homes classified as skilled are truly skilled nursing facilities, it will save public funds, and it will tend to upgrade facilities by clearly defining the market for them and the shortages which exist.

The Association has consistently deplored the fact that national standards and many state standards for skilled nursing facilities have not established a number of significant ratios *between patients and staffs* and between *supervisory staffs and nursing personnel.* The Association believes, for example, that the original proposals of HEW personnel to provide more professional nursing staff in long-term care facilities at this time deserve further study and further exploration. Despite the acute problem in establishing these ratios, it is the Association's contention that the solution is *urgent* and wholly *possible.*

In view of the fact that the proposed standards at best provide that a nursing facility of any size, even one with 500 beds, can legally be operated with only one licensed practical nurse on duty in the entire facility on two of its three shifts, the Association feels a sense of urgency about upgrading the standards of caring for the ill in such facilities. It poses these questions: what is an adequate ratio of professional nurses to patients? what is an adequate ratio of professional nurses to auxiliary personnel? what is an adequate ratio of all nursing personnel to the number of patients they serve? While the Association is mindful of the inherent difficulties in these questions—which include the difficulty of measuring quality by an quantitative standards—the Association also recognizes that some states have written ratios of this nature into their state codes. The Association would deplore the possibility that inadequate federal standards would undercut whatever progress may already have been achieved in these states.

Before concluding its testimony, which has dealt with issues which for the most part can be corrected by modifications of the standards published in the *Register* June 24, the Association would like to take this opportunity to mention in passing two items concerning which it hopes it will have an opportunity to offer this committee formal testimony at a later date.

The first deals with additional inadequacies in these published standards for Title XIX facilities, which apparently can be rectified only by legislation. The standards make no reference to rehabilitation, social service, activities for patients, and similar programs. Since the Association is vitally concerned about affording institutionalized aging people the cluster of values and activities it has identified with the phrase "the social components of care," it is interested in any steps which can be taken to rectify this omission.

The Association, in response to a request from Senator Fong, is accumulating evidence to document its stated opposition to the recent HEW (Bureau of Health Insurance, SSA) action in discontinuing the additional 2% allowed by it to provider institutions above the reasonable costs of caring for patients. Since this inequitable curtailment does indirectly and may directly affect patterns of Title XIX care also, the Association believes this action can be a matter of major concern not only to its members but also to this committee and that the committee may desire, at some more convenient date, to hear these concerns formally expressed by the Association.

I thank you.

STATEMENT OF REVEREND EGGERS

Reverend EGGERS. I will try to shorten it as much as possible.

On the first page I will only call your attention to the fact that I speak of the air of unreality about these hearings. Lest this be misinterpreted, I point to the fact that legislation already exists and we are sort of going over what already is the law of the land.

In the middle of the second page I express some beliefs that many people had. Some years ago medicare had just been created by Congress. Many people associated medicare with the institutional health field and stated that the amount and intensity of care needed by patients under the emergency title XIX program would prove to be essentially the same as the quality and degree of care needed by title XVIII patients.

I don't think that knowledgeable people really questioned this generalization. On the basis of it many were persuaded, and still are

persuaded, that the standards under title XIX should be equivalent of those for title XVIII, and, moreover, the standards the Nation adopted for title XVIII were precisely what they were advertised to be, minimum standards.

The conditions for participation were not at the time of their adoption a description of an ideal skilled care facility and they remain a far cry from that ideal. The proposed standards for title XIX facilities published in the Federal Register of June 24, about which we are primarily commenting today, in order to implement the Moss amendment to the Social Security Amendment of 1967, not only do not provide for the elevation of standards which was the intent of the amendment, but also fail to provide at this moment for the level of care which had previously been established.

This, of course, goes to the problem of the waivered licensed practical nurse. The American Association of Homes for the Aging deplores any postponement of the enforcement of standards which had previously been annunciated.

The Last Postponement?

In the past the association raised a question and again today raises the question as to the guarantee it can obtain that this postponement will be the last and that the dates set forth in the Federal Register are unequivocally firm dates. At the time it first raised this point, it received no satisfactory answer. It was informed that theoretically none is possible.

The Department of HEW may in theory regularize additional postponements of standards by the publication of new materials from time to time in the Register. While there currently exists no reason to doubt the Department's good faith, there can also be no final assurance that additional postponements of the effective dates of standards will not take place.

We support in our statement the evidence which has previously been offered that the waiver matter proved to be a minor problem in connection with title XVIII and we also support the idea that the specific State agency which licenses nurses should be named to administer the activities of the entire LPN program and all that is connected with it.

On page 4, and there was testimony to this point this morning, we urge that current Federal programs be utilized to the fullest and new agencies created, if necessary, with adequate funds appropriated to provide a national program to study national needs for health care personnel to outline efficient and suitable methods for providing the training and education necessary to meet these needs under voluntary nonprofit auspices and to implement such a program.

We want to speak to another significant matter. It is further the position of the American Association that those facilities which cannot qualify as skilled nursing homes because of personnel or other major deficiencies be designated by a name other than "skilled nursing facilities" and that until the time at which they qualify under adequate standards as skilled nursing facilities, they be reimbursed at a lower and more appropriate level of reimbursement.

This problem, by the way, is one which has repeatedly been mentioned in today's testimony. We believe that our proposal would be a satisfactory way of disposing of it, and that the creation and consistent use of such nomenclature and financial distinctions will accomplish several worthwhile ends.

It will assure the public that homes classified as skilled are truly skilled nursing care facilities. It will save public funds and it will tend to upgrade facilities by clearly defining the market for them and the shortages which exist.

The association has consistently deplored the fact that national standards as well as many State standards for skilled nursing facilities have not established a number of significant ratios between patients and staff and between supervisory staffs and nursing personnel.

The association believes, for example, that the original proposals of HEW personnel to provide more professional nursing staff in long-term care facilities on a ratio basis at this time deserve further study and further exploration. Despite the acute problem in establishing these ratios, the association believes that its solution is urgent and possible.

I might add as a commentary to this paragraph that in many nonprofit facilities a survey would show that we do have an adequate ratio of supervisory and professional personnel. We are able in our own facility, for example, to maintain an adequate staff of about 25 to 30 registered and licensed practical nurses out of a total staff of 75 nursing personnel.

I think this is typical of what many facilities under nonprofit auspices are doing. In view of the fact that the proposed standards at best provide that a nursing facility of any size, even one with 500 beds, can legally be operated with only one licensed practical nurse on duty in the entire facility on two of its three shifts, the association feels a sense of urgency about upgrading the standards of caring for the ill in such facilities.

Questions About Ratios

It therefore poses the questions about ratios. The association would deplore the possibility that inadequate Federal standards would undercut whatever progress may have already been achieved in States in which such standards are a part of the legal structure of the nursing home codes or whatever code is appropriate.

I would like to add a footnote just to round out the record. Some reference was made this afternoon to the Joint Commission on the Accreditation of Homes and its standards. I would like to point out that it presently accredits under two sets of standards.

There are the standards referred to by Dr. Salmon, I think it was, and there is a second set of JAHC standards, a sort of Grade A above Grade B standards, and the two major distinctions between the higher and lower standards revolve around the fact that the grade A facility must have an organized medical staff in order to qualify under the higher standards and it must also have registered nurses in charge of nursing around the clock rather than licensed practical nurses.

So the Commission itself is quite concerned about elevating standards and has taken steps to help bring this about on a voluntary basis.

On the last page I simply refer to the fact that I hope that the association will have an opportunity to speak to the other matters at another more suitable time. Since the subject of the committee is trends in long-term care we would like someday to speak about other inadequacies in the title XIX facilities and about the 2-percent decision that is under review at the present time.

We will be happy to answer any questions. I believe that John Mason also has a statement to make.

Senator Moss. Very good, Reverend Eggers. We are glad to have your statement. Perhaps we could hear from Reverend Mason now and if we have any questions, we can then ask them of you three gentlemen at the table.

STATEMENT OF THE REVEREND JOHN MASON

Reverend Mason. Thank you, Senator Moss.

I happen to be the director of the Department of Services to the Aging of the American Lutheran Church. We have been in the business of delivering health service to older people for over a hundred years and for the past 15 years I have been the director of this department.

We have over 100 homes, about 115 in operation in 20 different States. I am going to supply you with some statistics from our homes that I think could be interesting to you. I won't go into them at all except to point out that the ones on the yellow page have been asked for here today. It is a staff analysis run on our 100-some homes for the month of November 1968. It shows very clearly how much staff personnel is involved in each of the various categories in a well-qualified nursing home.

Senator Moss. Very good. We will be glad to have that and it will be made a part of the record.[1]

Reverend Mason. We are also going to supply you with an analysis of revenue and expenses in the operation of nursing homes [2] and these all come from CPA-audited reports and we would be happy to have you look at them.

There is some other material there, too.

Senator Moss. That will all be included. We are happy to have it.

Reverend Mason. I have a position paper, the position of the American Lutheran Church on the delivery of health service to elderly people.[3]

Needs in Rural Areas

Every once in a while today I have heard it said that it is difficult to get staffed in small towns and rural areas. I would say this is not so. We opened a home just 2 weeks ago in Glasgow, Mont. I have a letter on my desk that came from the administrator and he said the least of his problems was securing professional staff.

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[1] Retained in committee files.
[2] Retained in committee files.
[3] See appendix 1, p 144.

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This we find throughout the country. As I say, our homes are in 20 different States. Most of our homes are in smaller towns and rural areas. We have them in the metropolitan centers like New York and Chicago and a number of other cities, too, but we find staffing problems are easier handled in the smaller communities than in the big metropolitan centers.

The reason is obvious. Nurses come to a hospital and after a while a young businessman proposes and they get married and they settle down there, or a young farmer proposes and they settle down and now they come back from this kind of work to take work in our homes. Now we have had no problem in the smaller communities like that.

I think it should be said that the operational philosophy and the policies under which a home operates go a long way to determine whether you will hold your staff or not. Poorly run homes, homes that don't have a good philosophy of care for people are not going to be pleasant places in which to work. But homes, on the other hand, that have high ideals and are striving for a good program and service, we found a good professional staff is attracted to this type of program.

I would say that there is a misconception abroad in the country as to the titles XVIII and XIX. Actually in practice—I can go to more than a hundred homes under my supervision to test this out—the people cared for under title XVIII very likely or very often need less skilled nursing care than the people that are in the long-term facility.

"Meshing" of Titles XVIII, XIX

The persons in the long-term facility of people 80 to 100 and some years of age, there is no prognosis of rehabilitation and putting them back into the community. Those people are there for the balance of their lives. Most of them have two or three or four different chronic illnesses and the level of care in a long-term care facility that is licensed as a skilled nursing home really is higher in my estimation than NECF under title XVIII.

After all, a fellow has a heart attack, for example, goes into the hospital and after 2 or 3 or 4 weeks or less he is ready to come out to an ECF and he is covered. That is just routine business.

I don't want to minimize it, but it isn't a big deal. But the poor fellow who is in a long-term care facility and has maybe three or four debilitating illnesses, there you have got a problem. So I think that the standards for title XIX should be actually as high as the title XVIII standards. I can't see skilled nursing care is skilled nursing care. If it isn't that, it isn't anything. If a home is going to get a license as a skilled nursing care home, then it's got to provide that kind of care.

So I say these standards as proposed in the Register are very inadequate. There are many other things. I know our time is limited, but I will give you my report for the record and if you have any questions, I will be very happy to try to answer them.

Senator Moss. Thank you, Reverend Mason, for that testimony and for offering us these figures on the study that has been made. They will be placed in the record if you will deliver them to the staff. They will render additional meaning to your testimony.[4]

[4] See app., item 4, p.142.

I am heartened to hear you say that you do not experience great problems with getting personnel at your homes, and that especially in the rural areas you can get personnel with more certainty than you can in the big metropolitan areas.

Reverend MASON. And permanent personnel. Their homes are there, they live there.

Senator MOSS. They are more likely to stay on the job.

Reverend MASON. We don't have a high turnover.

Senator MOSS. That is encouraging and this is one thing we are very concerned about. Miss Shaughnessy felt there was great difficulty there and I am reassured to find you have had some experience the other way.

I was pleased with your testimony, Reverend Eggers, and the full statement which we have placed here in the record.

I understand that you gentlemen both agree that if you are going to license a facility as a skilled nursing home, that it certainly ought to meet the requirement that there is available skilled nursing care to the people who are in that home. You seem to agree also that we ought to be moving toward a ratio of nurses to patients to make that requirement more meaningful, too.

I think that this is very helpful to our records. Thank you.

Senator Miller?

Senator MILLER. Thank you, Mr. Chairman.

Reverend Mason, you have roughly 115 homes in your association. Now is yours the American Association of Homes for the Aged?

Reverend MASON. No, the American Lutheran Church, the national church body.

Senator MILLER. You have 115?

Reverend MASON. Yes.

Senator MILLER. Are you an affiliate of this American Association of Homes for the Aged?

Reverend MASON. Yes, many of our homes belong and I am on the board of directors of the American Association.

Senator MILLER. How many homes are there in the American Association of Homes for the Aged?

Reverend EGGERS. There are over a thousand, Senator.

Senator MILLER. How much over a thousand?

Reverend EGGERS. Somewhere between a thousand and 1,100.

Senator MILLER. Of those, do I understand that 115 are members?

Reverend MASON. You see, I represent a national church body. We have 115 homes. These homes have the right to choose to belong to Bill Egger's organization or not. Some of them do, some of them don't. I recommend that they do, but they don't all follow my recommendation.

Senator MILLER. I am just trying to get a little perspective as to where we are. Would one of your members be in Sioux City?

Reverend MASON. No, not in Sioux City, but we have 12 in Iowa. We just opened one in Dubuque two Sundays ago.

Senator MILLER. What percentage of the patients in those homes are qualified for medicaid on the average?

Reverend MASON. Our figures will show that in 1968 5.1 percent of our resident days were medicare-covered dates.

Senator MILLER. Either one; medicare or medicaid.

Reverend MASON. 5.1 percent of all of our resident days were covered under medicare. I could not say what the percentage would be for medicaid.

Senator MILLER. Do you have any medicaid patients?

Reverend MASON. Oh, yes. But I don't have that percentage.

Senator MILLER. As I understand it, you have a high-quality nursing home and I am wondering if you have a higher proportion of those people who stay at your nursing homes who are financing this privately rather than through governmental assistance.

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Reverend MASON. 34.9 percent of our residents are on old-age assistance, that is our national figure. We cared for 12,220 people in 1968 and 34.9 were on old-age assistance. The balance were, as we say, paying privately.

A person who is paying privately, he may have social security and this sort of thing.

Senator MILLER. Roughly a third, then?

Reverend MASON. About a third.

Senator MILLER. Do you have any idea how that compares with national figures?

Reverend MASON. No, but we have kept figures like this for 35 years and I would say 15 or 20 years ago the percentage on what we would then say was public assistance was much, much higher. With the advent of social security, the figure dropped down to this figure and it has stayed within, oh, 1 or 2 percentage points for the last 5 or 6 years.

Senator MILLER. What are the smaller type communities that you are referring to?

Reverend MASON. Hills, Minn., a town of 650 people.

Senator MILLER. What is the nearest big town?

Reverend MASON. Luverne, Minn., and Sioux Falls, S. Dak. It is 17 miles to Sioux Falls, 12 miles to Luverne, an excellent program there.

Senator MILLER. Not too difficult for somebody who wants to drive out there?

Reverend MASON. No problem, no problem.

Senator MILLER. How about Glasgow? What is the population of Glasgow?

Reverend MASON. Oh, Glasgow has a population of 9,000. It dropped when you removed the airbase.

Senator MILLER. I have a feeling you and I are not on the same wavelength. I am talking about something the size of Hills, but I suggest to you that a little town like Hills is not quite the same as a little town out in the sand flats of Nevada.

The point I want to make is this. I understand very well in some small communities you may not have a problem, and especially if you are near to a larger town, for example, Indianola south of Des Moines. It is no problem.

I want you to know that Senator Fannin and I were not teasing anybody when we pointed out that there were deeply serious problems in obtaining qualified nurses and doctors and medical personnel in many of our smaller communities.

Reverend MASON. I am sure that may be right. I am just saying that we have not had the problems in the 100 years we have been working in it.

Senator MILLER. I know you run a very good nursing home group, because I have heard favorably of you. I don't know, maybe it is expertise, maybe you have a little higher income from some of the private bases, but believe me, there is a problem.

All you have to do is to talk to some communities that are trying to get a doctor, it is almost impossible.

Reverend MASON. I do. We have hospitals, too.

Senator MILLER. But I appreciate your testimony. I also appreciate yours, Reverend Eggers.

Thank you.

Senator MOSS. Thank you, gentlemen. We appreciate your being here today and for bringing us this testimony and your experience. I was interested to get this estimate of the number on welfare or old-age assistance holding rather steadily around one-third. In some of our big cities it is much higher.

Sister Mary Ambrosette is unable to be here and has filed her statement for the record. The statement will appear in the record at this point.

(The statement referred to follows:)

PREPARED STATEMENT OF SISTER MARY AMBROSETTE, O.S.F., ADMINISTRATOR, ST. PAUL HOME, KAUKAUNA, WIS.

Mr. Chairman and members of the Subcommittee on Long-Term Care. My name is Sister Mary Ambrosette. I am a religious in the Order of St. Francis. I am the administrator of the St. Paul Home in Kaukauna, Wisconsin. I have been the administrator there for the past ten years. I submit this testimony to you in that capacity.

By way of background, I am a member of the National Advisory Council on Nursing Home Administration. I am also the President of the American College of Nursing Home Administrators. In providing these items of background, I do so only to suggest that I have a measure of competence in the areas of skilled nursing home care and in long-term care. I must make abundantly clear to you, however, that in submitting this testimony I do not do so as the representative of either the NAC–NHA nor the ACNHA. In the matter of the latter, the Board of Governors of the American College of Nursing Home Administrators has adopted the following resolution:

> "The ACNHA supports the highest standards of patient-care feasible for all patients in this Nation regardless of the State in which they reside or their personal ability to pay for care and that such care should be provided according to the patient's needs and consistent with the dictates of human dignity."

However, the Board of Governors has not adopted a position relative to specific items pertaining to standards for patient-care, as for example, the June 24 Statement of Interim Policy issued by the Department of Health, Education and Welfare. Therefore, I am at pains to make it abundantly clear that in submitting this statement to the Subcommittee, I do not therein speak for the American College of Nursing Home Administrators but speak only as an experienced administrator of long-term care who has specific observations to put to you on the subject before you, namely, "Trends in Long-Term Care.".

Mr. Chairman, I regret that the imperatives of my prior obligations as a religious in the Order of St. Francis make it impossible for me to appear personally before the Subcommittee. I take comfort in the certainty that you and the members of the Subcommittee fully understand the matters of loyalty and the faithful adherence to one's vows, in this instance, the vow of obedience. I am grateful, therefore, to be able to submit this statement to the Subcommittee and I request that it be made a part of the record of this hearing.

I will limit my statement to remarks relative to the standards for payment for skilled nursing home care under Title XIX of the Social Security Act as these pertain to the standards for the organized nursing service in a skilled nursing home participating in Title XIX.

As the Subcommittee knows, the Social & Rehabilitation Service of the Department of Health, Education & Welfare published in the June 24, 1969 Federal Register, on pages 9788–9790, an Interim Policy Statement which has for its subject: The Standards for Payment for Skilled Nursing Home Care under Title XIX; and which has for its purpose: The implementation of Section 1902(a)(28) of the Social Security Act. The implementation of Section 1902(a)(28) would of course require the implementation of Section 1902(a)(28)(B) which provides for the standards required of the nursing service in a skilled nursing home participating in Title XIX. My remarks go to that part of the June 24 Interim Policy Statement which has to do with Section 1902(a)(28)(B), that is, with the standards for the nursing service.

It is indeed tragic that the June 24 Interim Policy Statement is a marked retrogression rather than the significant progression in standards for skilled nursing care which many of us hoped it would be and which the Congress intended it should be. Rather than being the better for it the Nation is the worse for it:

(1) The quality of patient-care is at best frozen:

(2) Public monies intended to purchase skilled nursing care will continue to purchase care that is less than skilled nursing care;

(3) Those State agencies and private facilities which, in the past, have made no efforts to upgrade standards are encouraged to continue not to do so by still another postponement of a deadline for meeting standards;

(4) Those State agencies which have taken steps to establish and enforce high standards are now placed in jeopardy by still another lowering of standards;

(5) Facilities which have made the effort of reaching the previous higher standards are now tempted to fall back upon lowered standards;

(6) State agencies are encouraged to continue to utilize the medical assistance program as an umbrella for all types of care rather than to seek alternative institutional settings for those requiring other than skilled nursing care;

(7) The development of alternative institutional settings in the system of delivering health care is retarded, if not blunted;

(8) Finally, the more efficient use of health manpower is discouraged rather than encouraged by lower standards for the organized nursing service.

All in all, the national effort to produce the best possible system of delivering health care gains nothing from the June 24 Interim Policy Statement.

The June 24 Interim Policy Statement represents another link in the chain of events relating to Title XIX standards for the organized nursing service in a skilled nursing home, which events have, in succession, lowered previous standards while, at the same time, they have both granted generous waivers from the lowered standards and postponed the absolute deadline for meeting these same lowered standards. I would like now to detail that chain of events:

July, 1965—P.L. 89–97 enacted and signed into law. *Comment:* Skilled nursing home services specified as one of the required services under a State Plan for Medical Assistance. No definition of what constitutes a "skilled nursing home" as distinguished from any other nursing home is included in the law. The law includes no mention of nursing home services other than "skilled nursing home service." Several states employed the term "skilled nursing home" among their classification of licensed facilities but—no two agree as to the definition of a skilled nursing home. Consequently, it was necessary for the Secretary to formulate a definition of a skilled nursing home for purposes of Title XIX skilled nursing home services. This was done.

June 17, 1966—Section D–5141.1 of the Handbook of Public Assistance was published, in which a skilled nursing home for purposes of Title XIX was defined. The definition reads as follows: "4.1 Skilled Nursing Home: A 'skilled nursing home' is defined as a facility, or a distinct part of a facility, which (a) is licensed, or formally approved, as a nursing home by an officially designated State standard-setting authority and, effective January 1, 1967, (b) is qualified to participate as an extended care facility under Title XVIII of the Social Security Act; or is determined currently to meet the requirements for such participation; except that clause (b) shall not become effective until January 1, 1968 with respect to facilities which do not currently meet the requirements of clause (b) but which show reasonable expectation of meeting the requirements of clause

(b) by January 1, 1968." *Comment:* Thus, the first standards for the organized nursing service in a skilled nursing home were that they be the same as that required of an extended care facility in Title XVIII. These are:

(1) 24 hour nursing service

(2) Director of nursing service: a full time registered professional nurse

(3) Charge nurse: two possibilities, either a registered professional or a licensed practical/vocational nurse who is a graduate of a state-approved school of practical/vocational nursing.

March 2, 1967—D-5141.1 of the Handbook of Public Assistance was revised *downwards.* The standards for the organized nursing service now read:

(1) 24 hour nursing service (no change)

(2) Director of nursing service: a full time registered nurse (no change)

(3) Charge nurse: (a change) where before only two possibilities, now three possibilities exist, either a registered nurse or a licensed practical/vocational nurse who is a graduate of a state-approved school of practical/vocational nursing or (here is the change) an L.P.N. or an L.V.N. who is not a graduate of a state-approved school of practical/vocational nursing who meets these conditions:

(*a*) she was successfully discharging the duties of a charge nurse on July 1, 1967; and

(*b*) she has completed training satisfactory to the appropriate state licensing authority (later defined by the Secretary to be that state agency which licenses nurses) [this is different from and less than the June 1966, standard where all L.P.N.'s or L.V.N.'s who were to be Charge Nurses had to be graduates of a state-approved school of practical/vocational nursing].

January 2, 1968—P.L. 90-248 was enacted into law. Section 1902(a)(28)(B) was intended to upgrade nursing service standards and read as follows: "(B) have and maintain an organized nursing service for its patients, which is under the direction of a professional registered nurse who is employed full-time by such nursing home, and which is composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for such patients during all hours of each day and all days of each week.

November 5, 1968—Interim Policy Statement #19 was published in 33 Federal Register 16165 to implement Section 1902(a)(28)(B) which had an effective date of January 1, 1969. Interim Policy Statement #19 repeated the standards for an organized nursing service as contained in the revised Handbook of Public Assistance of March 2, 1967.

June 24, 1969—The present Interim Policy Statement is published in 34 Federal Register 9788. This revoked all previous standards for the organized nursing service in a Title XIX skilled nursing home and lowered all three (3) previous standards, each of which in turn had been lowered by its successor. The standard for the organized nursing service now reads:

(1) 24 hour nursing service

(2) Director of nuring service: an R.N. full time (no change)

(3) Charge nurse: *any* licensed nurse, whether she/he be a professional, a practical or a vocational nurse. In the instance of the licensed practical or vocational nurse, no conditions required as to experience, training and/or education. Thus, the charge nurse could conceivably be a teenager with less than a day's experience, with neither training nor education for the task. (This is the absolute lowest standard ever—completely different from any previous standard.)

The above constitutes a chronology of the successive lowering of standards for the organized nursing service in a Title XIX skilled nursing home. The standards have gone from being equal to those for an E.C.F. to the absolute permissible nadir. This latter is true since the Federal law itself requires the R.N. Director of Nursing Service. Hence, rules and regulations cannot lower that. In the area of the Charge Nurse the June 24 Interim Policy Statement has scraped the bottom.

Each time the standards have been successively lowered, a waiver of the lower standards has been provided and the deadline for meeting the new but now lowered standards has also been postponed. What is more, this chain of postponements has never been accompanied by any data to support the implied argument that the previous standards or deadline were "unrealistic." The chronology of postponements is as follows:

June, 1966—a "lead-in" period of one and one-half years was provided. This lead-in period was necessary and generous. It provided time for both the state agency and the facility to make the necessary adjustments. Both had until January 1, 1968 to meet the requirement that the organized nursing service in a Title XIX skilled nursing home be equal to that in a Title XVIII E.C.F.

March 1967—For the period extending from March 1967 to January 1, 1968, payments were permitted not only to skilled nursing homes but to all licensed nursing homes if the latter could present a "reasonable" plan to fully qualify as a skilled nursing home by January 1, 1969. The plan had to be presented no later than July 1, 1968. Hence, the original lead-in period of one and one-half years ending January 1, 1968 was now extended another year, ending January 1, 1969.

January 1, 1969—Some states—not all—began to give notice that they would no longer make Title XIX payments for skilled nursing home services in facilities which did not meet the standards for a Title XIX skilled nursing home. However the Medical Services Administration did not press enforcement. Therefore, by indirection a kind of postponement took place.

June 24, 1969—Interim Policy Statement lowers the standards to the absolute minimum—even grants a six months waiver from the absolute minimum—and postpones the deadline for meeting the standards, originally issued in March 1967 until July 1, 1970. When one adds to July 1, 1970 the permitted six months waiver, the effective deadline is really January 1, 1971, almost four years after the standard was originally issued. Finally, the June 24 Interim Policy Statement revokes forever the original standard that the organized nursing service in a Title XIX skilled nursing home equal that in a Title XVIII E.C.F.

The effect of this chain of successive Policy Statements which both lower the previous standard and postpone or extend the deadline for meeting the lowered standard has been to place the Department in the position of the boy who cried "Wolf!" when there was no wolf. Thus, during all this time there is lacking any substantial evidence that either the state agency or the facilities which had complained that the standards were unrealistic have ever made any significant effort to reach the previous standard, even when it was lowered from the prior standard.

The June 24 Interim Policy Statement touches bottom as to standards and again excessively postpones a previous standard without supportive data and without either evidence of real effort or promise of future effort to meet either the standard or the deadline. The carrot without the stick is a perversion. If the carrot of a waiver is offered, it should be accompanied by the stick of a lesser reimbursement while the waiver is in effect. Only then can there be promise of an effort to meet both the standard and the deadline. As a corollary thereto, only then do we have "realism".

The effect of the June 24 Interim Policy Statement, which purports to implement Section 1902(a)(28)(B), is *to nullify* the thrust of the 1967 Amendment: (1) by providing standards lower than those in effect at the time Section 1902(a)(28)(B) was enacted, and (2) by postponing until July 1, 1970, at the earliest, the implementation of those standards *which were already in effect* at the time Section 1902(a)(28)(B) was enacted. Thus, we have an Alice in Wonderland episode wherein that which was intended to upgrade is accomplished by downgrading. In effect then, what is "up" is "down" and an "increase" is a "decrease". What is more, we have at least a mockery of the law, if not a violation of the law, wherein what was to be in effect no later than January 1, 1969 is now not to be in effect until January 1, 1971, at the very latest, purportedly.

Finally, we have what is at least a dangerous situation if not a "no man's land." When the June 24 Interim Policy Statement lowers to absolute zero the standards for charge nurses, it mercilessly exposes those states which now have higher standards to attack from forces within the state who would now call the state's standards "unrealistic" and who would seek to lower them.

Such states are left naked to that type of attack. The high standards of such a state are not necessarily protected by the Title XIX provision which requires that a State must maintain its previous effort. It was never clear whether this requirement went beyond the matters of appropriations by the State and the individual's income eligibility for medical assistance. Thus, it cannot be argued with prudence that this provision in Title XIX relative to a State's previous effort renders inviolable the higher standards which a State might now have.

In summary then, the June 24 Interim Policy Statement is deficient as follows:

(1) It revokes apparently forever the original (1966) standard that the organized nursing service in a skilled nursing home equal that required of an Extended Care Facility under Title XVIII.

(2) It purports to implement Section 1902(a)(28)(B) by lowering the standard in effect at the time that section was enacted.

(3) It grants a waiver from even this lowest of possible charge nurse standards.

(4) When providing such a dubious waiver, it fails to put force behind it and incentive within it.

(5) It pushes back until possibly as late as January 1, 1971 the deadline for meeting the standards which were to be met no later than January 1, 1969. This despite the fact that these standards were originally published on March 2, 1967 and again on November 5, 1968.

(6) In lowering previous standards to absolute zero relative to the charge nurse, in granting waivers from such absolute minimal standards, and by postponing deadlines, the June 24 Interim Policy Statement threatens the existing high standards long in effect in certain of the states. (New York, to identify one, now requires RN's on every tour of duty in a nursing home having 50 or more beds.)

Additional deficiencies in the June 24 Interim Policy Statement are:

(7) It continues to create confusion by failing to provide separate definitions for nursing personnel and for auxiliary nursing personnel.

(8) It fails to implement Section 1902(a)(28)(B) by refusing to provide a yardstick by which to measure adequate nursing coverage, such as a ratio between nursing staff and patients.

(9) It further fails to implement Section 1902(a)(28)(B) by refusing to provide a yardstick by which to measure properly supervised nursing care such as a ratio as between a charge nurse and other members of the nursing staff on a given tour of duty.

Recommended improvements which should be made in the June 24 Interim Policy Statement relative to the standards for the organized nursing service:

(1) Make effective immediately the standards originally announced in March 1967 and subsequently published as Interim Policy Statement #19 (33 F.R. 16165).

(2) Require the States to meet no later than July 1, 1970 the standard originally announced in 1966, namely, that the organized nursing service in a skilled nursing home Under Title XIX equal that required of an ECF under Title XVIII.

(3) Define nursing personnel separately from auxiliary nursing personnel.

(4) Clearly specify that nursing personnel means "nurses" only. The term should be limited to the following: 1) RNs; 2) LPNs or LVNs who are graduates of a state-approved school; 3) LPNs or LVNs not state-approved school graduates but certified to be the equivalent by the State authority which licenses nurses.

(5) Clearly specify that auxiliary nursing personnel are LPNs and LVNs who are neither graduates of state-approved schools nor who have been certified by the State authority which licenses nurses to have training and/or experience deemed to be the equivalent to graduation from a state-approved school as well as aides, orderlies, attendants and ward clerks.

(6) Clearly specify that the appropriate State licensing authority relative to certifying an LPN or an LVN as qualified to act as a charge nurse is that State agency which licenses nurses.

(7) In order to provide for adequate nursing care on a given tour of duty, it should specify a minimum ratio as between the total nursing staff (nursing personnel plus auxiliary nursing personnel) and the total number of patients.

(8) In order to provide for properly supervised nursing care on a given tour of duty, it should provide a minimum ratio as between a charge nurse and auxiliary nursing personnel.

(9) Relative to the standards for the organized nursing service exclude the charge nurse requirements from any waiver.

(10) Permit a waiver, however, from the ratios outlined hereinabove in (7) and (8). Permit such a waiver only when the facility establishes its inability to meet the standard despite persistent and total effort on its part to meet the standard.

(11) Such a waiver should be for six months only and no facility should be permitted to receive two successive waivers for the same condition.

(12) As a condition of any waiver, the facility should be required to agree to less reimbursement during the period of the waiver than that received by those facilities in the area which meet in full the prescribed standards. In this way only will there be both an incentive and a guarantee that the facility will make every effort to overcome the deficiency and to meet the deadline.

(13) As a condition of any exercise of waiver, the State should be required to certify in writing that the granting of a given waiver does not constitute a hazard to neither the safety nor the well-being of the patient regardless of the hardship worked upon the facility.

It is evident that I agree with those who maintain that there should be no difference in standards as between an extended care facility under Medicare and a skilled nursing home under Medicaid insofar as these relate to patient-care. The Congress created these two terms only to identify the facility with the Title in the Social Security Act in order to distinguish between the two different sources of funding for the care. In each instance, the institution is a medical care facility requiring the same degree of skilled care. In fact, if there is a difference in the degree of skill required, it would be that a greater degree of skill and care are required in the skilled nursing home because the condition of the patient is more serious and more complicated.

The argument is frequently made that Title XIX care is different from Title XVIII care and for this reason Title XIX skilled nursing home standards should be less than those for extended care facilities under Title XVIII. This argument is without merit. It is true that the care under Title XIX is different from that under Title XVIII. However, the difference is not in the skill required but in the duration and intensity of that care.

Extended care is what the term implies: an extension of the care required by a patient for the condition for which he was hospitalized. Hence, the patient is in the recuperative stage of the illness for which he was previously hospitalized. The care required is skilled care over a period of time longer in duration than that of the hospital but shorter than that of the skilled nursing home.

Skilled nursing home care is also what the term implies: skilled care for a medical condition which requires skilled nursing. The patient here is more often than not suffering from several conditions at the same time, for example, a cardiac condition complicated by emphysema coupled with diabetes. Another example, a malignant hypertension case complicated by a diseased kidney resulting in an edema. Still anouther example, an osteoporosis case coupled with fractures. None of these are unusual but rather they are what skillled nursing care is all about and they are the cases for which skilled nursing homes are or should be designed to serve.

The point I am trying to make is that these patients are patients requiring skilled nursing care—and they require such care 24 hours each day. If they do not require such care, they do not belong in skilled nursing home beds. Rather, they belong in intermediate care beds. Further, they are not extended care patients only because they have a lingering illness rather than an acute condition now in its post-hospital recuperative stage. Again, the difference between the care under Medicare (Title XVIII) and that under Medicaid (Title XIX) differs only in the length of time involved, not in the skilled care required.

Again, I urge you to do all that you are able to do to prevent the standards required of skilled nursing homes under Title XIX from being lowered. I also urge you to do all within your power to make these at least equal to those required of extended care facilities under Title XVIII.

There are those of course who have argued and still do that it is not "realistic" to make one standard for both ECFs and skilled nursing homes because such standards would result in a shortage of beds due to the large number of facilities which would be unable to meet such high standards due to a shortage of skilled nursing personnel. I would direct your attention to the experience in Medicare. When certification of facilities took place under Medicare, similar arguments against high standards were heard. The Bureau of Health Insurance stood by its standards. I think that there are now some 5000 ECFs in the country. At the outset of the ECF program, something in the neighborhood of 250 ECFs were provisionally certified. As of April 1968, all but 17 of these had overcome their deficiencies. This impressive experience should be drawn upon for Medicaid. The very existence of these 5000 ECFs belies the argument that high standards will produce a shortage of beds. In fact, making EFC standards the same for skilled nursing homes could result in the certification of more ECF beds since facilities might increase the number of beds which they now have certified as distinct part ECFs. This would be even more the case were the intermediate care facility encouraged as an alternative institutional setting for those requiring less than skilled nursing care.

In P.L. 90–248, the Congress made provision for those indigent who require less than skilled medical care. It did so in section 1121 (a) and (b) of that law wherein it provided for assistance in the form of institutional services in intermediate care facilities. An intermediate-care facility was defined as one which provided *less* than skilled nursing care and *more* than room and board. In short,

the Congress intended that the right patient be in the right bed. High medical-care standards for skilled nursing homes coupled with the implementation of the intermediate-care facility can assist in that endeavor. I fear the contrary will ensue if Title XIX standards for skilled nursing homes are lowered.

Lowering standards for skilled nursing homes will only fix into place the present system and will abort the coming into being of the intermediate-care facility because there will be no need for a facility to become an ICF since it will be so easy to be a skilled nursing home under low standards.

If the intermediate-care facility fails to emerge, States will continue to be forced to place patients requiring less than skilled care in the higher priced bed in what under the lower standards provided by the June 24 Interim Policy Statement would only be a so-called skilled nursing home. The skilled nursing home and the intermediate-care facility are intended to complement each other. They will do so only if the standards for skilled nursing homes are kept properly high to identify them as medical-care facilities and to thus retain their distinction from intermediate-care facilities which are not medical-care facilities.

The above recommendations far from being "unrealistic" constitute *minimal* standards for a medical-care facility such as Congress intended the skilled nursing home to be. These standards will prove an incentive to those wishing to be medical-care facilities which provide skilled nursing care. At the same time they will encourage facilities unable to meet these standards to become intermediate-care facilities. When both the skilled nursing home and the intermediate-care facility are in existence, then and only then, can real savings be realized in Medicaid as it applies to long-term care. Only then will we be able to approach the concept of a continuum of care with the right patient in the right bed.

The proper standard and one for which we should strive is a standard which would require at least 1 RN on duty at all times in both EFCs and skilled nursing homes. This is not "unrealistic". Witness New York and other States. What is unrealistic is to provide low standards and then to provide waivers for those low standards. What is true realism is to provide the highest possible standard and then to provide waivers from these in order to meet the prevailing conditions at a given time in a specific place. I commend this concept to you for revision of the June 24 Interim Policy Statement or the enactment of legislation if needs be.

Mr. Chairman, I wish to thank you and the members of the Subcommittee for having graciously invited me to testify before you and failing that to submit this statement. Thank you, indeed.

Senator MOSS. Our next witness will be Mrs. Eleanor Baird, the vice president of region I, the American Nursing Home Association.

We will be glad to have you, Mrs. Baird.

I had a telegram from my home State, the Utah Nursing Home Association, saying that you speak for them, and I am very happy to have this telegram, which I will make a part of the record.

(The telegram referred to follows:)

JULY 30, 1969.

Senator FRANK E. MOSS,
U.S. Senate, Washington, D.C.:

Our association always participates in the discussions made by the American Nursing Home Association. We concur in the recommendations made by them in our behalf before your subcommittee [yesterday]. Utah more than most States is affected by your action.

UTAH NURSING HOME ASSOCIATION.

Mr. PICKENS. We also have Mr. Walker, the president of the American Nursing Home Association, and Mr. A. L. Schluter, from Iowa, who is chairman of our Skilled Nursing Home Conference.

Mrs. Baird will be the one who will give it.

Senator MOSS. We are pleased to have you. Your statement in full is in the record and you may give us those parts of it you want to emphasize or deal as you will with it.

STATEMENT OF MRS. ELEANOR BAIRD, VICE PRESIDENT REGION I, AMERICAN NURSING HOME ASSOCIATION; ACCOMPANIED BY JOHN PICKENS, LEGAL COUNSEL, ANHA; A. L. SCHLUTER, NATIONAL CHAIRMAN, SKILLED NURSING HOME CONFERENCE; ED WALKER, PRESIDENT, ANHA, AND HAROLD SMITH

Mrs. BAIRD. Mr. Chairman, as has been my intent, and your request, I will read the first six pages of my testimony and ask that the rest be admitted in the record.

My name is Eleanor Baird. I am a medical social worker as well as vice president for region I of the American Nursing Home Association representing the New England States. I am also vice president of the American College of Nursing Home Administrators. Today, I am appearing here in behalf of the American Nursing Home Association.

For the past 20 years, I have been administrator of the Twin Pines Convalescent Hospital, a proprietary nursing home located in New Milford, Conn. My prior experience as a director of medical social services has encompassed administrative responsibilities in a 500-bed voluntary acute hospital, a 400-bed nonproprietary chronic disease hospital and its affiliated 100-bed facility for the aging. In addition, I have served, and currently serve, on the board of a variety of social agencies, including visiting nurse associations currently involved as home health agencies. I have also worked with the conditions of participation under medicare as a consultant to the Public Health Services and Social Security Administration during development of conditions of participation. I was a commissioner and first chairman of the National Council on Accreditation of Nursing Homes, established through the joint effort of the American Medical Association and ANHA which has been merged with the Joint Commission on the Accreditation of Hospitals. In fact, along with others, I helped draft the standards for that program.

I recite these facts to demonstrate my longstanding commitment to high standards and to assure you that I would not support, nor speak in behalf of, an organization that did not share my commitment.

We are aware, from your letter dated July 2, 1969 to ANHA President Ed Walker inviting our testimony, that your subcommittee had originally intended to devote this hearing to sample opinion on a variety of matters relating to trends in long-term care. But, we share your view, as reported in the Congressional Record of July 10, 1969, that a crisis of major proportions has developed concerning implementation of standards for payment of skilled nursing home care under the medicaid program. We, therefore, wish to restrict our remarks at this time to an explanation of the ANHA position regarding these proposed standards. We sincerely hope that ANHA will have an opportunity at a future date to share with you our views on the broader topics which are of continuing concern to your subcommittee.

HIGH STANDARDS, LIMITED REIMBURSEMENT

It is academic to say that high standards cost more money than lesser standards. The Federal Government has demonstrated in its administration of the medicare program that it wants high standards. But, perversely, it has also demonstrated it is unwilling to provide

adequate reimbursement to pay the cost of high standards. Instead, through its regulations, it passes on part of the cost to the extended care facility and another part to the private paying patient. Thus, in preparing these remarks, we have kept in mind not only the desire and need for improving standards of care, but also the concern of both the Federal and State Governments with the increasing costs of title XIX, particularly in view of the large portion of medicaid costs attributable to the skilled nursing home program.

It is in this context that we of the American Nursing Home Association state our support for the intent of the proposed standards, while expressing grave concern and strong reservations about the ability of the States to implement them. We believe, and recommend, that provision should be made to allow the States time to "tool up" to meet the new standards. This leadtime would allow the States to properly classify patients as to the level of care needed, to acquire the additional funds that will be needed to pay for higher standards to permit the States to upgrade their staffing patterns in those States where lower standards have prevailed in the past and, most importantly, to provide for a workable system of qualifying experienced, trained LPN's and RN's in order to create the pool of manpower that implementation of the proposed standards would necessitate.

Indeed, financial considerations aside, the manpower needs to meet the nursing service standards proposed is the most critical problem that will confront the States and the participating facilities in seeking to implement the new standards—even if leadtime is provided. That is, even if adequate funding can be obtained, and this is by no means a certainty, it is an absolute certainty that neither this year, nor next, will the supply of licensed personnel be adequate in many States to meet the staffing patterns proposed.

The Manpower Administration of the U.S. Department of Labor has just completed a draft of an industry manpower survey, No. 116, entitled "Nursing Homes and Related Health Care Facilities" which demonstrates the magnitude of the manpower problem. The survey is based on data collected as of March 1968, more than a year ago, and shows a job vacancy rate for the position of licensed practical nurse of 13.7 percent. Forty-eight percent of these jobs had been vacant for periods up to 6 months, and 34 percent of the vacancies had existed for periods over 6 months. The presumption must be, and, based on the experiences of hundreds of nursing home administrators with whom I have had personal contact, I believe it to be, that a severe shortage of LPN's presently exists.

Health Manpower Shortage

As regards the critical manpower shortage in the health field, I would like to pose a few pertinent questions which I believe should be of vital concern to this subcommittee. If leadtime is not provided, where will the States find the trained, licensed, or vocational, nurses to fill existing vacancies, and to staff the positions created by the new standards? Why are LPN's—LVN's—in short supply? What agencies of Government, and what private organizations, have impeded efforts to develop an adequate supply of qualified, licensed nursing personnel?

The answer to the first question is self-evident. The jobs will not be filled because the manpower pool does not exist. The answer to

the last question lies in part in the failure of the Department of Health, Education, and Welfare to initiate programs of training to qualify persons to fill these positions and its failure to implement programs to enable presently waivered LPN's to upgrade their training and education to qualify for full certification and in part in the determined, aggressive and apparently selfishly motivated opposition of the American Nurses Association, to the continued existence of programs which have produced by far the greatest number of qualified LPN's—LVN's—in the past.

We wish to commend the programs cited by Miss Shaughnessy. You will note that most of the programs Miss Shaughnessy has testified to are directed to the registered nurse level.

I wish to pose another question at this point. If and when an adequate supply of nursing personnel becomes available, who is going to pay for their employment; that is, the share under the title XIX formula that is not funded by the Federal Government? Are the States going to be able to pay for them or, like medicare, is the cost to be shifted to the private paying patients and the nursing home owners?

Based on recent history, it appears highly unlikely that adequate funding can be expected in the immediate future for the additional costs that will be entailed by implementation of the nursing service standards. Let me demonstrate this fact with a brief summary of per diem rates paid, as of January 1, 1969, for skilled nursing home care under the title XIX program or other programs in States which have not yet adopted a title XIX program. As of January 1, 1969, maximum per diem rates for maximum care ranged from a low of $4 to a high of slightly over $20 per day among the 43 States responding to the survey. A majority of the reporting States, 24 to be exact, have a maximum rate of $10 per day or less for maximum care, including room, board, and nursing services. But the average payment per patient day actually made by the State agencies was $7 or less in 25 States and $10 or less in 40 of the 43 States reporting. And in fact, 12 States pay less than the cost of care and are forced to encourage supplementation payments from families and local subdivisions to finance skilled nursing home care.

State Payment Levels

The survey, conducted by ANHA among the State welfare agencies, also showed that while 25 States had increased payments between January 1, 1968, and January 1, 1969, five actually had decreased payments and 13 had retained maximum payments at the same levels despite the obvious increase in the cost of care over the preceding year.

Thus, it becomes clear why ANHA, as I stated earlier, expresses its support for the intent of the proposed standards, but grave concern and strong reservations about the ability of the States to implement them—unless adequate leadtime is provided.

We feel certain that the proposed standards will increase the cost of care per patient in virtually every State. In some States, we fear, the increased costs may prove prohibitive. The practical result will be improved "paper" standards, while the States are encouraged,

in fact forced, to seek a lesser degree of nursing service for their patients without full regard for patient needs, in order to conserve funds.

Where standards have been increased too rapidly in some States in the past, we already have experienced wholesale reclassification of patients without any real concern for the level of nursing care they require. It is not unrealistic to assume that given insurmountable budget requirements and an insufficient number of certified facilities, due to inability to achieve staffing patterns proposed, a new round of wholesale patient reclassifications will be triggered.

We have dwelt at great length on the financial and manpower problems which immediate implementation of the proposed standards would create—and aggravate. There are other areas of concern which we have dealt with in our prepared statement to be submitted for the record in order to conserve the time of this subcommittee.

Periodic Medical Review

However, we would like to call your attention to one aspect of the proposed standards that holds the potential for creating a chaotic situation unless very carefully, and cooperatively, implemented. We have reference to the discussion draft of May 9, 1969, further implementing the guidelines on periodic medical review and medical inspection in skilled nursing homes issued by HEW. As developed, the initial guidelines can and should revolutionize the health care field. However, this must not become another crash program. Representatives of the institutional providers, the concerned State agencies—health and welfare—and the medical societies, must be allowed time to work together to develop an orderly program with priorities to be taken step by step in order of their urgency and importance. Otherwise, in 18 months, we will have another chaotic situation perhaps rivaling that created by utilization review and retroactive denial under the medicare program.

Thank you for the opportunity of making this presentation. We will be very happy to answer any of your questions.

(The prepared statement referred to follows:)

Prepared Statement of Eleanor Baird

We offer the following comments and analysis of other sections of the proposed standards for your subcommittee's review and appraisal.

Under Section 249.33(c)(vi) "Meet conditions relating to environment and sanitation as specified in paragraph (b)(9) of this section, applicable to extended care facilities under Title XVIII of the Social Security Act."

We agree with the intent to require health, safety and sanitation requirements of Title XVIII. However, SRS's definition by "reference" to 20 CFR 405.1134 should be rewritten since the above regulations for Title XVIII extended Care facilities incorporate fire safety regulations. As you are aware, the amendments of 1967 and SRS's proposed standards (see section 240.33 paragraph (1) (vii) require after December 31, 1969 such provisions of the Fire Safety Code, of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes. Obviously, the requirement of different fire safety standards from those specified in the Act would not fulfill the intent of Congress. So that the intent may be fulfilled, we recommend the following changes to the proposed standards so that paragraph 9, "Conditions relating to environment and sanitation", reads as follows:

"*Safety of Patients*—The facility is constructed, equipped and maintained to insure the safety of patients. It is structurally sound and meets State and local

codes governing construction. The building is maintained in good repair and kept free of hazards such as those created by any damaged or defective parts of the building. No occupancies or activities undesirable to the health and safety of patients are located in the building or buildings of the facility.

"*Favorable Environment for Patients*—The facility is equipped and maintained to provide a functional, sanitary and comfortable environment. Its electrical and mechanical systems (including water supply and sewage disposal) are designed, constructed and maintained in accordance with recognized safety standards and comply with applicable State and local codes and regulations.

"*Elevators*—Elevators are installed in the facility if patient bedrooms are located on floors above the street level.

"*Nursing Unit*—East nursing unit has at least the following basic service areas: Nurses' station, medicine storage and preparation area, space for storage of linen, equipment and supplies, and a utility room.

"*Patients' Bedrooms and Toilet Facilities*—Patients' bedrooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. Each bedroom has or is conveniently located near adequate toilet and bathing facilities. Each bedroom has direct access to a corridor and outside exposure with the floor at or above grade level.

"*Facilities for Isolation*—Provision is made for isolating infectious patients in well-ventilated single bedrooms having separate toilet and bathing facilities. Such facilities are also available to provide for the special care of patients who develop acute illnesses while in the facility and patients in terminal phases of illness.

"*Examination Rooms*—A special room (or rooms) is provided for examinations, treatments, and other therapeutic procedures. This room is of sufficient size and is equipped with a treatment table, lavatory or sink with other than hand controls, instrument sterilizer, instrument table, and necessary instruments and supplies. If the facility provides physical therapy, areas are of sufficient size to accommodate necessary equipment and facilitate the movement of disabled patients. Lavatories and toilets designed for the use of wheelchair patients are provided in such areas.

"*Dayroom and Dining Area*—The facility provides one or more attractively furnished multipurpose areas of adequate size for patient dining, diversional and social activities.

"*Kitchen or Dietary Area*—The facility has a kitchen or dietary area adequate to meet food service needs and arranged and equipped for the refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas comply with the local health or food handling codes. Food preparation space is arranged for the separation of functions and is located to permit efficient service to patients and is not used for nondietary functions.

"*Maintenance of Sanitary Conditions*—Sanitary conditions are maintained in the storage, preparation and distribution of food. Dishwashing procedures and techniques are well developed, understood and carried out in compliance with the State and local health codes. Written reports of inspections by State or local health authorities are on file at the facility with notation made of action taken by the facility to comply with any recommendations."

Since SRS's interim policy already includes, as required by the statutes, a requirement that the nursing homes meet the NFPA Life Safety Code, the Fire Safety requirement contained in Title XVIII Conditions of Participation are unnecessary; therefore, we strongly suggest the adoption of the above changes.

We also urge reconsideration on page 9789 of section (iv) (a) (3) that reads "no more than two successive agreements for six months are executed with any skilled nursing home having deficiencies, and no second agreement is executed if any of the deficiencies existing are the same as those which occasioned the prior agreement." Such requirements would be too binding and severe in many instances where minor deficiencies cannot be corrected or where such deficiencies cannot conceivably be corrected within the six month period. We recommend deleting "no second agreement is executed if any of the deficiencies existing are the same as those which occasioned the prior agreement."

Finally, we object to the inclusion of Title XVIII standards in section (b) paragraph (5) "Satisfactory policies and procedures relating to maintenance of medical records", paragraph (6) "Satisfactory policies and procedures relating to dispensing and administering of drugs and biologicals", and paragraph (7) "Satisfactory policies and procedures relating to physician coverage." Quite obviously, had Congress intended such standards to be imposed by reference to requirements of extended care facilities under Title XVIII, the wording of the Act (Amendments of 1967) would so indicate. Where Congress made such reference regarding environment and sanitiation standards, there is no such reference

to standards pertaining to maintenance of medical records, dispensing and administering of drugs and biologicals and physician coverage. It is quite apparent Congrees intended sufficient flexibility to be allowed the states in establishing standards pursuant to those areas of regulation. In order that this intent may be fulfilled, we strongly urge the standards referred to be written as follows:

"*Clinical Records*

Maintenance of Clinical Record—The facility maintains a separate clinical record for each patient admitted with all entries kept current, dated, and signed.

Retention of Records—All clinical records of discharged patients are completed promptly and are filed and retained in accordance with State law or for 5 years in the absence of a State stutate.

Confidentiality of Records—All information contained in the clinical records is treated as confidential and is disclosed only to authorized persons.

Staff Responsibility for Records—If the facility does not have a full or part-time medical record librarian and employee of the facility is assigned the responsibility for assuring that records are maintained, completed and preserved. The designated individual is trained by, and receives, regular consultation from a person skilled in record maintenance and preservation.

Pharmaceutical Services

Procedures for Administration of Pharmaceutical Services—The facility provides appropriate methods and procedures for the obtaining, dispensing and administering of drugs and biologicals, developed with the advice of a staff pharmacist, a consultant pharmacist, or a pharmaceutical advisory committee which includes one or more licensed pharmacists.

Conformance with Physicians' Orders—All medications administered to patients are ordered in writing by the patient's physician. Oral orders are given only to a licensed nurse, immediately reduced to writing, signed by the nurse and countersigned by the physician within 48 hours. Medications not specifically limited as to time or number of doses, when ordered, are automatically stopped in accordance with written policy approved by the physician or physicians responsible for advising the facility on its medical administrative policies.

Administration of Medications—All medications are administered by licensed medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of each State. Each dose administered is properly recorded in the clinical record.

Labeling and Storing Medications—Patients' medications are properly labeled and stored in a locked cabinet at the nurses' station.

Control of Narcotics, etc.—The facility complies with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics, those drugs subject to the Drug Abuse Control Amendments of 1965, and other legend drugs.

Physician Services

Medical Findings and Physicians' Orders—There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, rehabilitation potential, a summary of the course of treatment followed in the hospital, and orders from a physician for the immediate care of the patient.

Supervision by Physician—The facility has a requirement that the health care of every patient is under the supervision of a physician who, based on an evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of medical care which covers indicated medications, treatment, restorative services, diet, special procedures recommended for the health and safety of the patient, activities, plans for continuing care and discharge.

Availability of Physicians for Emergency Care—The facility provides for having one or more physicians available to furnish necessary medical care in case of emergency if the physician responsible for the care of the patient is not immediately available. A schedule listing the names and telephone numbers of these physicians and the specific days each is on call is posted in each nursing station. There are established procedures to be followed in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.

Senator Moss. Thank you, Mrs. Baird, for that statement on behalf of the American Nursing Home Association.

41-304—70——7

You indicated the strong concern you have about the increasing cost because of the standards, and yet the regulations we are talking about actually have decreased the standards, isn't that right?

Mrs. BAIRD. Senator, it is my understanding, and possibly I am wrong, that supplement D, as issued, was to be used by the State agencies in defining skilled nursing homes when they developed their State plan for title XIX and submitted it for approval to the Secretary. Supplement D had nothing to do with institutional qualifications.

The regulations as published in the Federal Register are concerned now with the standards each individual facility must meet prior to signing an agreement for participation in the program. So we are not decreasing any standards.

Senator MOSS. You argue, then, that this is not a decrease in the standards we had earlier?

Mrs. BAIRD. I do not believe it was a decrease over what was published in supplement D. In reading the testimony of several people today I have noticed reference to one licensed nurse for 500 patients. I have been involved in long-term health care for 30 years since I decided to be a social worker. I have watched and been involved in evolution of these programs I know of very few States in this country today that do not specify a ratio of personnel to patients. There are a few, possibly a dozen, maybe 18, that do not definitely say so may nurses to so many patients. Some State regulations go further than that. Some say so many professional nurses or licensed nurses to so many nonprofessional, nonlicensed staff. I cannot conceive of any institution in this country where there could be one licensed nurse for 200 patients. It is possible, but the average size facility is licensed for 60 patients.

The other thing that no one has looked at is that the regulations keep referring to charge nurse. A charge nurse, by law, in the majority of the States licensing laws, is a nurse who has overall supervision of all of the nursing care, that is, a director of nurses in an acute hospital.

What we are talking about for a licensed practical nurse is in reality a shift supervisor. This shift supervisor does not make the judgments. If I may quote from the ANA paper or letter to Miss Switzer, "the responsibilities of assessing, planning, directing, implementing, supervising and evaluating the nursing care of the patients is done by the charge nurse . . ." the director of nurses, the registered professional nurse. The licensed practical nurse on the other shifts or even a registered nurse on another shift merely is charged with the responsibility of carrying out patient care plans, policies that have been developed by a director of nurses or a charge nurse.

Senator MOSS. You are saying, then, because most of the States, you think, have regulations on nursing ratios that, therefore, it is unnecessary in any of the Federal regulations to have a minimum standard?

"UNNECESSARY AT THIS TIME"

Mrs. BAIRD. I think it is unnecessary at this time. Possibly when the ANA has developed patterns of care, there may come the day that we would like to say you can have or should have or must have x number of nurses to x number of patients. But this varies. Today you

may have 1 licensed nurse to 25 patients. Tomorrow, because your patients are not that sick or because your licensing law has changed, you may have 1 to 60.

We are talking overall nursing patterns. You may with a very sick house have a ratio of nursing care staff of 1 to 6 or 1 to 10. I don't think this is something anyone can put down.

For 30 years I have watched the physicians, the nurse educators try to define quality of care. Thirty years later I am still waiting for an answer.

Senator Moss. Didn't you say the majority of States had such requirements and that is the reason—I gathered the implication was that is the reason—we didn't need to be concerned about it in these regulations.

Mrs. Baird. You don't have to spell a ratio out because if a State already has it by Federal requirement no State may lower their existing standards when the Federal regulations go into effect. Therefore, if they have a ratio of 1 to 60 now they can't go below 1 to 60. Frankly, I could not see any State lowering its requirements anyway.

Senator Moss. But if the States didn't have any ratio set out of course, it is ineffective to freeze them at any level.

Mrs. Baird. That is right.

Senator Moss. I understood you to say that there was no manpower pool at all and Miss Shaughnessy had said that there were 69,000 LPN's available who are not now working and 400,000 RN's. Is that enough to call a pool of manpower or not?

Mrs. Baird. I am sure it is a pool of manpower. I am sure that many of the LPN's being trained today under programs funded by the Federal Government will graduate in 3 months and go to work in factories. No one wants to work on Saturday, Sunday, or holidays. Nursing homes, until the last 2 years, in fact hospitals, and all health care facilities, have paid substandard wages. They have not offered, as a general rule, the majority of the fringe benefits offered by industry. Therefore, these people do not wish to work in health-care facilities. I do not agree with Miss Shaughnessy that it is always because conditions in nursing homes are depressing.

Senator Moss. You heard Reverend Mason say that they really didn't have any problem in the Lutheran homes. How do you explain that?

Mrs. Baird. They have, on my recollection, excellant personnel policies. I have never had any problems, and I, obviously, knock wood, in 20 years of operation, have had excellent personnel policies. But then I worked in a hospital and knew about substandard salaries.

Senator Moss. Does it all come back, then, to salary, the low salary scale plus the extra hours?

Mrs. Baird. I think this is much of it. I think some of it is the nursing homes and hospitals, again by State regulation, have had to say a nurse must work from 7 to 3 or 8 to 4. We have recently seen the hospitals trying to adjust their shifts so a nurse could come in and work 9 to 5 or 9 to 2 when her children are in school. If hospitals are doing it, why should a State licensing agency say to a nursing home you may not do it? What difference does it make if there are two registered nurses covering a shift or there is one, if we are going to utilize the skills that people have?

"CANNOT PAY THE SALARIES"

Senator, I believe that every health-care facility in this country has the desire and the ability to deliver the highest level of care any agency requests if you are willing to pay for it and help train the needed staff. Good care costs money. We cannot pay the salaries the nurses are entitled to. They have a life in their hands, as an earlier speaker said. Can we afford to pay them less than we pay carpenters?

Senator MOSS. Can we afford to do otherwise?

Mrs. BAIRD. We are doing otherwise. We are not paying them what they deserve. The homes would like to pay them. We don't have the money.

Senator MOSS. By lowering our requirements for the training that these nurses need aren't we encouraging the homes, then, to stay in this low-paid category?

Mrs. BAIRD. I don't think so.

Senator MOSS. You can hire what was called a ward clerk at a lower salary than an LPN and certainly less than an RN.

Mrs. BAIRD. A ward clerk may not give patients care. A ward clerk may write notes.

Senator MOSS. That is one of the things I think that was posed as a problem, because of the limitation of personnel and the periods of time that there is an inadequate number of qualified people on, you found medication being given by people who were not authorized to do it.

Mrs. BAIRD. Here, again, I do not feel this is true in the majority of the States because of the Nurse Practices Act and because most of the professional nurses and the licensed practicals are concerned about the medication their patients are getting. There are, to my knowledge, a few States which allow a nurse on a day shift to pour the medication and have them dispensed by trained—and the laws are very explicit—by aides, meaning someone who has had training in giving the medication and in recognizing signs of distress from the medication.

Senator MOSS. I wish I could be as optimistic as you.

Mrs. BAIRD. I have been in several thousand nursing homes, Senator.

Senator MOSS. I have been in quite a few, myself.

Senator Miller?

Senator MILLER. Thank you Mr. Chairman.

Are you familiar with the opinion of the advisory group regarding the implementation of nurse staffing?

Mrs. BAIRD. I believe the advisory group on title XIX, Senator, voted 16 to 1 that the standards as published in the Register stand and that we allow leadtime, possibly even beyond what has been published in the Register, to allow licensed practical nurses to qualify under the new regulations as shift supervisors.

Senator MILLER You don't know how much leadtime they recommend?

Mrs. BAIRD. The original leadtime, and I think the committee met 4 or 5 months ago, was 25 months. I believe the regulations have reduced that to now what would be 1 year.

Senator MILLER. Would you say that the main problem, or at least the foundation of the problems that you have been discussing gets us down to two things, leadtime and money?

Mrs. BAIRD. And training programs to upgrade the so-called waivered LPN.

Senator MILLER. Which requires leadtime?

Mrs. BAIRD. Yes.

Senator MILLER. And money?

Mrs. BAIRD. Yes.

Senator MILLER. So if we don't have the money or if we don't provide the leadtime, then the thrust of your comments seems to indicate that we will end up forcing the States to reclassify and give us inadequate care for the people who should be receiving better care.

Mrs. BAIRD. That is right.

Senator MILLER. Mr. Chairman, I notice on the panel one of my fellow Iowans. Because we have, I think, the second-highest percentage of people over 65 in Iowa, naturally we have a number of nursing homes. I would like to ask a couple of questions of Mr. Schluter.

Senator MOSS. I am sure he will be glad to respond and you are free to ask him a question.

Senator MILLER. Can you tell us whether using title XVIII standards for title XIX patients in Iowa has caused any problems?

STATEMENT BY MR. SCHLUTER

Mr. SCHLUTER. Yes, Senator, it has, considerable problems. They are using not only the standards for physical structure for the facility but, likewise, the medical standards to qualify the patients medically being the same as title XVIII.

In January of this year, we had in excess of 2,000 patients on title XIX. Obviously, some of them were there as a wrong classification. However, by using the medical standards for that particular patient in reclassifying them it has been reduced to less than 500 and with the recent revision of the medical standards we found that the coffin lid must be approximately halfway closed in order for the patients to qualify for title XIX under the title XVIII regulations. There have been approximately—well, there have been exactly seven as of last week that have actually withdrawn from both programs until there is clarification and more improvement of the guidelines, and, hopefully, that the title XIX regulations would not be enforced as a part of title XVIII, would not be enforced on title XIX skilled nursing homes.

Senator MILLER. Do you have any estimates on how many more might withdraw if the standards are effectuated on the date of July 1, 1970?

Mr. SCHLUTER. Yes, Senator. I happen to be chairman of the ECH and Skilled Conference in the State of Iowa. At a recent meeting, there was an indication if there was not a change made that approxmately 75 percent or more of the homes would withdraw from the program. We have in excess of 80 homes—there are 500 licensed nursing homes in the State and in excess of 80 of them qualify and participate in both programs. They will not only withdraw but, presently, in addition to the seven that have withdrawn, there are probably in excess of 20 by indication at this meeting and since then in conversation that are no longer actively accepting new admissions under title XVIII or title XIX programs. So while, in effect, they have not published the fact that they have withdrawn from the program, for all practical purposes they have, because they will no longer admit patients under the program.

Senator MILLER. What is happening to the patients that they otherwise would be admitting?

INAPPROPRIATE PLACEMENT

Mr. SCHLUTER. Some of them, quite a number, in fact, are spending an excess period of time in the hospitals at a much greater cost under both the XVIII and XIX programs. Some are being inappropriately placed under the old age assistance program in a nursing home that is not skilled to provide the proper services. However, when they are unable to be placed in a title XIX facility, they automatically become an old age assistance recipient under a point system in our particular State, where the average reimbursement is approximately $220 per month which is in many cases less than the actual per patient day costs to provide the care for that individual.

Senator MILLER. Then what you are saying is that what Mrs. Baird testified would happen is actually happening now.

Mr. SCHLUTER. That is correct, sir. I would like to, for the record, clarify one thing. The implication has been made in many instances today in these testimonies to the fact that staffing would be done on the basis of one nurse for 200, 300, 400, or possibly 500 patients when, in fact, the national average for nursing homes is approximately 60 beds per nursing home.

So it is very erroneous to imply that all of the nursing homes in the country are going to be staffing 100 or 200 beds, patients, with one nurse.

Senator MILLER. What is the average size nursing home in Iowa?

Mr. SCHLUTER. The average size nursing home in Iowa is 38.4 beds. There happens to be the largest category of numbers of home sizes in Iowa range from 10 to 19 beds, of which there are 191 of them.

The next size is 36 to 50 beds, of which there are 125. There are 76 to 100 beds, 37; 101 to 150 beds, 10; over 150 beds, 5. There is a total of 499. I stated earlier 500.

Senator MILLER. How much time do you think it would take to implement the regulation which now has a target of July 1, 1970, to enable the Iowa nursing homes to accommodate the patient loads under title XIX and title XVIII?

PROFESSIONAL TRAINING

Mr. SCHLUTER. Well, I think we have to correlate this with education. Possibly correlate it with the same amount of effort in the press, and on the radio and on television that was given trying to educate the elderly citizen as to the benefits and the use of medicare.

We need to encourage people, No. 1, to attend school and take up this professional training. While there is this reserve staff that Miss Shaughnessy made reference to, I think the Federal Government has experienced problems in trying to encourage the hard-core unemployed to become employed.

Likewise, if this group no longer desires to work or in any case the husband no longer wishes for the wife to work, then we are talking about a group that is for all practical purposes nonexistent. I think we have to consider that we are talking in terms of a minimum of 2 years reasonably for education.

Therefore, it should be 2 years or greater. Preferably 3, if we are going to follow the nurses' requests of greater education, but at least 2 years.

Senator MILLER. I would like to ask a question of both you and Mrs. Baird, you on the Iowa level and Mrs. Baird on the national level.

What is being done to qualify the waivered LPN?

Mr. SCHLUTER. For Iowa they are having licensed practical nurse schools in the various community colleges. The great problem is how do you cause this individual to leave their present employment and go away to school for a year or 2 years to secure this degree? Most of them are working of necessity to support families and things of this nature.

Unless there is adequate funding on a Federal level funneling it down to a State level, in all probability this person who received their waiver will not be able to further their education, even though it is made available.

BARRIERS TO CAREER DEVELOPMENT

Mrs. BAIRD. Nationally, Senator, it is practically nonexistent. Some of the States, as Mr. Schluter has mentioned for Iowa, have similar programs which people, because they are working to support families, cannot afford to attend frequently. But nationally there is absolutely no opportunity for continuing education for the licensed practical nurse to move up in the career ladder.

If she wished to become a registered nurse, she must start all over again. No recognition is given for her years of experience or if she has gone to school to an approved school, no recognition is given of her year in school toward RN classification.

Senator MILLER. Thank you very much.

Thank you, Mr. Chairman.

Senator MOSS. Thank you. You have heard Senator Miller describing earlier how the requirements for Iowa teachers moved from high school graduation until they were required to have a college degree. If it were made a requirement to hold the job, wouldn't your LPN's move in as they have now done in Iowa in the teaching profession?

Mrs. BAIRD. I am quite sure they would, Senator, You see, we talk LPN's and waivered LPN's. There are many kinds of waivered LPN's. There was the waivered LPN who may have been a student for 2 years in a registered nurse class. For a variety of reasons she dropped out.

The State's licensing board for nurses has said you only lack obstetrics, usually emergency room and visiting nurse and we will allow you to sit the LPN examination. She passes the LPN examination. She has had more practical experience or more practical training than the school LPN. She has passed a written examination. Therefore, while she may be a waiver, she still has more competence than the LPN who got the waiver during the war years.

There are the LPN's who have sat an examination, but who have trained in Europe and their training has not been sufficient to secure an RN license here, but is more than sufficient to secure an LPN license.

Senator Moss. We are talking about a sort of grandfather clause, then after that period of time, the waiver is no longer good, you have to then qualify.

Mrs. Baird. But these people are qualified, they have qualified by training at a higher level and they have sat and passed a written examination. We are not talking just a letter and then give me a license. This is why many of our medicare homes were able to qualify—dropping from 245 to 17 who could not—because the State agency was allowed to determine on an individual basis whether a person was qualified.

Senator Moss. Maybe I don't understand the waiver. I understand the waiver is to not require meeting all of the standards. Now what I am talking about is getting beyond the points where a waiver will be adequate to permit a person to hold down a position as an LPN.

Mrs. Baird. When most nurses talk waiver and LPN, they are talking about the people qualified during and immediately after the war, on recommendation of three physicians. These people never sat an examination, these people never went to school. They are what I am afraid most of the professional nurses still have in the back of their minds.

This waiver for the most part, has been abolished in the majority of the States. I can think of only one State that still allows this kind of a waiver. The rest of them will waiver the educational qualifications and allow the person to sit an examination.

Incidentally, it is the same examination nationally, it is not an individual State.

Senator Moss. Maybe if we had the word "waiver" defined, it might be helpful.

Mrs. Baird. True.

Senator Moss. I see that Mr. Smith has joined the group at the table. Do you have any comments you would like to make, Mr. Smith?

STATEMENT BY MR. SMITH

Mr. Smith. Except the only comment I have to make, Senator, has reference to the questions posed to Mr. Laughlin this morning regarding the date that I was involved in recommendation for comments regarding the standards which are in question.

I posted my recommendations and comments on January 15. I have a copy of those recommendations and comments which I would like to present to your committee for the record.

Senator Moss. We will be glad to have them for the record.[1]

Mr. Smith. I remember I was at home on the 13th and 14th, the dates that you questioned Mr. Laughlin about. My comments, as will be noted, indicate that I have always supported adequate nursing personnel in a nursing home.

I came from Louisiana. I supported the amendments in 1967 with the intents and with the understanding that this was the ideal and the aim of a nursing home in Louisiana as well as my understanding of what those amendments intended to do.

I did not seek to impose my will upon the members of the staff of HEW. I was one of many people consulted during the time in question.

[1] Retained in committee files.

I served consistently during a period of time from January through early in 1968, through January, February, March of 1969.

Senator Moss. What was that, you were serving as a consultant during that period?

Mr. Smith. The Department requested that I serve as a consultant on an intermittent basis, sometime early in 1968. I agreed to do that with the understanding that they were aware of the fact that I also consulted with the American Nursing Home Association.

When I filled out the employment papers of HEW, I so stated that I was on retainer with the American Nursing Home Association. I made no effort to conceal that fact. I never made any effort to conceal that fact with the press, with members of the staffs of the congressional committees.

I feel, and I have not made the statement—I have avoided discussing the matter with anyone and I attempted to avoid it here. There has been an inferred utilization of a conflict of interest on my part.

Knowing this when I agreed to assist in the development of the standards, I was very careful to avoid utilizing that conflict of interest. To my knowledge and as the record will indicate, I submitted comments to the Department in November, also of 1968, on the proposed standards and for some reason the Department was unable to furnish me with a copy of those recommendations.

I also have a copy of all the other recommendations I made, which I will be glad to submit to the committee. If at any point there has been any indication on my part that I have utilized the conflict of interests, I would present myself as having done so.

Senator Moss. What is your particular field in which you consult?

Mr. Smith. Nursing home administration.

Senator Moss. And you still consult with the association?

Mr. Smith. I am now a full-time employee of the American Nursing Home Association, having since resigned in the capacity of serving as a consultant to the Department. I was not substantially employed in the first place with the Department.

For the period of time in question I served as a consultant for about 4 months. The only work I did during this period was about 3 or 4 days at their request, for which time I was paid approximately $160.

Senator Moss. Thank you, Mr. Smith, for clarifying that matter and I am glad to have the matters that you submitted, which I am sure will clarify the record for us.

Mr. Smith. One more thing, Senator, just for clarification, along the lines of questioning this morning with Mr. Laughlin prior to my being called in to advise or consult with the Department, there had been some 20 pages withdrawn from the draft in the document that was being worked on.

I was not consulted or advised nor did I participate in any way on the original redraft in cutting down of the draft in question.

Senator Moss. Thank you. I thank all of you for appearing here today. We appreciate having your testimony.

Senator Moss. Our next witness will be Mr. Garland Bonin, Commissioner of the Louisiana State Department of Public Welfare.

STATEMENT OF GARLAND BONIN, COMMISSIONER OF THE LOUISIANA STATE DEPARTMENT OF PUBLIC WELFARE

Senator MOSS. Mr. Bonin, we are very glad to have you, sir. Your statement will be included in full and you may proceed to advise us of the important parts of it, if you would like.

Mr. BONIN. Thank you, Mr. Chairman.

Mr. Chairman and members of this most esteemed subcommittee, my name is Garland Bonin from Lafayette, La. I have been commissioner of Louisiana State Department of Public Welfare since June 1965. Prior to my appointment as commissioner of public welfare, I served as senator in the Louisiana State Legislature for a period of many years. I was a member of that body long enough to know first hand how State legislators think and act, what their concerns are and to what extent they are willing to appropriate money for State welfare programs. As commissioner of public welfare, I am on the other side of the fence, that of requesting appropriations and supporting such requests.

Today I am appearing before this subcommittee in behalf of the State of Louisiana. However, more importantly, I am appearing in earnest behalf of some 10,000 patients in Louisiana nursing homes. More than anything else, I must consider their well-being and health.

When the amendments of 1967 were adopted by Congress for establishing minimum Federal standards for nursing homes participating under title XIX, no one applauded the intent of the legislators more than I.

It now appears that perhaps I did not understand what their intent was. My understanding of the amendments led me to believe that, at most, States would not be required to impose standards of nursing services greater than those in effect for extended care facilities participating in the medicare program. I suppose that understanding existed because of the Senate finance report regarding these amendments which clearly states:

> The committee amendment also specifies that proper conditions relating to meal planning, nursing staff, medical record keeping, and, to the extent feasible, appropriate arrangements with hospitals for transfer of patients be met. It is understood that, in general, the type of care rendered by skilled nursing homes under title XIX is not identical to the extended care provided under title XVIII. Title XIX care tends to be long-term care, while title XVIII is designed for care of a more intensive and relatively short-term nature. In this context, therefore, the committee expects that the Secretary and the States will not seek to impose unrealistic requirements upon title XIX skilled nursing homes.
>
> In particular, requirements relating to nursing personnel (other than the requirement of a full-time registered nurse on the staff of the institution) should give due recognition to shortages of such personnel where such shortages exist, and determine needs for other nursing and auxiliary personnel on a realistic basis consistent with the actual needs of the types of patients in particular institutions. Such an approach is not intended, however, to excuse or permit continued understaffing.

It appears clearly from the foregoing that Congress intended the States to have a say in the matter of numbers and kinds of nursing personnel related to the needs of patient care in such institutions. This is what Louisiana over the years has attempted to do. I can find no fault in the nursing personnel standards contained in the proposed regulations, as they relate to the standards for skilled nursing home services in Louisiana.

However, if the purpose of this subcommittee hearing is to question the appropriateness of the proposed regulation and to urge the Secretary of Health, Education, and Welfare to add greater nursing personnel requirements I cannot sit idly by and watch chaos emerge.

Proper direction and proper motivation at this point can do much toward assisting the States in molding and administrating good title XIX programs. However, to require standards for long-term skilled nursing homes under title XIX beyond those of extended care facilities under medicare—a federally funded and administrated program—is absurd in view of the apparent intent of Congress.

As a citizen of the State of Louisiana and one of its appointed officials, I would feel indignation toward a Government which says in effect "for our program you will have this kind of standard; however, for your program (State) you must provide more." Federal appropriations for medicare are almost a formality. Appropriations in States are not easy in this day and time. They are difficult and at times almost impossible.

I know that if standards which are being urged approximate those contained in the December draft discussed with the State and territorial health officers and later in the December 12–13, 1968, Atlanta meeting of the National Advisory Commission on Nursing Home Administration—which I viewed sometime ago—without consideration of the effect of such costs to the States and without concern for the ultimate effect on patients in facilities in the States, then it is time for Congress to consider returning such regulatory authority for nursing home standards to the State agency which knows their citizens' needs and what the taxpayers can afford.

For instance, nursing homes in Louisiana voluntarily improved standards years ago which made nursing services identical to, and in many cases in excess of, medicare standards. With certain adjustments we can meet the proposed standards contained in the regulations at issue.

Sharp Rise in Costs

The cost of nursing home care in Louisiana has risen from $16.4 million in fiscal year 1966–67 to $23.2 million in 1968–69. Nursing home care costs in Louisiana approximate 50 percent of our total title XIX costs even in view of reductions each year for the past 2 years in the rate paid for nursing home care.

The Atlanta draft of last December which proposed a 300-percent increase over medicare standards in staffing requirements, would have cost an additional $4.9 million to fund in Louisiana. We just do not have the resources to pay for that kind of care. I want to make it clear that although it will cause me great anxiety if such standards are adopted, we would have no choice but to reduce the skilled nursing home program in Louisiana in equivalent proportions.

In all probability, only the most seriously ill posthospital patient could be afforded such care. Those in actual need of long-term nursing home care would have to be cared for in an intermediate care facility or elsewhere. This is not to detract from the appropriateness of intermediate care, because they provide and were intended to provide a much needed level of care for thousands of patients throughout the country.

However, they were not intended or contemplated to care for the long-term nursing home patient. I would regret having to make such a decision. However, circumstance could require that decision. While I am in Washington and before I leave, I intend to contact each member of the delegation from the State of Louisiana to request their surveillance over the promulgation of these proposed standards. I think they know what is happening back home, and I think they are going to be concerned over the long-range effect of unrealistic standards.

We have a good nursing home program in Louisiana and are trying to keep it that way. We do not need regulations which stifle our ability to adjust to the needs of our patients coupled with our ability to pay for those needs. We need assistance and we need assistance now.

Mr. Chairman, I hope the concern of the State of Louisiana, which I feel may be the indication of the concern of all States, means enough to you to join hands with the rest of us in this country who want nursing homes which provide appropriate care at reasonable cost—actual nursing homes that provide actual services, not theoretical nursing homes operating according to paper standards.

Thank you, sir.

Senator Moss. Thank you, Mr. Bonin, for your testimony. We appreciate it.

Senator Moss. Now, Mrs. Rose Martin, executive director of the National Association for Practical Nurse Education Service, Inc.

STATEMENT OF ROSE G. MARTIN, NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION AND SERVICE

Senator Moss. Mrs. Martin, we are glad to have you.

Mrs. Martin. Thank you, Senator Moss. I do express our appreciation for your courtesy and may I also to this audience, those of you still remaining on so very late in the day. However, I appreciate this opportunity, late or not.

I would like, Senator, to ask that a correction be made on our record, our paper of record here on page 2, line 10. I have spoken to your staff about that.

Senator Moss. Is that where the number is changed to 1,154?

Mrs. Martin. Yes, sir, that is it. Also, Senator, I asked that you receive as an addendum a reprint from the March 1969 issue of the Journal of Practical Nursing and an attachment that goes with that.

Senator Moss. Very good. That will be an addendum to your statement and will be printed in the record.

(The prepared statement of Mrs. Martin follows:)

Prepared Statement of Rose G. Martin on Behalf of the National Association for Practical Nurse Education and Service

My name is Rose G. Martin. I am the Executive Director of the National Association for Practical Nurse Education and Service. I am a registered nurse, wife of a physician, who is chief of medicine in a 140-bed hospital in a community of just under 10,000 persons. I am a graduate of the South Baltimore General Hospital School of Nursing and attended Davis-Elkins College in Elkins, West Virginia. I served in the Army Nurse Corps in World War II, and am a former director of nursing service at Memorial General Hospital in Elkins, West Virginia. I have served in a volunteer capacity with the National Association for Practical Nurse Education and Service for the past 15 years and have just completed four years as its elected president. I serve in my present capacity at the request of the Board of Directors of NAPNES, which Board is composed of practical nursing

educators, licensed practical nurses, and consumers of nursing service, namely, hospital administrators, physicians, professional nurses, and public members.

The National Association for Practical Nurse Education and Service, out of concern for the welfare of patients in long-term care facilities, urges that practical nurses licensed by waiver not be automatically disqualified from serving as charge nurses in these facilities.

In making this proposal we are in no way denying the value of formal education for licensed practical nurses. One of the major objectives of our Association, since its founding in 1941, has been the development of educational programs in practical nursing. As a result of our efforts and those of other agencies, particularly the Federal Government which made funds available for practical nursing education, there are 1,154 such programs graduating about 27,000 students per year. Although these figures represent a tremendous increase from those of 15 years ago, when 150 schools graduated 3,000 students, the output of our educational system has not kept pace with the demand for licensed practical nurses. According to the survey of manpower resources in hospitals in 1966, conducted by the Bureau of Health Manpower of Public Health Service and the American Hospital Association, an additional 41,000 LPNs were then needed in hospitals alone. The deficit is greater today. The rapid growth in numbers of long-term care facilities is putting an added strain on the available supply of LPNs.

In the face of the present critical shortage of nursing personnel, we believe it is important to recognize that some LPNs licensed by waiver have, through experience and tutelage by physicians, developed competence equivalent to or greater than that of many graduates of state-approved schools. This is borne out by the fact that practical nurses who were licensed initially by waiver and were then permitted, after taking NAPNES' extension courses (the 64-hour and the 240-hour courses), to sit for the statutory licensing examination, frequently made much higher scores than did graduates of state-approved schools of practical nursing taking the same examination. Many waivered nurses have supplemented their knowledge and skills by taking advantage of continuing education programs. Those who have had several years of experience in long-term care facilities have demonstrated their interest in working with the aging and those who are chronically ill—an interest not shared by all nurses, some of whom do not possess the patience and tolerance required for working with the elderly. To remove such nurses from their positions would, we believe, be detrimental to the welfare of the patients they are now serving.

It should be pointed out that LPNs licensed by waiver have been licensed by the respective states only after evaluation of their background by the appropriate state agency, usually the state board of nursing. Many states require that the waivered LPNs pass the state licensing examination, which is the same examination taken by graduates of state-approved schools. Licensure by waiver implies recognition by the state of the principle of equivalency of prolonged experience in employment situations to formal training. Our Association, like most educational organizations, also recognizes this principle of equivalency.

Under no circumstances do we recommend the retention of any personnel whose service might constitute a hazard to patients. Rather, we ask that criteria and tools be developed for the identification of waivered LPNs who are competent to hold charge nurse positions in skilled nursing homes and other long-term care facilities.

We suggest the following criteria as appropriate:

(*a*) The LPN must, during the past five years, have had three years' employment as an LPN, of which at least two years were in the position of charge nurse in a hospital, skilled nursing home, or related facility, and must have achieved a passing score on the practical nurse licensing examination in the state in which he/she is employed or

(*b*) The LPN must have had five years' employment as an LPN, at least three of which have been during the past five years, and must have achieved a passing score of the practical nurse licensing examination in the state in which he/she is employed, and must have satisfactorily completed a course in the administration of medicines recognized for this purpose by the official state agency responsible for nursing education. For the waivered LPNs who fail to meet the proposed criteria we urge the establishment of courses especially tailored to their educational needs.

This proposal would help our health services to meet the most serious challenge facing them today—the fullest use of skilled health personnel. Therefore, we are sure that it will receive thoughtful attention from all who, regardless of their professional and organizational attachments, accord top priority to the welfare of the citizens of this country.

There is one observation that we would like to leave with this committee: Many of the existing conditions found in "poor" nursing homes occur as a result of intolerable physical conditions of the facility itself, for instance, a dozen or more elderly patients being assigned one bathroom. These conditions which occur at the administrative level will not be corrected at the professional care level, regardless of regulations designed in the best of faith to govern personnel.

Declaration of Functions of the Licensed Practical/Vocational Nurse by National Association for Practical Nurse Education and Service, Inc.

This statement was prepared at the direction of the Education Committee of the National Association for Practical Nurse Education and Service by a study committee comprised of representatives from practical/vocational nursing education, nursing service in hospitals and nursing homes, hospital inservice education, hospital administration, and LPN/LVN practitioners.

It was then approved by the Board of Directors and adopted unanimously by the voting membership of the National Association for Practical Nurse Education and Service in convention assembled, May 1969.

PURPOSE

This statement is intended to guide administrators of nursing services to develop sound and consistent written policies for assignment of functions to the licensed practical/vocational nurse.

The LPN/LVN recognizes and is able to meet the basic needs of the patient. The LPN/LVN is taught the underlying principles of nursing care and is prepared to execute therapeutic and technical skills. The LPN/LVN may assist in teaching and demonstrating nursing procedures to other personnel.

DEFINITION OF THE ROLE OF THE LPN/LVN

An LPN/LVN through education and clinical experience has acquired the necessary knowledge, skill, and judgment to provide nursing care under the direction of a registered nurse, a licensed physician, or a licensed dentist. Through continuing education, the LPN/LVN prepares to assume progressively more complex nursing responsibilities.

FUNCTIONS

1. Participates in the planning, implementation, and evaluation of nursing care, and teaches the maintenance of health and prevention of disease.
2. Observes and reports to the appropriate person significant symptoms, reactions, and changes in the condition of the patient, and records pertinent information.
3. Performs and/or assists in nursing functions such as:
   a. the administration of medications as prescribed.
   b. therapeutic and diagnostic procedures.
   c. procedures requiring the use of medical/surgical aseptic technique.
4. Assists with the rehabilitation of the patient and family according to the patient care plan:
   a. provides support for emotional needs.
   b. teaches appropriate self-care.
   c. advocates use of community resources.
5. Assists in performing nursing services in specialized units.
6. Participates in inservice programs for self-enrichment to maintain the high quality of nursing service.
7. Prepares to assume responsibilities as a charge nurse under direction.

VOCATIONAL RESPONSIBILITIES

The LPN/LVN:

1. Practices nursing according to state law.
2. Performs those nursing functions for which he/she has been prepared.
3. Seeks further growth through educational opportunities.
4. Participates in nursing organizations.

CLOSING STATEMENT

The LPN/LVN should by example of dignity and grace maintain a spiritual approach to all nursing care.

THE LICENSED PRACTICAL/VOCATIONAL NURSE AS CHARGE NURSE IN EXTENDED CARE FACILITIES: THREE POSITIONS

THE NFLPN POSITION

"Whereas, Due to greater responsibilities placed upon the LPN, it is necessary for good safe patient care that the charge nurse in an extended care facility be a well prepared person.

"Be it resolved, That the NFLPN in convention assembled go on record in support of requirements for charge nurse in an extended care facility to be an LPN who is a graduate of an approved school of practical nursing with additional preparation in unit management."

(*Resolution adopted by the National Federation of Licensed Practical Nurses, Oklahoma City, October 4, 1968.*)

THE ANA POSITION

"The registered nurse, alone, is prepared, by education and experience, to assume charge nurse responsibilities. The educational programs for the practical nurse are not designed to include content that would enable her to assume such functions. . . . The position of the American Nurses' Association is that a registered nurse should carry charge nurse responsibilities; that licensed practical nurses who are graduates of state approved programs in practical nursing should be relieved of such responsibilities as quickly as possible; that under no circumstances should a practical nurse licensed by waiver be permitted to assume these responsibilities."

(*Excerpted from the American Nurses' Association's Statement Regarding Personnel Qualifications Study, prepared October 4, 1968, and distributed November 1, 1968, by the ANA Government Relations Department.*)

THE NAPNES POSITION

The Board of Directors of the National Association for Practical Nurse Education and Service has carefully considered the document dated November 1, 1968, circulated by the political arm of the American Nurses' Association, regarding the limitations the ANA would like to see imposed on the important contributions which licensed practical/vocational nurses are making to the health services of this country. We deplore this proposal, which would bar all licensed practical/vocational nurses from serving as charge nurses in extended care facilities during afternoon and night tours of duty—a role in which, over the years, they have demonstrated outstanding competence.

Our main concern is the welfare of the public. If the course advocated by the ANA were followed, many patients who are now receiving good nursing care in extended care facilities would have to be transferred to situations in which they would receive no care whatsoever by nurses. Patients in hospitals might also be affected adversely, since registered nurses might be drained off from these institutions into positions in extended care facilities which no not require personnel with their preparation.

As for the educational qualifications of the licensed practical/vocational nurse in a charge nurse position, the National Association for Practical Nurse Education and Service was founded on the belief that the basic knowledge and skills required for the practice of practical/vocational nursing are most readily acquired in organized educational programs and, in line with this belief, has promoted the development of such programs for twenty-eight years. However, like most other educational organizations, including universities, it recognizes the possibility of alternate routes to the attainment of abilities that are usually acquired through formal education. Moreover, the history of all nursing would seem to indicate that managerial skills are to a considerable extent developed in an employment situation. Therefore, we believe it is possible that some practical/vocational nurses who have been licensed by waiver are, because of their experience, equally well or even better prepared to function as charge nurses in extended care facilities than are graduates of practical/vocational nursing or professional nursing programs who have had little or no appropriate employment experience.

Accordingly, we oppose the automatic disqualification of "waivered" licensed practical/vocational nurses from charge nurse positions. We propose, instead, the development of criteria and tools for evaluating the ability of such nurses to carry the responsibilities required of afternoon and night charge nurses in extended care facilities.

Our proposal would help our health services meet the most serious challenge facing them today—the fullest use of skilled health personnel. Therefore, we are sure that it will receive thoughtful attention from all who, regardless of their professional and organizational attachments, accord top priority to the welfare of the citizens of this country.

(*Statement adopted by the Board of Directors, National Association for Practical Nurse Education and Service January 13, 1969*)

Note: Reprinted from The Journal of Practical Nursing, official publication of the National Association for Practical Nurse Education and Service, Inc.

THE EQUIVALENCY ISSUE

(Reprinted From the Journal of Practical Nursing, Official Publication of the National Association for Practical Nurse Education and Service, Inc.)

The Board of Directors of NAPNES recently issued a statement on the qualifications of the charge nurse in extended care facilities certified for Medicare patients. It urged that automatic barriers set up solely on the basis of formal education be reconsidered. The action is important because the standards of nursing service adopted for Medicare may serve as a model for other legislation, particularly for Title XIX under Medicaid. Under the present medicaid regulations, practical/vocational nurses licensed by waiver must be relieved of charge nurse responsibilities no later than July 1, 1970.

The NAPNES Board, composed of educators, registered nurses, physicians, hospital and nursing home administrators, licensed practical/vocational nurses, and public members, recommended that criteria be established to evaluate the competence of the LPN/LVN who is licensed by waiver to serve as charge nurse on evening and night tours of duty. The Board's action is consistent with a nationwide trend toward closer scrutiny of the educational equivalence of experience among health personnel. Two other nursing organizations which have taken positions on this issue have vetoed the desirability of equivalency considerations (*JPN*, *March* issue).

The NAPNES position was adopted after a careful review of a wide range of factors in extended care facilities certified for Medicare. Consideration was given to the type of patients, the amount and kind of supervision, and the accessibility of medical assistance in an emergency. The patients in these facilities are those who no longer require the level of nursing care ordinarily furnished in a general hospital. The services of a physician must be available around the clock to every patient. Each facility must have an organized nursing service under the supervision of an RN. She is on duty during the daytime, when nursing care plans are made and when the bulk of diagnostic, therapeutic, and rehabilitative activities are carried out. It is within this framework that an RN or LPN/LVN functions as a charge nurse.

The determination of the equivalency value of experience and other factors is a difficult but not impossible task. First, however, must come the willingness to accept the concept of equivalency, given the present critical health manpower situation and mounting sentiment on the part of the public that improved comprehensive health service is its due. In this essential commodity of health, standards of care and public need and demand are so interrelated that they cannot be dealt with in isolation from one another.

NAPNES, as an educational organization with accreditation responsibilities, is committed to the principle that the education of health personnel is most effectively carried out in a formal educational setting. At the same time, it is an organization dedicated to maximum effort in meeting public need.

It is in response to this overwhelming need that the NAPNES Board has recommended reconsideration of a standard based on formal education alone. Such a standard precludes the utilization of a larger category of experienced health personnel in an essential capacity.

Mrs. MARTIN. I have been preceded by a distinguished parade of persons who know a great deal about the subject into which you

are inquiring today and I will certainly, in the interest of your time and that of the people here, not read this entire statement. I think that will be unnecessary.

Senator MOSS. Thank you. The entire statement will be in the record.[1]

Mrs. MARTIN. Yes, sir. I would like to say as you have already announced, my name, of course, that I serve now as the executive director of the National Association for Practical Nurse Education Service. I would like to point out, too, that I am a registered nurse, the wife of a physician who practices, if you please in a rural community. I am so sorry Senator Miller has left. Dr. Martin practices in a 140-bed hospital. I am a former director of nursing service in a rural community hospital.

I was in the Army Nurse Corps during World War II and was quite familiar with the capabilities of the medical corpsmen who were mentioned here today and I would most earnestly advocate that every consideration be given to these men. They are well trained on many levels.

I have served in a voluntary capacity. I say that in order to qualify the fact that I have no vested interest. The things I will be saying this afternoon are not a matter of dollars and cents. At this present moment I would say I am now employed but I have just completed a 4-year term as the elected president of the organization I represent.

One of the points that I have written down while listening to other speakers today is that we, for instance, as an association, did not receive a notice of this hearing which was critically important to the people we represent.

We have a membership of some 30,000 people. Most of these are licensed practical and vocational nurses. These are the same nursing entity except that in the States of Texas and California they are defined as licensed vocational nurses. In the remainder of the States, Guam, Puerto Rico, and the Virgin Islands they are called licensed practical nurses. We did not receive an invitation and I was surprised to hear Miss Shaughnessy, representing the American Nurses' Association, mention that she received an invitation on July 2 to testify.

Naturally we would be concerned about this. I am a member of the American Nurses' Association and I can understand that it is a pretty sizable and wealthy association. It is my professional organization. The NAPNES as an organization and I as an individual certainly commend the ANA for the work it has done in professional nurse education and in professional nursing.

Actually, however, we would be deeply concerned if the nursing interests in the United States were to be left to the judgment of a single organization no matter which organization it would be. If it were the one I come today to speak for, this would still be a mistake.

"SIMPLY A MANPOWER SHORTAGE"

To speak to another issue, the business of the image of nursing homes not being an attractive one, I would submit, Senator Moss, most certainly that the acute nursing shortage exists not only in

[1] See p. 104.

nursing homes, but in every general hospital in this country, rural, urban, metropolitan, or what-have-you. It is not a matter of the image of anything. It is simply a manpower shortage.

The fact that lies just under the surface and that perhaps I would be less than honest and less than helpful to you, Senator Moss, if I were not to say so, however unpopular it might be, is that it is unlikely that all branches of Government working as hard as they do—and I cannot see criticizing the administration. Certainly if I were attempting the job that you are, I would be doing it less well, I can assure you—are aware that the American Nurses' Association has directed most of its efforts toward the advancement of professional nurses oftentimes to the detriment of the total health care picture. I feel that I may say this because I am a registered nurse.

I have had an interest in the care of sick and aging people. I have a couple of them, one 85 and one 87, in my immediate family, along with having four children. I know that there are times when a professional nurse or a licensed practical nurse who is a married woman will not be able to nurse, not because of the image of anything, but because of the needs of children.

It is quite simple. I would like to submit here that the American Nurses Association in December of 1965 published what is titled the "First Position on Education for Nursing." It is to be found in the December 1965 issue of the American Journal of Nursing, and you may be familiar with this, Senator.

This paper advocates that nursing must be placed in the mainstream of education, that the minimum preparation for a registered professional nurse must be the baccalaureate degree program at the college level, that the minimum preparation for the technical nurse must be the associate degree program at the junior college level, that the American Nurses Association will—and I think I know this so well that I can quote it without reading—"will work systematically to replace programs of practical nursing with programs for beginning technical nursing—associate degree programs—in junior and community colleges."

That may not be verbatim, there may be some adjectives missing but the essence is there.

The impression has been given and was given less than a year following all the furor following the publication of this paper that this was intended for some long-term future date. Senator Moss, let me tell you, this was intended for yesterday and it is being implemented as rapidly as the ANA and its constituent State associations can do.

I do not have for you the figures of the diploma schools of nursing that have gone out of existence in the last 2 to 3 years, but I am sure your office can make these available to you. I have them, but I do not have them with me today because I did not realize that this would be pertinent. I did not come prepared to make this statement, but it has become quite evident that this information is not known.

This is not some long-term goal and I believe that the figures will bear this out regardless of what is said.

What is happening, Senator, is that this is hurting, and hurting badly, recruitment into the field of nursing at every level. An earlier speaker brought out the fact that there is no ladder from practical nursing to registered nursing.

The association that I speak for today was the first one that said, "Please, please, give these men and women—and there are a number of men in the practical nursing field—give them credit for the year they have spent. Don't lose them to nursing."

If you have people who have completed a practical nursing program, have successfully passed their State board examination and want to go upward, we must make it possible for them to do so rather than lose them to nursing by requiring them to repeat both theory and practice that they have already mastered. This is the job of nursing, to plan for this.

Now I hope not to take a great deal of time, but there are one or two more points here to substantiate the fact that this is not a long-term goal of the American Nurses Association.

The National Advisory Committee on Vocational Education received from the ANA a statement dated as recently as May 7, 1969, which carried as its No. 1 recommendation that vocational education funds be diverted from practical nurse education programs to associate degree programs in nursing—vocational education funds that have been the backbone, the heart and core of practical nursing programs since they were made available by both the George-Bardin Act and the Manpower Development and Training Act.

I am not reading from a manuscript here. These are things I have worked with for 15 years and I know them. I haven't made money on them at all. I know them and I know that coming from the State, the small State that I do, and dividing my time between there and midtown Manhattan, I have seen both ends of the spectrum and I know how nursing works.

Effects of Waivers

You were asking about waivers. Your interpretation was quite correct that waiver does mean letting something happen without requiring certain things. Every discipline had certain people waivered in at the outset; medicine, law, professional nursing and certainly practical nursing has done the same. As a matter of fact, there was not a licensure or law in the District of Columbia until 1960. It was that recent. There were States going right along, that were preparing practical nurses that had to go to another State to sit for a State board examination to qualify and then come back to wait for their own State legislatures to enact licensing legislation.

In the State of West Virginia, with which I am quite familiar, the licensing law was passed in 1957. There was a waiver period of 2 years. During that time the nurses simply were waivered in, as you say, without any requirements whatsoever except that two physicians attested to the fact that they had been practicing what appeared to be practical nursing for at least 2 years.

After that time, Senator, NAPNES, the national association that I am serving, designed extension courses to bring some uniformity to the background of these women—and at that time they were mostly women—they then attended classes through the State and county boards of education and took these extension courses. They were then permitted under West Virginia law to return and sit for the State board examination. By this time we had graduated students from approved schools of practical nursing.

The waivered nurse who took the extension course made consistently higher scores taking the same State board examination than did the graduate of the approved schools. It is for this reason that I ask your indulgence and your consideration that a nurse not be arbitrarily disqualified. This was the thrust of my statement today, that a waivered licensed practical nurse who has sat for the State board examination not be disqualified simply because she has not met certain formal academic requirements.

I would like to quote from a Government statement that was put out by the U.S. Civil Service Commission. It is dated early June, required to be back with comments by July 7, 1969.

It says this, which I think is helpful:

> In setting occupational standards within the framework of the Federal position classification system, it is imperative that qualification requirements be expressed in terms of the work assigned and the skills and knowledges required to perform it. Standards should not establish curtailing barriers that keep out employees who have training for the work and can do the work, but were not trained for it according to a specific academic pattern.

As I bring my comments to a close, I would like to say that in the face of the present critical shortage of nursing personnel, we believe it is important to recognize that some LPN's licensed by waiver have, through experience and tutelage by physicians and by registered nurses, developed a competence equivalent to and in many instances greater than a young woman or man who has graduated from a school of practical nursing and has just passed his or her State board examination.

Men and women who serve in this field at the present time are highly motivated people. We heard earlier today that they cannot stop, quit their jobs and go to school, and this is true. But there is an alternative. There can be a course designed for these people that they can take while they are employed and they can work and they can learn and they can upgrade themselves, which certainly seems to be in line with the social trend in our country today.

They do not have to quit their jobs. Under no circumstances, of course, do we recommend the retention of any personnel whose service would constitute a hazard to patients; rather, we ask that criteria and tools be developed for the identification of the waivered LPN's who are competent to hold charge nurse positions on a single tour of duty in nursing homes and in other long-term care facilities, and we have suggested specific criteria which do appear in our statement of record.

Recommended Criteria

The first of these is that the LPN must during the past 5 years have had 3 years' employment as an LPN, at least 2 years of which were as a charge nurse in a hospital, a nursing home or related facility and must have achieved a passing score on the practical nurse licensing examination in the State in which he or she is employed.

Second, that she must have had 5 years' employment as an LPN, at least 3 of which have been during the past 5 and must have achieved a passing score in the practical nurse licensing examination in the State in which he or she is employed and must have satisfactorily completed a course in the administration of medicines recognized for this purpose by the official State agency responsible for nursing education.

We would recommend that the National Association for Practical Nurse Education and Service, which is listed by the U.S. Commissioner of Education as an accrediting agency for schools and programs of practical nursing, be consulted on matters pertaining to practical nurses. We offer our services to your committee and to all committees that have an interest in this particular field. We have publications available that include courses of study. We would ask to be made a part of anything that concerns practical nurses and practical nurse education and would call to your attention that we are the oldest nursing organization in the country that has its total commitment to practical nursing.

We began our work at the beginning of World War II and we have continued steadily since then. You will not find us listed in the directory "Facts About Nursing," published by the American Nurses' Association. It arbitrarily decided to eliminate the NAPNES from the record at the end of 1964 when the position that I have spoken to you about was undertaken. It was at the beginning of that year that NAPNES for the first time was not included.

When I personally checked to see why this was, I was given a very perfunctory reply that it was the prerogative of the American Nurses' Association to decide who would be included within its directory. Yet this directory is defined as a complete directory of nursing organizations, and the NAPNES that is recognized by the U.S. Government, by the U.S. Commissioner of Education, is not listed. Our address is on our statement of record and we hope you will call us again.

I do thank you.

Senator Moss. Thank you, Mrs. Martin, for your very fine statement and for clarifying several things for us.

I don't know why you had not received notification of the hearings and I am embarrassed that you had not.

Mrs. Martin. I think we were not in the book and that is why you did not find us.

Senator Moss. Well, we are very glad that you found out about it and that you are here. We are very glad to have your testimony.

I personally appreciate what you have said about the thousands of practical nurses who are serving and have been serving adequately. They have the skill and training from having done the job, and it would be tragic to lose their services. It is like other fields, when you shift from an untested entrance to a tested entrance, there is this squeeze.

I agree with you most heartily that to require them to stop work and go back to school is not a solution. Many of them could not do that. But I see no reason why you could not have extension courses, as you described, and that they be given some degree of credit for the practical experience that they have had and then sit for a board. I would suspect that maybe 95 percent of them would come through a board examination if they have had the practical experience and apply themselves to a little extension study.

Certainly we ought to encourage this. But ultimately, someplace down the road, I think perhaps you are going to have to have a person who has completed the board and done the study before he or she goes in with the title of licensed practical nurse. Your discussion of this whole subject is very interesting and I think very helpful to the committee to have it. We are all seeking, I think, the same thing, to

upgrade the care that is given to our elderly ill who must be in nursing homes or in extended-care facilities or other facilities where they must be cared for, and we want to be sure that they receive the best possible care that can be provided for them.

Mrs. MARTIN. Senator, could I say just one thing? I have been concerned because when we begin to generate more heat than light on a subject—and this is one on which this could easily happen, but you have presided so well that it has not happened today—I sometimes wonder if we are confusing poor physical plants with other factors.

The business that I heard a couple of weeks ago of some home that had assigned 14 aging people to the use of one bathroom, this is what engenders the heat rather than the light. This is an administrative problem where it occurs. It is not a problem that could ever be remedied at the professional care level, however well designed the regulations were.

This is something else entirely.

Senator MOSS. I certainly agree with you. If they have inadequate facilities, they cannot get care. On the other hand, you can have first-class facilities and not have the skilled personnel.

Mrs. MARTIN. It kind of goes hand in hand. If you have one, you will be more apt to have the other.

Senator MOSS. Thank you very much. I thank all of you who have remained through this hearing today. I think it has been a good hearing. We are going to continue these hearings later on this year on the trends in long-term care.

I would point out that the record that we have made today will remain open for 10 days, so that if any of the witnesses or others who were not called have something that they would like to contribute to this record that they think is important, either by way of comment on testimony that was given or additional acts that they may have that did not come out in the testimony, any addition of that sort may be mailed either to me or to the committee, just by the name of the Senate Committee on Aging, and it will be placed in the record and be part of the record.

Copies of this record will be sent to all of those who testified and others who wish to make a request for it can receive a copy from our committee when it is printed.

With that, this hearing is adjourned.

(Whereupon, at 5:03 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.)

APPENDIX

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1: SUBMITTED BY PAUL DE PREAUX,[1] PRESIDENT, CONNECTICUT ASSOCIATION OF NONPROFIT HOMES AND HOSPITALS FOR THE AGED

EXHIBIT A. PUBLIC HEALTH CODE OF CONNECTICUT: REGULATIONS GOVERNING THE OPERATION AND MAINTENANCE OF CHRONIC AND CONVALESCENT NURSING HOMES

All institutions licensed under Section 19–32 to 19–42 of the General Statutes, as amended, must comply with the requirements set forth in these regulations before a license is issued.

Section 19–13–D 8—Chronic and Convalescent Nursing Homes—is repealed and the following substituted in lieu thereof:

(*a*) *Physical Plant*

(1) The building shall be of sound construction and shall be designed so as to provide a pleasant atmosphere and comfort for all patients. Minimum services required shall include business and administration offices, patient rooms, nurses' station, service areas, dietary facilities, sitting and dining areas, recreation areas, adequate storage, laundry, employees' facilities, physical therapy unit and examining room. Each patient room shall be numbered; the number, together with the licensed capacity of each room shall be posted at each door. The census shall not exceed the number for which the license is issued, nor shall the number of patients in any room exceed the licensed capacity of that room.

Each nursing unit of thirty beds shall have a nurses' station of at least one hundred square feet of floor space. A central nursing station may serve two thirty bed units, but shall have one hundred fifty square feet of floor space and a separate clean utility room. A central nursing station shall not serve more than sixty beds.

(2) The site shall be away from nuisances detrimental to the facility, such as industrial development, or other types of business that produce noise, polluted air or foreign odors. Roads and walks shall be provided within the lot lines to the main entrance and for service, including loading and unloading space for delivery trucks. Adequate off-street parking shall be provided. There should be one visitor parking space for every three patients and three employee parking spaces for every four employees on the 7:00 a.m. to 3:00 p.m. shift.

(3) The building, equipment and precautions taken to provide for the safety of patients and employees shall be approved by the state department of health. Exit facilities shall comply with the requirements for exit facilities in the state fire safety code. Minimum width of doors to all rooms needing access for beds or stretchers shall be three feet eight inches. Doors to patient toilet rooms and other rooms needing access for wheelchairs shall have a minimum width of three feet. An annual certificate from the local fire marshal that precautionary measures meet his approval shall be submitted with the annual application for license.

(4) The heating system shall be adequate to provide a minimum temperature of seventy-five Fahrenheit degrees at all times.

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[1] See statement, p. 31.

(5) Emergency electrical service shall be provided to circuits as follows:

(a) Lighting:

1. Exitways and all necessary ways of approach thereto including exit signs and exit direction signs, exterior of exits, exit doorways, stairways, and corridors.
2. Dining and recreation rooms.
3. Nursing station and medication preparation area.
4. Generator set location, switch-gear location and boiler room.
5. Elevator (if required for emergency).

(b) Facilities essential to life safety and for protection of important equipment or vital materials:

1. Nurses' calling system.
2. Alarm system including fire alarm actuated at manual stations, water flow alarm devices of sprinkler systems if electrically operated, fire detecting and smoke detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed.
3. Fire pump, if installed.
4. Sewerage or sump lift pump, if installed.
5. All required duplex receptacles in patient corridors.
6. One elevator, where elevators are used for vertical transportation of patients.
7. Equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization.
8. Equipment necessary for maintaining telephone service.

(c) Where electricity is the only source of power normally used for space heating, the emergency service shall provide for heating of patient rooms. Emergency heating of patient rooms shall not be required in areas where:

1. The design temperature is higher than twenty degrees Fahrenheit, based on the Median of Extremes as shown in the current edition of the ASHRAE Handbook of Fundamentals, or
2. The nursing home is supplied by at least two utility service feeders, each supplied by separate generating sources, or a network distribution system fed by two or more generators, with the hospital feeders so routed, connected and protected that a fault any place between the generators and the hospital is not likely to cause an interruption of more than one of the hospital service feeders.

(6) A complete electrical system shall be installed to provide an adequate electrical service to the facility. All materials and equipment shall comply with applicable standards of Underwriters Laboratories, Inc., or other similarly established standards.

(7) All chronic and convalescent nursing homes where either patient beds or inpatient facilities, such as diagnostic, recreation, patient dining or therapy rooms, are located on other than the first floor, shall have electric or electri-hydraulic elevators. Elevators shall have automatic leveling of the two-way automatic type with accuracy within plus or minus one-half inch.

(8) Temperature of hot water at plumbing fixtures used by patients and employees shall not exceed 110 degrees F.

(9) The building, equipment and site shall be maintained in a good state of repair and shall be kept clean at all times.

(b) *Administration*

(1) The proprietor or administrator of the institution shall be responsible for operation of the institution in compliance with these regulations.

(2) The proprietor or administrator of the institution shall be responsible for submitting to the state department of health the annual application for license and such reports as may be required.

(3) The proprietor or administrator of the institution shall be responsible for the appointment of a qualified medical director, and a competent director of nursing as provided in these regulations.

(4) The proprietor, corporation or administrator shall furnish with his initial application, three references to assist the state department of health in evaluating his suitability to operate a chronic and convalescent institution, as follows: One from a physician licensed to practice medicine or surgery or from a registered nurse indicating his professional qualifications or degree of experience in

the care of chronic and convalescent patients, one from a bank or fiinancial institution and a character reference from a suitable and unrelated person. The sponsor shall submit to the state department of health an audited statement of assets and liabilities and evidence of operating capital sufficient for the size of the proposed institution based on criteria approved by an independent, reputable lending insurance and/or auditing firm.

(5) Sufficient capable personnel of good character and suitable temperament shall be employed in sufficient numbers to provide satisfactory care for the patients. They shall be competent in their respective work areas and shall be instructed regarding their share of the responsibility for caring for patients and in evacuation procedures in cases of emergencies including those required in section 29–40–199 of the state fire safety code.

(6) The proprietor or administrator shall furnish, with his initial and each subsequent annual application, a certificate of physical and mental health signed by a physician.

(7) The management, personnel, equipment, facilities, sanitation and maintenance of the home shall be such as reasonably to ensure the health, comfort and safety of residents at all times.

(8) In institutions of sixty beds or more the administrator shall be fulltime and for only one institution, and shall not serve as director of nurses.

(9) On or after January 1, 1970, all administrators shall satisfactorily complete at least a one-week course of instruction approved by the commissioner of health of at least thirty hours of classroom time or its equivalent in nursing home administration.

(10) Effective January 1, 1970, nursing home administrators shall show evidence of at least two years' experience in a responsible administrative position in a health care institution or equivalent administrative experience acceptable to the state department of health.

(11) Authority and responsibility of the administrator for the internal operation of the nursing home shall be stated in writing by the governing body.

(c) *Medical Supervision*

(1) There shall be a medical director licensed to practice medicine and surgery in Connecticut, who will be available, if emergency should require, for service in the institution and who shall be responsible for the adequacy of medical and nursing care rendered and special diets served patients in the institution. The medical director shall be a member of the medical staff of a general hospital licensed in Connecticut.

(2) All patients admitted, who are not accompanied by a record of physical findings and diagnosis and signed doctor's orders for treatment, diet and activity shall be seen by their personal physician, or by the medical director within twenty-four hours of admission and medical history, physical findings, laboratory findings and signed medical orders shall be recorded and each twelve months thereafter a thorough medical examination shall be made and recorded.

(3) No medications or treatments shall be given without doctor's orders. If orders are given by telephone, they shall be recorded by the licensed nurse on duty with the doctor's name and shall be signed by the doctor on his next visit.

(4) If a nursing home is engaged solely in administering treatment in accordance with any one of the healing arts only, there shall be a duly licensed resident practitioner or consulting practitioner of that healing art available as above.

(5) The medical director shall visit the nursing home at least once each month and shall indicate, in a statement over his signature, conditions existing in the institution relative to the adequacy of nursing care and diets furnished to the patients.

(6) The medical director shall receive reports from the director of nurses on significant clinical developments that might require medical attention.

(7) If the patient has a personal physician, that physician shall be summoned in instances where a clinical development might require medical attention. If the personal physician does not respond promptly, the director of nurses shall notify the medical director who shall examine the patient in a manner adequate to the clinical problems present and order necessary care. An adequate progress note shall be entered into the patient's chart at that time.

(8) Each patient shall be seen by a physician at least once each month.

(9) A record shall be kept by the nursing home of the medical director's visits and statements for review by the state department of health.

(*d*) *Medical Records*

(1) A medical record including a patient care plan shall be started for each patient immediately upon admission with complete identification data and the licensed nurse's note of the patient's condition on admission. To this shall be added any records, reports or orders which accompanied the patient. A nurse's progress note shall be recorded at least once a month.

(2) Within twenty-four hours of admission a physician shall examine the patient and initiate a record of the patient's medical history, physical and laboratory findings, diagnosis and orders and sign his name, provided this shall not be required if current reports and orders, signed by a physician, accompanied the patient.

(3) The medical record shall note all medications and treatments each time they are given and signed by the licensed nurse who gives them. Nurses' notes shall also report any accidents, changes in patient's condition or other unusual occurrences.

(4) A careful and accurate record shall be kept of all narcotics and sedative drugs in accordance with the requirements of the state department of health, which shall include as a minimum an audit every eight hours at change of shifts.

(5) A roster shall be maintained of all patients admitted and discharged on forms prescribed by the state department of health. A copy of the roster, together with the annual census report, shall be submitted to the state department of health not later than January thirty-first each year.

(6) All medical records shall be prepared, maintained and filed in a manner approved by the state department of health. They shall be kept for a minimum of ten years after discharge of patients.

(7) Physicians' progress notes shall be written at the time of each visit describing significant observations and changes in the patient's condition so that, if another physician is called to see the patient in an emergency, he will have an adequate understanding of the patient's underlying medical condition.

(8) Narcotic records shall be kept at least three years by the nursing home.

(9) The type of medical records used by the nursing home shall be subject to the approval of the commissioner of health.

(*e*) *Nursing Service*

(1) There shall be a competent director of nurses who shall be responsible for the nursing care of patients, for adequate staffing of the nursing service of the institution, proper care of drugs, proper maintenance of medical records, and proper dietary procedures. If the director of nurses is responsible for administrative duties outside the nursing service, an assistant shall be provided.

(2) For an institution of thirty beds or over, the director of nurses shall be a nurse registered in Connecticut. For an institution of under thirty beds, the director of nurses may be a practical nurse licensed in Connecticut. A nurse-in-charge appropriately registered or licensed, shall be provided seven days a week.

(3) There shall be at least one nurse registered in Connecticut or one practical nurse licensed in Connecticut on duty, in uniform, at all times. Additional registered nurses or licensed practical nurses shall be provided as necessary; at no time shall there be less than one registered nurse or licensed practical nurse for every thirty patients or fraction thereof from 7 a.m. to 3 p.m.; and one registered nurse or licensed practical nurse for every forty-five patients or fraction thereof from 3 p.m. to 11 p.m. and one registered nurse or licensed practical nurse for every sixty patients or fraction thereof from 11 p.m. to 7 a.m.

(4) The director of nurses shall be on duty in uniform and cover the day shift.

(5) The charge nurse shall approve all menus for regular meals and for special diets.

(6) Nursing care plans shall be prepared on all patients in a manner approved by the commissioner of health.

(7) There shall be additional nursing attendants or aides on duty sufficient to provide not less than one nurse or attendant for each ten patients or fraction thereof on the day shift and one nurse or attendant for each fifteen patients or fraction thereof on the evening shift, and one nurse or attendant for each twenty patients or fraction thereof on the night shift. The calculation of this ratio shall not include the director of nurses on the 7 a.m. to 3 p.m. shift in a nursing home of 61 beds or more and charge nurse or supervisor on the 3 p.m. to 11 p.m. shift in a nursing home of 121 beds or more.

(8) In multiple story buildings, nurse and attendants shall be on duty on each patient-occupied floor at all times.

(9) All medications shall be given by a nurse registered in Connecticut or by a practical nurse licensed in Connecticut.*

(*f*) *Dietary Service*

(1) Adequate space, equipment and qualified personnel shall be provided to ensure proper selection, storage, preparation and serving of regular and special diets to patients at regularly scheduled hours.

(2) Menus shall be prepared and posted and filed and shall meet state department of health requirements for basic nutritional needs.

(3) The time scheduling of regular meals and snacks shall be approved by the commissioner of health with not more than fourteen hours between supper and breakfast.

(4) Methods of dishwashing and dish sanitizing, food handling and garbage disposal shall comply with section 19-13 B 42 of the Public Health Code.

(*g*) *General Conditions*

(1) Patients shall be admitted only on referral from a responsible source. No patients may be admitted on an emergency basis except in the event of a major disaster, in which case the state department of health shall be notified at the earliest possible time.

(2) Provisions for visiting hours shall be as liberal as may be consistent with good patient care. Personnel shall be instructed to treat both patients and their visitors with courtesy and consideration at all times.

(3) Any accident, disaster or other unusual occurrence in the institution shall be reported within seventy-two hours to the state department of health.

(4) Proper heat, hot water, lighting and ventilation shall be maintained at all times.

(5) There shall be a system of communication sufficient to meet the needs of the institution and the requirements of the state department of health.

(6) Adequate housekeeping, laundry and maintenance services shall be provided.

(7) Licenses are not transferable and are in effect only for the operation of the institution as it is organized at the time the license is issued. The state department of health shall be immediately notified if the licensee plans any structural changes, plans to sell the institution or plans to discontinue operation.

(8) When an institution changes ownership, the new licensee shall not only comply with all requirements of these regulations but shall, in addition, comply with the requirements of new structures insofar as existing structural and mechanical systems will permit.

(9) Institutions caring for more than four persons shall comply with the state fire safety code (see reg. 29-40-1 et seq.).

(10) The site of new institutions shall be approved by the state department of health.

(11) Private water supplies and/or sewerage shall be installed in accordance with the public health code and with written approval by the local director of health.

(12) All plans and specifications for new construction or alterations shall be submitted to the state department of health, the local fire marshal, the local building inspector, if any, and the local zoning authorities for approval before construction is undertaken.

(13) No person shall be admitted to or housed in the institution if such person is not under the direct supervision of the licensee.

(14) There shall be a day space or recreation area on each floor of the institution adequately equipped for the purposes intended.

(15) Effective July 1, 1969, no chronic and convalescent nursing home shall be constructed without a certificate of need issued by the state department of health to the sponsor which certificate shall be issued in accord with the Connecticut construction plan for hospitals and medical facilities as prepared by the state's Hill-Burton authority.

(16) All licensed nursing homes shall carry an adequate amount of malpractice and public liability insurance.

(*h*) *Special Conditions*

(1) Children under fourteen years of age shall not be admitted unless a separate unit with special staff and children's facilities is maintained for the care

* Reference to eight hour periods of nursing service as beginning at 7 a.m., 3 p.m., and 11 p.m. is not mandatory; the eight hour periods may begin, for example, at 8 a.m., 4 p.m., and 12 midnight at the discretion of the proprietor or administrator with the approval of the state department of health.

of children as indicated in the regulations governing children's nursing homes. When a patient achieves his fourteenth year of age, he shall be transferred to a facility suitable to his needs.

(2) Supervised recreational activities shall be provided.

(3) The state department of health shall be immediately notified if the licensee changes his consulting physician.

(4) The state department of health shall be immediately notified if the licensee changes the administrator, the medical director or the director of nursing.

(5) If the institution is additionally licensed for a separate children's nursing home unit and is also authorized to care for persons suffering from harmless chronic mental unsoundness, children of normal mentality should not be admitted to the separate children's unit.

FEBRUARY 28, 1969.

EXHIBIT B. CONNECTICUT STATE DEPARTMENT OF HEALTH PHYSICAL STANDARDS

CHRONIC AND CONVALESCENT NURSING HOMES AND REST HOMES WITH NURSING SUPERVISION

General

Chronic and convalescent nursing homes and rest homes with nursing supervision are planned for the long-term care of patients requiring nursing care under medical supervision. These facilities shall contain all the elements described herein and shall be built in accordance with the construction requirements outlined.

Site

The site shall be away from nuisances detrimental to the proposed project's program, such as industrial development, or other types of facilities that produce noise, air pollution or foreign odors. Facilities shall be located close to where competent medical consultation is readily available, and where employees can be recruited and retained.

Roads and walks shall be provided within the lot lines to the main entrance and for service, including loading and unloading space for delivery trucks. Adequate off-street parking shall be provided.

There shall be level graded or paved outdoor area suitable for walking with a minimum of 100 sq. ft. per patient in facilities of 60 beds or less, with an additional 50 sq. ft. for every patient over 60 in facilities with more than 60 beds.

Code

Every building hereafter constructed or converted for use, in whole or in part, as a chronic and convalescent nursing home or rest home with nursing supervision shall comply with the requirements of the Basic Building Code, as prepared by the Public Works Department, State of Connecticut; except as such matters are otherwise provided for in the local municipal charter, or other ordinances or statutes, or in the rules and regulations authorized for promulgation under the provisions of the Basic Code.

In addition to the Basic Code, all chronic and convalescent nursing homes and rest homes with nursing supervision must comply with the State Fire Safety Code, NFPA–101 Life Safety Code, Public Health Code of the State of Connecticut, local fire safety codes, zoning ordinances, and in cases where private water supply and/or sewerage is required, written approval of the local health officer and environmental Health Division of Connecticut State Department of Health must be obtained.

Minimum Services Required

1. Business or Administration Office (to include Director of Nurses Office).
2. Nursing Unit (Patient rooms and toilets, Nurses Station and Service areas in each nursing unit).
3. Dietary Facilities.
4. Sitting and Dining.
5. Recreation Area (including Office for Recreation Director).
6. Storage.
7. Laundry.
8. Employees' Facilities.
9. Physical Therapy Unit (occupational therapy recommended).

10. Details of Construction.
11. Mechanical, Electrical & Elevators.

Note: (*a*) The above services are minimum and do not necessarily reflect the requirements for Chronic and Convalescent Nursing Home Classifications.
(*b*) In cases where more than one code is mentioned as a reference, the more restrictive code shall apply.

A. NURSING UNIT

Patient Rooms.—Each patient room shall meet the following requirements:
1. Maximum room capacity: 4 patients.
2. Minimum room area exclusive of closets, toilet rooms, lockers, wardrobes, and vestibules: 100 square feet in one-bed rooms and 80 square feet per bed in multi-bed rooms.
3. Multi-bed rooms shall be designed to permit no more than two beds side by side parallel to the window wall.
4. Windows: Sill not be higher than 3'0'' above the floor and shall be above grade.
5. Nurses' calling system (See item F, p. 128.).
6. Lavatory. In single and two-bed rooms, the lavatory may be located in a private toilet room.
7. Wardrobe or closet for each patient. Minimum clear dimensions: 1'10'' deep by 1'8'' wide with full length hanging space; provide clothes rod and shelf.
8. Cubicle curtains, or equivalent built-in devices, for privacy for each patient in multi-bed rooms.
9. No patient room shall be located more than 120'0'' from the nurses' station, the clean workroom, and the soiled workroom.
10. All patient rooms shall be outside rooms with minimum light equal to 10% of the floor space and outside ventilation equal to 50% of the required light space. All patient rooms shall be above grade.
11. Patient rooms must open into a common corridor in new nursing homes.
12. Beds shall not be placed closer than 3 feet from an exterior wall or other beds. The head of a bed may be placed against a properly insulated exterior wall.
13. The furnishings for each patient must include an adjustable hospital bed with latch spring, side rails, a standard enclosed bedside stand, bedside light and one chair.

B. SERVICE AREAS IN EACH NURSING UNIT

Each nursing unit of 30 beds shall require a nurses' station of at least 100 square feet. Counter space of at least 10 linear feet of standard height and depth shall be provided for charting, etc.

A central nursing station may serve two 30-bed units but shall have 150 square feet of floor space and a separate clean utility room. A central nursing station shall not serve more than 60 beds.

1. Nurses' station. For nurses' charting, doctors' charting, communications, and storage for supplies and nurses' personal effects.
2. Nurses' toilet room. Convenient to nurses' station.
3. Clean workroom. For storage and assembly of supplies for nursing procedures; shall contain 10 feet of work counter and sink space for autoclave, space for storage of suction machine, portable oxygen and other medical supplies.
4. Soiled Utility Room:
(*a*) A segregated area of at least 5' x 9' must be provided for bedpan washing and disinfecting equipment for each 30-bed nursing unit.
(*b*) A bedpan washer is optional, however, if not installed, a flush rim sink must be provided.
(*c*) Individual bedpans and urinals are recommended but if this system is not used, an approved sterilizer must be provided with storage space for bedpans and urinals.
(*d*) Besides the facility for washing and sanitizing bedpans this room should provide space for a large wheeled hamper for soiled linen, a covered waste can, counter space for urine testing and cleaning supplies. Commodes may be stored under the counter.
(*e*) The floors must be moisture resistant and the wall should be moisture resistant to a point above the splash line.
(*f*) A hand washing sink shall be provided.

5. Medicine room. Adjacent to nurses' station; with sink, refrigerator, locked storage, and facilities for preparation and dispensing of medication. (May be a designated area within clean workroom if a self-contained cabinet is provided, cabinet to be at eye level and well lighted.)

6. Clean linen storage. Enclosed storage space. (May be a designated area within the clean workroom.)

7. Nourishment station. Storage and sink for serving between-meal nourishments. (May serve more than one nursing unit.)

8. Equipment storage room. For storage of IV stands, inhalators, air mattresses, walkers, and similar bulky equipment.

9. Patient baths. One shower stall or one bathtub for each 15 beds not individually served. There shall be at least one bathtub in each nursing unit. Grab bars shall be provided at all bathing fixtures. Each bathtub or shower enclosure in central bathing facilities shall provide space for the private use of the bathing fixture, for dressing, and for a wheelchair and attendant. Showers in central bathing facilities shall not be less than 4'0'' square, without curbs, and designed to permit use from a wheelchair. Soap dishes in showers and bathrooms shall be recessed. Controls to be located outside shower stalls. At least one bathtub must be of the "free-standing" type and provide 3 feet clearance on 3 sides. A water-closet lavatory shall be directly accessible.

10. Stretcher and wheelchair parking area or alcove.

11. Janitor's closet. Storage of housekeeping supplies and equipment. Floor receptor or service sink. One janitor's closet for each 60-bed unit.

C. PATIENT TOILET ROOMS

1. A toilet room shall be directly accessible from each patient room and from each central bathing area without going through the general corridor. One toilet room may serve two patient rooms but not more than 4 beds. (The lavatory may be omitted from the toilet room if one is provided in each patient room. The minimum dimensions of any room containing only a watercloset shall be 3'0'' by 6'0'').

2. Waterclosets must be easily usable by wheelchair patients. Grab bars shall be provided at all waterclosets.

3. At least one room shall be provided for toilet training; this shall be accessible from the nursing corridor and may serve the bathing area, and shall provide 3'0'' clearance at the front and sides of the watercloset.

4. Doors to toilet rooms shall have a minimum width of 3'0'' to admit a wheelchair.

D. SPECIAL PURPOSES ROOM(S)

Rooms may serve more than one nursing unit on the same floor. For consultation, examination and treatment, and therapeutic and nursing procedures. Provide lavatory, storage, and space for treatment table.

Sitting and dining area

1. Lounge or sitting space should be provided on each floor with at least an area of 225 square feet for each 30 beds.

2. A separate Patient Dining area is recommended.

Dietary facilities

1. Kitchens should be centrally located, segregated from other areas and large enough to allow for adequate equipment to prepare and care for food properly. Personal locker and rest rooms shall be provided.

2. Floors should be waterproof, greaseproof, smooth and resistant to heavy wear, with corners and wall junctions coved. There shall be floor drains located where the most cleaning is required as in the dish machine room near the cooking area, etc.

3. All equipment and appliances shall be installed to permit thorough cleaning of the equipment, the floor and the walls around them.

4. Outside ventilation openings shall be screened, and provide at least 10 air changes per hour. A working vent fan is required. A strong exhaust fan in the hood over the range and steam equipment is necessary. The hood should be a box type with straight sides.

5. Service pipes and lines in food cooking and preparation areas must be enclosed.

6. All wall surfaces shall be smooth and waterproof to a point at least 4 feet above the floor.

7. Ceilings in the kitchen and dishwashing areas shall be insulated when located beneath a patient area.

8. A dishwashing machine shall be provided in any home with 30 or more beds. The dishwashing machine shall be in a separate room or in an area separated from the main kitchen by a partition 5 feet minimum height. There shall be adequate openings for entrance and exit of carts, preferably two doors. There shall be space for trucks with dirty dishes at the beginning of the counter and area for the clean dish storage carts. The disposer and pre-rinse and soak sinks should be at the beginning of the counter.

9. Sinks: Sinks that must be provided include:

(*a*) A food sink to be used only for food.

(*b*) Two or three compartment sink for pot and pan washing with drain shelf on each end and a pot rack shall be provided.

(*c*) A handwashing sink.

(*d*) A chef's sink in the cook's table is very desirable.

10. A minimum width of 9 feet is required for the cooking work center; this includes ranges, ovens and tables.

11. There shall be adequate space for garbage storage in a fly-tight enclosure away from food preparation or patient areas outside the kitchen area. It must be so installed as to be easily cleaned. A can washing facility is recommended.

12. Sufficient dry storage space that is ventilated and accessible to the kitchen shall be provided. A separate storage area for cleaning supplies, soaps, insecticides, etc., is required.

13. Refrigeration—Adequate refrigeration should be provided for the storage of food. Tray slide refrigerators are recommended. Reach-in refrigerators are considered more effective and efficient than walk-in.

14. Space should be provided for the storage of: Setting of trays by assembly line with adequate space for glasses, utensils, trays, dish carts, etc.

15. The ice machine should not be installed in the kitchen.

16. A steam-jacketed kettle is very desirable for 90 beds or over.

17. Adequate clear counter working space in addition to the cook's table is essential. In addition, there must be a counter provided for the machines.

18. A breakdown area is necessary in the receiving section; also, space is needed for the holding of cases of soda bottles for pick up.

19. Wood top tables, benches or counters are not acceptable. All stainless steel tops are to be used.

20. A water supply at the range must be provided.

Recreation area

1. Recreation areas are required.

2. Space for recreation shall contain 450 square feet in a 30-bed institution, 600 square feet in a 60-bed institution, and 750 square feet in a 90-bed institution. And 150 square feet for each 30 beds over 90 beds this space shall be provided in one area. Lobby area is not included in recreation space. An office shall be provided for the program director, with a minimum of 80 square feet.

3. At least 100 square feet of storage space shall be provided for the storage of supplies and equipment.

4. Ten square feet per patient should be provided for outdoor porches or patio areas.

It is recommended that the recreation and patients' dining areas be adjacent.

Storage

1. Separate storage space shall be provided for patients' clothing and personal possessions not kept in the room, treatment equipment, stretchers and wheelchairs, linen and supplies. At least 15 square feet per bed.

2. Storage space should be located according to use and demand.

Laundry

1. Soiled linen room.

2. Clean linen and mending room.

3. Linen Cart Storage.

4. Lavatories. Accessible from soiled, clean, and processing rooms.

5. Laundry Processing Room. Commercial-type equipment shall be sufficient to take care of 7 day's needs within the work week.

6. Janitor's Closet. Storage for housekeeping supplies and equipment; floor receptor or service sink.

7. Storage for Laundry Supplies.

8. Each facility shall have a domestic type washer and drier for patient's personal clothing. Laundry must be remote from dietary areas.

*(Items #4, #5, #6, and #7 may be omitted if laundry is processed outside the facility)

Employees facilities

1. A watercloset and lavatory located in a separate room shall be provided for employees' use only. There should be a separate toilet for each sex.
2. Separate locker rooms for each sex shall be provided, with adequate segregated space for employees' clothing.
3. Separate dining space shall be provided for employee use; this area shall not be included in this space for any other purpose.

DETAILS OF CONSTRUCTION

A high degree of safety for the occupants in minimizing the incidence of accidents shall be provided. Hazards such as sharp corners shall be avoided. All details and finishes shall meet the following requirements:

A. Details

1. Exit facilities shall comply with the requirements for exit facilities listed in State Fire Safety Code or NFPA Standard No. 101, whichever shall be more restrictive. Minimum corridor widths shall be 8'0''. Minimum width of doors to all rooms needing access for beds or stretchers shall be 3'8''. Doors to patient toilet rooms and other rooms needing access for wheelchair shall have a minimum width of 3'0''.
2. Such items as drinking fountains, telephone booths, and vending machines shall be located so that they do not project into the required width of exit corridors.
3. Handrails with ends returned to the walls shall be provided on both sides of corridors used by patients in nursing homes with a clear distance of 1½ inches between handrail and wall.
4. All doors to patient-room toilet rooms and patient-room bathrooms shall be equipped with hardware which will permit access in any emergency.
5. All doors opening onto corridors shall be swing-type except elevator doors. Alcoves and similar spaces which generally do not require doors are excluded from this requirement.
6. No doors shall swing into the corridor except closet doors.
7. Thresholds and expansion joint covers, if used, shall be flush with the floor.
8. Grab bars and accessories in patient toilet-, shower-, and bath-rooms shall have sufficient strength and anchorage to sustain a load of 250 pounds for 5 minutes.
9. Lavatories intended for use by patients shall be installed to permit wheelchairs to slide under.
10. The location and arrangement of lavatories and sinks with blade handles intended for handwashing purposes shall provide clearance necessary for operation without use of hands.
11. Mirrors shall be arranged for convenient use by patients in wheelchairs as well as by patients in a standing position.
12. Paper towel dispensers shall be provided at all lavatories and sinks used for handwashing.
13. If linen and refuse chutes are used, they shall be designed as follows:
    - (*a*) Service openings to chutes shall have approved class "B", 1½ hour fire doors.
    - (*b*) Service openings to chutes shall be located in a room or closet of not less than 2-hour fire-resistive construction, and the entrance door to such room or closet shall be a class "B", 1½-hour fire door.
    - (*c*) Minimum diameter of gravity-type chutes shall be 2'0''.
    - (*d*) Chutes shall terminate in or discharge directly into a refuse room or linen chute room separated from the incinerator or laundry. Such rooms shall be of not less than 2-hour fire-resistive construction and the entrance door shall be a class "B", 1½-hour fire door.
    - (*e*) Chutes shall extend at least 4'0'' above the roof and shall be covered by an Explosion Proof Hatch.
14. Dumbwaiters, conveyors, and material handling systems shall not open into any corridor or exitway but shall open into a room enclosed by not less than 2-hour fire-resistive construction. The entrance door to such room shall be a class "B", 1½-hour fire door.

15. Protection requirements of X-ray and gamma-ray installations shall conform to NBS Handbooks, as follows:

(a) X-ray—Handbook 76.

(b) Gamma-ray—Handbook 73.

16. Ceiling heights:

(a) Boiler room. Not less than 2′6″ above the main boiler header and connecting piping with adequate headroom under piping for maintenance and access.

(b) Storage rooms, patients' toilet rooms, and other minor rooms. Not less than 7′6″.

(c) All other rooms. Not less than 8′0″.

17. Boiler rooms, food preparation centers, and laundries shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 85° Fahrenheit.

18. Approved fire extinguishers shall be provided in recessed locations throughout the building in accordance with NFPA Standard No. 10.

B. Finishes

1. For flame spread requirements, see State Fire Safety Code or NFPA 101, whichever is more restrictive.

2. Floors generally shall be easily cleanable and shall have the wear resistance appropriate for the location involved. Floors in kitchens and related spaces shall be waterproof and greaseproof. In al areas where floors are subject to wetting, they shall have a non-slip finish.

3. Adjacent dissimilar floor materials shall be flush with each other to provide an unbroken surface.

4. Walls generally shall be washable and in the immediate area of plumbing fixtures; the finish shall be moistureproof. Wall bases in dietary areas shall be free of spaces that can harbor insects.

5. Ceilings generally shall be washable or easily cleanable. This requirement does not apply to boiler rooms, mechanical and building equipment rooms, shops and similar spaces.

6. Ceilings shall be acoustically treated in corridors in patient areas, nurses' stations, nourishment stations, and dining areas.

ELEVATORS

A. *Elevators, Where Required*

All nursing homes where either patient beds or inpatient facilities such as diagnostic, recreation, patient dining, or therapy rooms are located on other than the first floor, shall have electric or electrohydraulic elevators as follows:

1. Number of elevators:

(a) At least 1 hospital-type elevator shall be installed where 1 to 59 patient beds are located on any floor other than the first. (For purposes of these requirements, the first floor is the floor first reached from the main front entrance.)

(b) At least 2 elevators, 1 of which shall be hospital-type, shall be installed where 60 to 200 patient beds are located on floors other than the first, or where inpatient facilities are located on a floor other than those containing the patient beds.

(c) At least 3 elevators, 2 of which shall be hospital-type, shall be installed where 201 to 350 patient beds are located on floors other than the first, or where inpatient facilities are located on a floor other than those containing the patient beds.

(d) For facilities with more than 350 beds, the number of elevators shall be determined from a study of the facility plan and the estimated vertical transportation requirements.

MECHANICAL REQUIREMENTS

A. *General*

1. Prior to completion of the contract and final acceptance of the facility, the architect and/or engineer shall obtain from the contractor certification that all mechanical systems have been tested and that the installation and performance of these systems conform to the requirements of the plans and specifications.

2. Upon completion of the contract, the contractor shall furnish the owner with a bound volume containing operating instructions, manufacturers' catalog numbers, and description and parts list for each piece of equipment.

B. *Incinerators and Refuse Chutes*

Incinerators shall be gas-, electric-, or oil-fired and shall be capable of, but need not be limited to, complete destruction of pathological wastes. Design and construction of incinerators and refuse chutes shall be in accordance with Part III of the NFPA Standard No. 82.

C. *Steam and Hot Water Systems*

1. Boilers. Boilers shall have the capacity, based upon the published Steel Boiler Institute or Insititute of Boiler and Radiator Manufacturers' net ratings, to supply the normal requirements of all systems and equipment. The number and arrangement of boilers shall be such that when one boiler breaks down or when routine maintenance requires that one boiler be temporarily taken out of service, the capacity of the remaining boiler(s) shall be 70 per cent of the total required capacity.
2. Boiler accessories. Boiler feed pumps, condensate return pumps, fuel oil pumps, and circulating pumps shall be connected and installed to provide standby service when any pump breaks down.
3. Valves. Supply and return mains and risers of space heating and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return end.
4. Covering. Boilers and smoke breeching, all steam supply piping and high pressure steam return piping, and hot water space heating supply and return piping shall be insulated.

D. *Air Conditioning, Heating, and Ventilating Systems.*

1. Temperatures. A minimum temperature of 75° Farenheit shall be provided for all occupied areas at winter design conditions.
2. Ventilation system details. All air-supply and air-exhaust systems shall be mechanically operated. All fans serving exhaust systems shall be located at or near the point of discharge from the building.

(*a*) Outdoor ventilation air intakes, other than for individual room units, shall be located as far away as practicable but not less than 25'0" from the exhausts from any ventilating system or combustion equipment. The bottom of outdoor intakes serving central air systems shall be located as high as possible but not less than 8'0" above the ground level or, if installed through the roof, 3'0" above roof level.

(*b*) The ventilation systems shall be designed and balanced to conform to accepted standards.

(*c*) Room supply air inlets, recirculation, and exhaust air outlets shall be located not less than 3 inches above the floor.

(*d*) Corridors shall not be used to supply air to or exhaust air from any room, except that exhaust air from corridors may be used to ventilate rooms such as bathrooms, toilet rooms, or janitor's closets which open directly on corridors.

(*e*) An approved fire damper shall be provided on each opening through each fire partition and on each opening through the walls of a vertical shaft. Ducts which pass through a required smoke barrier shall be provided with smoke or products of combustion other than heat actuated fire dampers and access panels at the points of penetration.

(*f*) Cold air ducts shall be insulated wherever necessary to maintain the efficiency of the system or to minimize condensation problems.

(*g*) Exhaust hoods in food preparation centers shall have a minimum exhaust rate of 100 cubic feet per minute per square foot of hood face area. All hoods over cooking ranges shall be equipped with fire extinguishing systems and heat-actuated fan controls. Cleanout openings shall be provided every 20'0" in horizontal exhaust duct systems serving hoods.

(*h*) Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and reasonable temperatures in the room and in adjoining areas.

E. *Plumbing and Other Piping Systems.*

1. Plumbing fixtures:

(*a*) The material used for plumbing fixtures shall be of non absorptive acid-resistant material.

(*b*) Lavatories and sinks required in patient-care areas shall have the water supply spout mounted so that its discharge point is a minimum distance of 5 inches above the rim of the fixture. All fixtures used by medical and nursing staff, and all lavatories used by patients and food handlers shall

be trimmed with valves which can be operated without the use of hands. Where blade handles are used for this purpose, they shall not exceed 4½ inches in length, except that handles on clinical sinks shall be not less than 6 inches long.

(*c*) Clinical sinks shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.

2. *Water supply systems:*

(*a*) Systems shall be designed to supply water to the fixtures and equipment on the upper floors at a minimum pressure of 15 pounds per square inch during maximum demand periods.

(*b*) Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

(*c*) Hot, cold, and chilled waterpiping and waste piping on which condensation may occur shall be insulated. Insulation of cold and chilled water lines shall include an exterior vapor barrier.

(*d*) Backflow preventers (vacuum breakers) shall be installed on hose bibbs and on all fixtures to which hoses or tubing can be attached such as janitors' sinks and bedpan flushing attachments.

(*e*) Flush valves installed on plumbing fixtures shall be of a quiet operating type, equipped with silencers.

(*f*) Bedpan flushing devices shall be provided in the utility room.

(*g*) Hot water distribution systems shall be arranged to provide hot water at each fixture at all times.

(*h*) Plumbing fixtures which require hot water and which are intended for patient use shall be supplied with water which is controlled to provide a maximum water temperature of 110° Farenheit at the fixture.

3. *Hot water heaters and tanks:*

(*a*) The hot water heating equipment shall have sufficient capacity to supply the water at the temperatures and amounts indicated below:

	Use		
	Clinical	Dietary	Laundry
Gallon/hour/bed	6½	4	4½
Temperature °F	110	180	180

b. Storage tank(s) shall be provided and shall be fabricated of corrosion-resistant metal.

4. *Drainage systems:*

(*a*) Piping over food preparation centers, food serving facilities, food storage areas, and other critical areas shall be kept to a minimum and shall not be exposed. Special precautions shall be taken to protect these areas from possible leakage of or condensation from necessary overhead piping systems.

(*b*) Building sewers shall discharge into a community sewerage system. Where such a system is not available, a facility providing sewage treatment which conforms to applicable local and State regulations is required.

5. Fire extinguishing systems. Automatic fire extinguishing systems shall be installed in areas such as: central soiled linen holding rooms, maintenance shops, trash rooms, bulk storage rooms, and adjacent corridors, attics accessible for storage, and laundry and trash chutes. Storage rooms of less than a 100 square foot area and spaces used for storage of nonhazardous materials are excluded from this requirement. Sprinkler heads shall be installed at the top and at alternate floor levels of trash and laundry chutes.

ELECTRICAL REQUIREMENTS

A. *General*

1. All material including equipment, conductors, controls, and signaling devices shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the electrical facilities shown in the specifications or indicated on the plans. All materials shall be listed as complying with applicable standards of Underwriters' Laboratories, Inc., or other similarly established standards.

2. The contractor shall be responsible for testing all electrical installations and systems and shall show that the equipment is correctly installed and operated as planned or specified.

B. *Switchboard and Power Panels*

Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboards and distribution panelboards shall be enclosed or guarded to provide a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons. The switchboard shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space devoid of corrosive fumes or gases. Overload protective devices shall be suitable for operating properly in the ambient temperature conditions.

C. *Distribution Panelboards*

Lighting and appliance panelboards shall be provided for the circuits on each floor. This requirement does not apply to emergency system circuits.

D. *Lighting*

All spaces occupied by people, machinery, and equipment within building. and the approaches thereto, and parking lots shall have electric lighting. Patients' bedrooms shall have general lighting and night lighting. A reading light shall be provided for each patient. At least one luminaire for night lighting shall be switched at the entrance to each patient room. Patients' reading lights and other fixed lights not switched at the door shall have switch controls convenient for use at the luminaire. All switches for control of lighting in patient areas shall be of the quiet operating type.

E. *Receptacles (convenience outlets)*

1. Bedroom. Each patient bedroom shall have duplex receptacles as follows: one on each side of the head of each bed (for parallel adjacent beds, only one receptacle is required between the beds); receptacles for luminaires, television, and motorized beds, if used; and one receptacle on another wall.

2. Corridors. Single receptacles for equipment such as floor cleaning machines shall be installed approximately 50'0'' apart in all corridors. Duplex receptacles for general use shall be installed approximately 50 feet apart in all corridors and within 25'0'' of ends of corridors.

F. *Nurses' Calling System*

A nurses' calling station shall be installed at each patient bed and in each patient toilet-, bath-, and shower-room. The nurses' call in toilet-, bath-, or shower-rooms shall be an emergency call. All calls shall register at the nurses' station and shall actuate a visible signal in the corridor at the patients' door, in the clean workroom, soiled workroom, and nourishment station of the nursing unit. In multicorridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two ore more calling stations, indicating lights shall be provided at each calling station. Nurses' call systems which provide two-way voice communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operative.

G. *Fire Alarms*

A manually-operated, electrically-supervised fire alarm system shall be installed in each facility that has a total floor area of more than 5,000 square feet. In multi-story buildings or in multibuilding facilities, the signal shall be coded or otherwise arranged to indicate the location of the station operated. Pre-signal systems will not be permitted.

H. *Emergency Electric Service*

1. *General.*—To provide electricity during an interruption of the normal electric supply that could affect the nursing care, treatment, or safety of the occupants, an emergency sources of electricity shall be provided and connected to certain circuits for lighting and power.

2. *Sources.*—The source of this emergency electric service shall be as follows:

(*a*) An emergency generating set, when the normal service is supplied by one or more central station transmission lines.

(*b*) An emergency generating set or a central station transmission line, when the normal electric supply is generated on the premises.

3. *Emergency generating set.*—The required emergency generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system. Exception: A system of prime movers which are ordinarily used to operate other

equipment and alternately used to operate the emergency generator(s) will be permitted provided that the number and arrangement of the prime movers is such that when one of them is out of service (due to breakdown or for routine maintenance), the remaining prime mover(s) can operate the requirements described in sec. 9–18H5 are met. The emergency generator set shall be of sufficient kilowatt capacity to supply all lighting and power load demands of the emergency system. The power factor rating of the generator shall be not less than 80 percent.

4. *Emergency electrical connections.*—Emergency electric service shall be provided to circuits as follows:

(*a*) Lighting:

(1) Exitways and all necessary ways of approach thereto including exit signs and exit direction signs, exterior of exists, exit doorways, stairways, and cooridors.

(2) Dining and recreation rooms.

(3) Nursing station and medication preparation area.

(4) Generator set location, switch-gear location, and boiler room.

(5) Elevator (if required for emergency).

(*b*) Equipment. Essential to life safety and for protection of important equipment or vital materials:

(1) Nurses' calling system.

(2) Alarm system including fire alarm actuated at manual stations, water flow alarm device of sprinkler systems if electrically operated, fire detecting and smoke detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed.

(3) Fire pump, if installed.

(4) Sewerage or sump pump. If installed.

(5) All required duplex receptacles in patient corridors.

(6) One elevator, where elevators are used for vertical transportation of patients.

(7) Equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization.

(8) Equipment necessary for maintaining telephone service.

(*c*) Heating. Where electricity is the only source of power normally used for space heating, the emergency service shall provide for heating of patient rooms. Emergency heating of patient rooms will not be required in areas where: (1) the design temperature is higher than +20° F., based on the Median of Extremes as shown in the current edition of the ASHRAE Handbook of Fundamentals, or (2) the nursing home is supplied by at least two utility service feeders, each supplied by separate generating sources, or a network distribtuion system fed by two or more generators, with the hospital feeders so routed, connected, and protected that a fault any place between the generators and the hospital will not likely cause an interruption of more than one of the hospital service feeders.

5. *Details.*—Wiring of all emergency lighting systems shall be so arranged as to actuate the emergency power system automatically to protect all specified areas when the artificial lighting from any such areas fails. All wiring for emergency lighting shall be in separate raceways independent of all other wiring and shall comply in every respect with proper and accepted standards. The emergency electrical system shall be so controlled that after interruption of the normal electrical power supply, the generator is brought to full voltage and frequency and connected within 10 seconds through one or more primary automatic transfer switches to all emergency lighting; all alarms; nurses' call; equipment necessary for maintaining telephone service; and receptacles in patient corridors. All other lighting and equipment required to be connected to the emergency system shall either be connected through the above-described primary automatic transfer switching or shall be subsequently connected through other automatic or manual transfer switching. Receptacles connected to the emergency system shall be distinctively marked for identification. Storage-battery-powered lights, provided to augment the emergency lighting or for continuity of lighting during the interim of transfer switching immediately following an interruption of the normal service supply, shall not be used as a substitute for the requirement of a generator. Where fuel is normally stored on the site, the storage capacity shall be sufficient for 24-hour operation of required emergency electric services. Where fuel is normally piped underground to the site from a utility distribution system, storage facilities on the site will not be required.

EXHIBIT C. CONNECTICUT STATE DEPARTMENT OF HEALTH, DIVISION OF HOSPITAL AND MEDICAL CARE—CHRONIC AND CONVALESCENT NURSING HOME CLASSIFICATION

REVISION TO BE USED FOR RATINGS EFFECTIVE JULY 1, 1969

Name of Nursing Home____________________

Capacity	__________	Plus Points	__________
Census	__________	Minus Points	__________
Date	__________	Net Score	__________

Definitions

Licensure.—Indicates compliance with miniwum state standards for operating a nursing home in the State of Connecticut.

Classification.—Indicates evaluation of attributes above those required for licensure.

Classification

1. Summary of Points:

Administration, physical plant and equipment	12½
Nursing Services	36
Medical Services	10
Dental Service	5
Podiatrist Service	2
Laboratory	5½
Speech Therapy Services	2
X-ray Department	3
Prescribed physical therapy	5
Dietary Service	8
Spiritual and Recreational Services	22
TOTAL	111

2. Classes:

E	0	20	A–1	80 or more
D	20½	32	A–2	70–79½
C	32½	46½	A–3	60–69½
B	47	59½		

Added requirements: Minimum of 15 plus points for nursing service and 5 plus points for medical service with no demerits on either to qualify for B class.

20 plus points for nursing and 8 for medical services with no demerits for A class.

3. Demerits: Up to 10 points to be deducted for each infraction of Public Health Code depending on severity of the infraction.

CHRONIC AND CONVALESCENT NURSING HOMES

Administration, Physical Plant and Equipment—12½ Points

	Points
Administrator full-time on administration, not charge nurse doing nursing or other non-administrative duties	1
Administrator's qualifications:	
College graduate (or ½ point for other acceptable training of 1 year or more beyond high school)	1
Master's degree in hospital administration	2
Approved emergency power supply adequate for light, heat, food storage and preparation	2
Excellence of housekeeping and maintenance (excellence of housekeeping and maintenance will be adjudged in accord with the standards listed for excellence for housekeeping in the conditions of participation for ECF's)	1
Pre-employment medical exams of employees including chest X-rays or tuberculin test (points may be given for this item if annual examinations of all employees including chest X-rays or tuberculine tests are performed)	1
Inter-communication signaling system between nurses' station and each patient's bed or room and evidence of its use—test for operational effectiveness	½
Hand rails both sides of all corridors and bathrooms	½
Variable height beds for 10% of patients or more	½

CHRONIC AND CONVALESCENT NURSING HOMES—Continued

Administration, Physical Plant and Equipment—12½ Points—Continued

	Points
1 alternating pressure mattress for each 100 beds or fraction thereof	½
Tube or nasal feeding in use or recorded use within six months for each 100 patients	½
Intravenous set and hypodermoclysis set and glucose and saline solutions in use or recorded use once within 6 months for each 30 patients	½
Oxygen therapy apparatus with proper storage with evidence of use within 6 months or suction apparatus used within 6 months—1 to 60 patients	½
Closed pressure sterilization or disposable equipment	½
Sterile catheter set in use or recorded use within 6 months for each 30 patients	½

NURSING SERVICE—36 POINTS

If charge nurse is an R.N.	5
Charge nurse qualifications: If charge nurse has a B.S. Degree	1
R.N. on duty two 8-hour shifts (this shall be interpreted as an R.N. on two separate 8-hour shifts, 7 days a week, 365 days a year)	3
R.N. on duty 24 hours a day, 365 days per year	2
At least one R.N. or LPN with at least 3 years' experience or combined training and experience in psychiatric nursing, one point per year, or one point for each aide with 6 months' approved psychiatric training plus 6 months' experience in mental hospital (maximum 3 points)	3
Written, well organized orientation program for new employees indicating hours and content involved	1
Records of in-service nursing education program of at least 4 hours per month and minutes showing evidence of same	2
Nurses' station on each floor, or wing of 30 or more patients	1
Medical and nursing records for each patient and daily descriptive nursing notes with legal signature	1
Individual patient plans including short and long-term goals	1
Written nursing procedures with copy at each nurses' station	1
Added nurses' time in addition to minimum required (basic unit of measurement for ratio of nurse and other nursing personnel to patients shall be a full-time equivalent of an R.N. or nursing personnel 7 days a week i.e. 56 hours a week. Additional hours shall be credited to the facility only if they are in excess of the 56 hours unit base)	5

Shift—7–3, 3–11, 11–7.
Required—1–30, 1–45, 1–60.
Points:
1–20, 2.
1–25, 1.
1–30, 2.
1–35, 1.
1–45, 1.
1–45, 1.

Added attendants' time in addition to minimum required (5 points)
Required—1–10, 1–15, 1–20.
Points:
1–8, 2.
1–9, 1.
1–10, 2.
1–12, 1.
1–15, 1.
1–15, 1.

Overall ratio of nursing personnel (R.N.'s—LPN's—Aides—Orderlies): (5 points).

(5 point maximum allocation allowable).

Points:
½ for additional 20 licensed nursing hours not credited in schedule.
1 for additional 40 licensed nursing hours not credited in schedule.
1½ for additional 60 licensed nursing hours not credited in schedule.
2 for additional 80 licensed nursing hours not credited in schedule.
1 for additional 40 attendant hrs. not credited in schedule.

NOTE.—Maximum point allocation for this item.

MEDICAL SERVICES—10 POINTS

	Points
Organized medical staff of five or more licensed physicians with bylaws and annual elections. Meetings of staff with at least 50% of physicians present of at least an hour to review cases, deaths, and accidents, six meetings a year with records of such meetings. Director of Nursing in attendance when these records are reviewed. (Requirement for organized medal staff shall be that this medical staff function in an organized fashion consistent with the general and specific responsibilities of the medical consultants as delineated in the licensure code. Further, the members of the organized medical staff will reside and practice within a reasonable proximity and in most instances this will mean within the same community. In instances where there is the same medical staff serving more than one institution, the judgment as to whether or not points will be awarded to more than one home for having an organized medical staff will be subject to the review and approval of the division's physician consultant and the director of the division.)	3
Regular medical rounds twice weekly by the consulting physician or his designee, without charge to the Welfare Department. His responsibilities shall be, as a minimum	5
(*a*) Visit the home at least twice a week or more often as required.	
(*b*) Receive reports from the charge nurse on any and all significant clinical developments that require clinical attention.	
(*c*) It is assumed that if the patient has a private physician, that private physician will be called in instances where a clinical development requires medical attention.	
(*d*) If the private physician has not responded, then the consulting physician shall examine that patient in a manner adequate to the clinical problem present. An adequate progress note shall be entered into the patient's chart at that time.	
(*e*) The foregoing shall be accomplished without charge to the Welfare Department.	
Two or more specialists on an organized staff (in order for this point to be awarded, this shall mean that there are two different kinds of clinical specialties represented by these individuals. Such specialists shall be so designated by virtue of having been certified by the appropriate American board or the physicians eligibility to take such examination.)	1
Twice a month consultants visits to the institution by a psychiatrist with records of findings and recommendations	1

DENTAL SERVICE—5 POINTS

Licensed dentist on staff to advise at least quarterly both administrator and physcians on dental needs of patients, oral hygiene and care of prosthesis, without charge to the Welfare Department	2
Portable or permanent dental equipment provided and used, including dental X-ray, without charge to the Welfare Department	3

PODIATRIST'S SERVICES—2 POINTS

Licensed podiatrist on staff to advise at least quarterly both administrator and physicians on podiatry needs and foot problems of all patients, where records of diagnosis and recommendations support this provision. This consultant service is without charge to the Welfare Department	2

SPEECH THERAPY SERVICES—2 POINTS

Speech therapy services where records of diagnosis and treatment support this provision. This service is without charge to the Welfare Department. (THIS POINT SHALL BE AWARDED ONLY IN THE EVENT THAT SUCH SERVICES WERE PROVIDED FOR WELFARE BENEFICIARIES. POINT WILL NOT BE GIVEN IN THOSE INSTANCES WHERE SUCH SERVICE WAS MADE AVAILABLE TO NON-WELFARE RECIPIENTS ONLY.)	2

LABORATORY—5½ POINTS

	Points
Laboratory space in use daily for urinalyses, hematology and blood chemistry. Qualified Laboratory technician in attendance at least: 8 hours a week for 25 patients or less; 16 hours a week for 26 to 50 patients; 24 hours a week for 51 to 75 patients; 36 hours a week for 76 patients or more	4
One blood hemoglobin a year on all Welfare patients without charge to the Welfare Department performed in an approved laboratory. If a hemoglobin has been performed within a year in an approved laboratory, credit will be given	½
Urinalysis for albumin and sugar once a year on all welfare patients without charge to the Welfare Department	½
EKG with demonstrated usage on 10% or more of patients. Credit will be given even though the doctor uses his own machine. This service shall be given to Welfare recipients without charge	½

X-RAY DEPARTMENT—3 POINTS (ALL OR NO POINTS)

At least a 200 M.A. unit with space and equipment for processing and reading films. X-ray technician full-time or available and on call at all times. All diagnostic X-ray reports to be read by a Board certified radiologist	3

PHYSICAL THERAPY—5 POINTS

Space and equipment including walkers, steps, parallel bars, including evidence of use	2
Qualified therapist visiting the home at least twice a week: at the rate of fire hours per patient per year; at home with 30 patients, 150 hours per year; 60 patients, 300 hours per year; 90 patients, 450 hours per year	3

This is computed on the basis of a 60-patient home having a physical therapist spend 2 morning a week for 3 hours, a total of 6 hours per week times 50 weeks per year equal 300 hours. This service is without charge to the Welfare Department. (This point shall be awarded only in the event that such services were provided for welfare beneficiaries.)

DIETARY—8 POINTS

Dietetic assistance from a qualified dietitian or graduate home economist. Full-time for 150 beds or more	1
Food Service: Food covered in transit to patients; Food served at correct temperature to patients	1
Adequate dining facility for ambulatory patients	1
Spacing of meals, not over fourteen hours between supper and breakfast	1
Qualified cook on duty for all 21 meals each week (qualified cook shall be interpreted as an individual capable of preparing a satisfactory meal for all patients in the institution.)	2
16 oz. whole, skimmed milk or its equivalent for daily calcium requirement	1
Between meal nourishment twice a day	1

SPIRITUAL AND RECREATIONAL SERVICE—22 POINTS—SPACE AND EQUIPMENT—4½ POINTS

One operable t.v. in each patient occupied area	½
Film equipment, 16 mm sound projector and satisfactory screen	½
An organ or piano	½
At least one radio per ten patients and one portable record player	½
Craft equipment, including ceramics kiln, and separate enclosed craft area	1
At least 20 sq. feet per patient for inside recreation areas (patient dining room, heated porches, Chapel area, and recreation rooms included	1
At least 100 usable, landscaped square feet per patient of outdoor recreation area—patio, porches, yards with benches, tables, umbrellas, rocking chairs	½

PROGRAM DIRECTORS—6½ POINTS

Shall work the following regularly scheduled hours, Monday through Friday, for licensed capacity of facility.

5 to 14 beds—10 hours per week (at least three days a week)
15 to 29 beds—20 hours per week (five days)
30 to 59 beds—30 hours per week (five days)
60 to 125 beds—40 hours per week (five days)
For additional beds the following hours will be required:
1 to 29 additional beds (154), 20 hours per week (five days)
30 to 59 additional beds (184), 30 hours per week (five days)
60 to 90 additional beds (224), 40 hours per week (five days)

	Points
Bachelor's degree from college or university or 1 point for two years college training or equivalent	2
Two weeks approved in-service training	1
A course of at least two semester hours of special training related to recreational service (programming, arts and crafts, recreational leadership) 30 classroom hours	1
Two years acceptable experience in recreation for elderly	1
Five years acceptable experience in recreation for elderly	½
At least one year of non-paid voluntary service in a leadership capacity (Voluntary, civic or social group)	½
Regular attendance at official and professional meetings (at least four one-day meetings a year)	½

PROGRAM (RECORDS OF) AND VOLUNTEERS (RECORDS OF)—6 POINTS

Approved program director training site	1
Craft program at least two days a week (and indication of crafts done on an individual basis when patient is confined to room or bed)	1
Cultural activity once a week (music, literature, dance, drama, etc.)	½
A film plus a birthday party at least once a month	½
Outside entertainment at least once a month (may include a slide presentation) and a special holiday party or picnic at least each three months	½
Personal services and bedside activities including letter writing, reading to patients, library service and patient visitations. Substantiated by reports	½
Special interest programs at least every two weeks which may include outside trips, hobby groups, outdoor activities, hospital newspaper activities, adult education programs	½
Active volunteers regularly scheduled	½
Periodic orientation or training of volunteers on the premises: volunteer recognition programs or ceremonies, with active patient participation	½

SPIRITUAL AND RELIGIOUS SERVICE—5 POINTS

A group religious service once a week under the auspices of recognized religious pastors, priests and rabbis, or I point for weekly religious services performed by the laity	3
Crisis counselling by qualified pastors, priests and rabbis as indicated by individual patient needs and desires. Crisis counselling or assistance may be recorded on patient interest counselling sheets with dates and names of clergy. Privileged information will not be recorded	1
Clergy or church sponsored laity visitation for non-crisis purposes routinely performed. (Indicated on patient participation record and may follow or be in conjunction with the weekly group worship service)	½
An area specifically designated as a chapel or meditation room or counselling area for private meditation or counselling	½

DEMERITS ON NURSING HOMES

Physical Plant:

Overcrowding of beds in unlicensed areas	each bed	5
Rooms not numbered		1
Capacity not posted		1
Furnishings in poor condition		5
Sub-standard housekeeping		5

DEMERITS ON NURSING HOMES—Continued

	Points
Administration:	
Failure to send application or annual report on time	3
No fire plan posted	5
Failure to report accidents	3
Failure to report change in nurse-in-charge	3
Failure to report change in consulting physician	3
Medical Supervision:	
Failure to keep record of consulting physician's visit	5
Medical Records (Incomplete or Illegible):	
Admission and identification sheet	5
History and Physical Findings and Diagnosis	10
Nurses' daily record of medicine and treatments	5
Narcotic Record	10
Roster	2
Patients in nursing home more than 24 hours without written doctor's orders	5
Nursing Service:	
No licensed nurse on duty ... each shift, each day	10
Short of one licensed nurse	5
Short of aides ... each	5
Dietary Service:	
Vitamin C shortage, less than 4 oz. of orange juice per day or equivalent	6
Protein shortage, less than 5 oz. of meat, fish or poultry daily or equivalent (1 oz. of American cheese or cottage cheese or 1 egg may be substituted for 1 oz. of meat)	6
Dishes:	
Stained, cracked, chipped or unclean dishes, glasses or trays	2
Improperly sanitized dishes	5
Menus:	
If not posted	2
If posted menu is not followed	2
Food Storage:	
Dangerous substances stored with food or in unlabelled containers or in uncovered containers	1–5
Improper storage and care of food	5
Sanitation:	
Poor housekeeping of kitchen	2

ITEM 2: SUBMITTED BY WILLIAM R. HUTTON,[1] EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

EXHIBIT A. WASHINGTON REPORT ON MEDICINE AND HEALTH, DATED JAN. 27, 1969

Backstage talk in the Capital:

Finch trying for shower of appointments this week.
Medicare future cost estimates revised sharply upward.
Regional medical program backers view budget with alarm.
New Congress faced with big pile of expiring health laws.
Medicaid nursing home regulations hit rough seas at HEW.

HEW Secretary Robert Finch is aiming at completion of his top staff this week. As has become a sort of Nixon Administration policy, he wants to make the announcements in one fell swoop. Delays in the appointments have been caused by difficulty in filling some of the jobs, and Finch's careful deliberation in making his selections. Most of the trouble has centered over a replacement for Dr. Philip R. Lee as Assistant Secretary for Health and Science. The list of candidates for the job has been changing almost from hour to hour. If nothing else, Finch has been getting a royal lesson on pressures that will be applied on him in months to come.

One Finch appointment leaked out over the weekend. The Chicago Daily News reported that its Executive Editor, Creed Black, is in line for the post of Assistant Secretary of HEW for Legislation. Black, who has served on a number

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[1] See statement, p. 46.

of newspapers in the South and Midwest, is taking the job as an alternative to a position outside HEW which he wanted but couldn't get. Expected to stay on, despite rumors he'll move to the Pentagon, is HEW's respected Comptroller, James Kelly.

The Social Security Administration has revised its long-term estimate of Medicare costs sharply upward. Unless changes in financing are made—as they certainly will be—the program could go bankrupt by 1976. The Boards of Trustees of the Social Security Trust Funds, in a report to Congress, say the original cost figures underestimated utilization rates for hospitals and extended care facilities. The present $7,800 earnings base for Social Security taxes will have to be raised to finance the increased Medicare costs. The Part B Supplementary Medical Insurance Trust Fund will have enough reserves to handle the 1969–70 $4 monthly premium. But beyond that, the Boards appear to favor an increase to $4.40 in recognition of higher physician fees and greater utilization.

POWERFUL PRESSURES CAUSE HEW TO SOFTEN NURSING HOME REGS

A set of regulations establishing standards for skilled nursing homes under Medicaid has become one of the most controversial documents to be written, and rewritten, in HEW for some time. The latest—much watered down—version was almost literally snatched from under outgoing HEW Secretary Wilbur Cohen's pen several days before he left office.

Now in the process of more re-writes, the regulations implement the so-called Moss Amendment, added to the Social Security laws in November of 1967 under the sponsorship of Sen. Frank Moss (D-Utah). A harder version of the regulations was completed last month. But nursing home interests, particularly the American Nursing Home Association, objected so violently that the regulations were vetoed by Social and Rehabilitation Service Administrator Mary Switzer.

After that, lower echelon HEW staffers were ordered to rewrite the regulations with the help of Harold G. Smith, who acts as a consultant both to HEW and to ANHA. The orders came from Dr. Frank Land, SRS's Medicaid chief. The rewrite met virtually all the objections of ANHA, especially with regard to requirements for supervision of nursing home shifts by registered nurses or licensed practical nurses.

Included in the rewrite was a new provision that a single state agency administer the regulations. This revived the old feud between welfare and health departments and gave welfare partisans a temporary victory. This version was approved by Land and Miss Switzer and sent to Cohen. But objections began to reach other HEW officials, and the document was pulled back at the last minute for another look.

The regulations, which can make a big dollars and cents difference to nursing homes, are expected to be completed in a week or two. The controversy now is up to new HEW Secretary Finch. Sen. Moss, who has strong feelings about nursing home standards, is watching closely.

STACK OF EXPIRING LAWS CONFRONTS NEW CONGRESS

Tops on the list of Congressional priorities this year will be the task of renewing a number of health programs which expire at the end of fiscal 1970. Since bills often don't clear Congress until well past mid-year, it is virtually mandatory that the programs be considered for renewal this year.

The laws include the Hill-Burton Act; the Comprehensive Health Planning and Services Act; the Heart Disease, Cancer and Stroke Amendments (Regional Medical Programs); the Health Research Facilities Construction Act; the Community Mental Health Centers Act; the Mental Retardation Facilities Construction Act; the Clean Air Act; the Medical Library Assistance Act; the Alcoholic and Narcotic Addict Rehabilitation Amendments; the Solid Waste Disposal Act; the Health Services for Migratory Agricultural Workers Amendments, and the Health Services Research and Development Amendments. The Allied Health Professions Personnel Training Act of 1966 was extended last year until June 30, 1970, as part of the Health Manpower Act of 1968. The rest of the manpower programs in the act were extended through fiscal 1971. HEW legislative experts are likely to sweep some of the expiring programs into one or more omnibus proposals as was done last year with the Health Manpower Amendments and the Health Services Amendments.

EXHIBIT B. NEWS ARTICLE FROM THE WASHINGTON DAILY NEWS, DATED FEBRUARY 14, 1969

[From the Washington Daily News Feb. 14, 1969]

DUAL ROLE CITED—PROBE RULES LETUP ON MEDICAID HOMES

(By Robert Crater)

Congressional investigators are looking into a possible conflict of interest in the writing of Medicaid standards for skilled nursing homes.

Target of the probe by a House Government Operations subcommittee headed by Rep. L. H. Fountain, D–N.C., is Harold G. Smith, a Washington consultant.

Mr. Smith was a $50-a-day consultant to the Health, Education and Welfare (HEW) Department in the writing of the nursing home standards. At the same time he was paid a monthly retainer by the American Nursing Home Association (ANHA), a sharp critic of stricter standards.

Following Mr. Smith's services for HEW's Social and Rehabilitation Services (SRS), which is writing the Medicaid standards, a 38-page draft calling for high standards was cut to only 15 pages and weakened considerably to calm ANHA protests.

Dr. Francis L. Land, SRS chief of Medical Services, is in charge of getting the nursing home standards in shape to present to HEW Secretary Robert Finch. Dr. Land denied he hired Mr. Smith to rewrite the 38-page draft.

"Smith was a consultant in January to my task force," he said. "He has more knowledge of the nursing home field than I or my people, but my staff headed by Dr. Herbert Kerr, did the rewriting."

"That's right," echoed Mr. Smith, a nursing home operator in Louisiana. He said Dr. Land summoned him after the 38-page draft failed to get clearance from Federal agencies related to the Medicaid program.

The revised draft of standards leaves a loophole thru which nursing homes could operate conditionally without having registered or licensed practical nurses on duty at all times.

The American Nurses Association is vehement about the weaker standards now proposed by Dr. Land's task force.

"We won't settle for less nursing for Medicaid patients than is required for Medicare," declared Miss Julia Thompson, Washington director for the Nurses Association. "That would mean the Medicaid patients would be the real victims of the compromise."

Dr. Land says he hopes to have the Medicaid standards ready within a week. They were due Jan. 1.

EXHIBIT C. NEWS ARTICLE FROM THE WASHINGTON POST, DATED FEBRUARY 16, 1969

[From the Washington Post, Sunday, Feb. 16, 1969]

NURSING HOME RULES SPARK HEW BATTLE

(By Eve Edstrom)

A battle over Medicaid nursing home regulations has brought into the open speculation that a top-ranking Health, Education and Welfare official wants to rise higher.

The official is Dr. Francis L. Land. He is playing a key role in the on-again, off-again softening and hardening of Medicaid nursing home standards.

Sources at HEW, Congress and in organizations seeking the upgrading of nursing homes suggest that Dr. Land has been "playing it safe" so that powerful health lobbies won't oppose him for Assistant HEW Secretary in charge of health.

That post supposedly was sewed up in January for the Nixon Administration's choice, Dr. John H. Knowles of Boston.

But the president of the American Medical Association, Dr. Dwight Wilbur, reportedly opposed Knowles and was said to be lobbying in behalf of his nephew, Dr. Richard S. Wilbur of Palo Alto, Calif. The AMA has opposed the hardened nursing home standards.

Meanwhile, a former president of the American Academy of General Practice opposed Knowles, while the organization endorsed Land.

Land served as vice president of the Academy in 1965, and has held important posts with the American Medical Association.

Those embroiled in the nursing home dispute have speculated that, if there is a stand-off between Knowles and Wilbur's nephew, Land might get the nod for the HEW Assistant Secretaryship.

The nursing home donneybrook, in any case, has created what one top-level HEW spokesman described as a "kind of messy" situation.

In fact, the "messy" situation already has sparked an inquiry—by the intergovernmental relations subcommittee of the House Government Operations Committee—to determine whether a "conflict of interest" issue is involved in the writing of the regulations.

An initial draft of the regulations was made available to state health licensing officials meeting here in mid-January before the Nixon Administration took over.

A DRAFT SHIFT

That draft included a provision for skilled nursing services in homes that care for the medically needy under the Federal-state program of Medicaid.

But the next day, the state health officers received another draft of the regulations which would have permitted unskilled aides to be in charge of some nursing shifts.

Dr. Land, HEW's Medical Service Commissioner in charge of Medicaid, said he was unaware until last week that the second draft had been circulated.

He said the regulations had been rewritten because they were "too long." He did not read the second version, he said, so he didn't know whether the regulations had been softened.

WATERED DOWN

However, those who saw the regulations said they were "watered down" to meet the objections of the AMA and the American Nursing Home Association, which has strong backing from many doctors who have nursing home interests.

Furthermore, HEW confirmed that a paid Nursing Home Association consultant also worked as a paid HEW consultant to help rewrite the rules. It is this situation that the House subcommittee is investigating.

Dr. Land said he had received complaints from several sources because neither money nor staff would be available to meet the initial nursing homes rules, which are still under review.

Meanwhile, the American Nurses' Association has said the initial regulations represent only "minimal" standards currently are in effect for Medicare patients and that Medicaid patients should receive equal treatment.

EXHIBIT D. RESOLUTION ON NURSING HOME STANDARDS OF THE NATIONAL COUNCIL OF SENIOR CITIZENS

NATIONAL COUNCIL OF SENIOR CITIZENS 8TH ANNUAL CONVENTION

Washington, D.C., June 5–7, 1969

Resolution on nursing home standards:

The National Council of Senior Citizens is deeply concerned for the well-being of nearly half a million of our fellow citizens who are in nursing homes under Medicaid and other Federal-State programs.

Mounting evidence of poor professional standards, exploitation, and neglect of these patients cries out for corrective action.

The National Council reiterates its appreciation for and support of the legislative leadership of Senators Frank E. Moss (D., Utah) and Edward M. Kennedy (D., Mass.) in their efforts to relieve the plight of these patients by improving the quality of nursing home care.

We note with dismay and indignation that the Department of Health, Education, and Welfare has done nothing of significance to make effective the commendable guidelines for Federally assisted nursing home care set out in the 1967 amendments to the Social Security Act.

The passive posture of Federal Medicaid administrators, their retreat from recognized professional standards for nursing home care in the face of opposition by provider groups, and the action of these administrators in employing a paid representative of the nursing home industry to write regulations for nursing home participation in the Medicaid program, all reflect on the integrity of the program's administration and cast doubt on its commitment to quality medical care for all.

The National Council of Senior Citizens calls upon the Department of Health, Education, and Welfare to: purge itself of undue influence of vendors' special interests; assume an aggressive role in looking after the health and welfare of the Medicaid patients in nursing homes; and assign resources and priorities to fully implement and enforce guidelines for nursing home standards laid down by Congress.

The National Council of Senior Citizens calls upon Congress to exercise its broad responsibility to assess the performance of Federal Medicaid administrators in implementing the nursing home standards, to insist that the law be fully enforced, and to assure that Congressional concern for the proper care and protection of patients is honored.

EXHIBIT E. LETTER TO MARY SWITZER FROM WILLIAM HUTTON, RE DRAFT REGULATIONS FOR STANDARDS FOR PAYMENT FOR SKILLED NURSING HOME CARE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

NATIONAL COUNCIL OF SENIOR CITIZENS, INC.,
Washington, D.C., July 25, 1969.

Subject: Draft Regulations for standards for payment for skilled nursing home care under Title XIX of the Social Security Act:

Miss MARY SWITZER,
Administrator, Social and Rehabilitation Service,
Department of Health, Education, and Welfare
Washington, D.C.

DEAR MISS SWITZER: During the past several years the National Council of Senior Citizens has received in its headquarters offices letters numbering in the thousands from members reporting and protesting the plight of a relative or friend confined in a nursing home. Expressions of concern over scandalous conditions reported in nursing homes have been transmitted to us by many of our offiliated clubs. There are few issues affecting the senior citizens of this nation about which our two and one-half million members feel more strongly.

The national council vigorously supported the amendments to the Social Security Act proposed by Senator Frank E. Moss in 1967. When these were enacted and signed into law we permitted ourselves to hope that the Department of Health, Education and Welfare, knowing the conditions that exist and the helpless plight of so many aged welfare patients in nursing homes, would take full advantage of its new legal authorities and that we would see the beginning of real progress toward assuring the aged sick the humane and professional care they so desparately need. Miss Switzer, we are bitterly disappointed.

The National Council of Senior Citizens pretends to no special expertise in medical care; but simply by comparing the provisions of the interim regulations with the provisions of the law and with the Department's past requirements, and by use of common sense, we can see clearly that the interests of the nursing home industry have been accommodated and the aged have been sold short.

The crucial element in skilled nursing home care is skilled nursing service. It is in this section, paragraphs (1) through (3) under "Definition of terms" that the Department fails to respect the law and fails to meet its responsibilities to Medicaid patients.

The law, which is quoted earlier in the proposed regulations, provides for "adequate and properly supervised nursing services during all hours of each day and all days of each week." What are adequate nursing services? The proposed regulations state that the phrase means: "Numbers and categories of personnel are determined . . . in accordance with accepted policies of effective nursing care." Whose policies? Accepted by whom? The whole of paragraph (3) says nothing more than that adequate nursing services are nursing services which are adequate. What is meant by "properly supervised nursing services." The proposed regulations are silent on this vital point. Other key terms in this section of the law are defined. The phrase "properly supervised," perhaps the most important words in the entire section, is ignored. Can this be oversight?

Such nursing care standards as these interim regulations contain are found under the heading "organized nursing service." These standards provide for nothing more than the Department required of skilled nursing homes before the Moss amendment was enacted.

In fact, the issuance of regulations under the Moss amendment was used as an excuse to postpone the qualification requirement for charge nurses already in effect. Under these proposed standards, a single, untrained practical nurse caring for 500 patients on the afternoon or night shift would meet all specific

requirements. It is not necessary to be expert in medical care to evaluate this standard. Any layman can see that it is preposterous. Can this honestly be called implementation of the law? The National Council of Senior Citizens protests this flouting of the intent of Congress.

The National Council of Senior Citizens makes the following recommendations for changes in the interim regulations.

1. Only licensed practical nurses who are graduates of approved schools or have equivalent education and training as determined by State nurse licensing agencies should be considered qualified as charge nurses. This should be effective immediately. In December 1968, former Secretary Cohen transmitted to the Congress a report on Personnel Qualifications of Medicare Personnel. That report states:

> The charge nurse is responsible for the total nursing care of patients during her tour of duty. This means that she is required to exercise varying degrees of independent judgment because of the complex nursing problems presented by many extended care facility patients. Moreover, extended care facilities usually have no house physicians who can be responsible for evaluating sudden changes in a patient's condition and for dealing with emergencies. Hence, the charge nurse must be prepared to recognize significant changes in the conditions of patients and to take initial action in connection with any special problems or medical emergencies that arise. The practical nurse licensed by waiver lacks the indepth knowledge that would permit her to safely assume such responsibilities.

These considerations are no less true of skilled nursing homes. The Department should be guided by its own findings.

2. With appropriate professional consultation the Department should determine the maximum number of patients which one nurse can reasonably be expected to keep under observation and for whom she can plan and supervise care. Regulations should require at least one qualified charge nurse for each number of patients.

3. Availability of registered professional nurse supervision should be required at all times either on duty in the home, or in small homes, on call.

4. Specify minimum ratios of nursing personnel to patients. We are not prepared to say what these ratios should be, but we cannot accept the notion that it is impossible to determine them. The Department should look at a sample of skilled nursing homes that are generally acknowledged to be good and see what ratios are in effect; consult with State licensing agencies which have developed and are using ratios, consult with its own nursing staff; and than set a staffing standard which will give patients some protection against neglect.

5. Amend paragraph 3. (2) (ii) to require review of a recent inspection report for initial certification of a skilled nursing home. As now written, no consideration need be given to the findings of inspections until 1970.

6. We question that one inspection per year as provided in paragraph 3. (2) (iii) is sufficient.

7. Strengthen the conditions under which waivers may be granted (paragraph (c)) by

   (a) Providing that no waivers may be granted if their are sufficient beds in the community which meet the standards for a skilled nursing home without waiver.

   (b) Amending paragraph (c) (2) deleting the words "after consultation with the surveying agency it finds" and substituting, "the surveying agency certifies to the single State agency." The surveying or licensing agency is more likely to have the knowledge and competence to make judgments about whether particular conditions jeopardize the health and safety of patients, and is less likely to be subject to the pressures of "finding beds" which can lead to temporizing with deficiencies. We appreciate your consideration of our views and suggestions.

We hope that through the procedures you have established for reviewing and revising the interim regulations the present meager standards for Medicaid nursing homes can be made what so many hoped for with the passage of the 1967 legislation.

Sincerely yours,

WILLIAM R. HUTTON,
Executive Director.

ITEM 3: SUBMITTED BY MARY E. SHAUGHNESSY,[1] MEMBER, AMERICAN NURSES' ASSOCIATION

EXHIBIT A. LETTER EXPRESSING OBJECTIONS OF AMERICAN NURSES' ASSOCIATION TO INTERIM POLICIES AND REQUIREMENT PERTAINING TO STANDARDS FOR PAYMENT FOR SKILLED NURSING HOME CARE

AMERICAN NURSES' ASSOCIATION, INC.
New York, N.Y. July 9, 1969.

MISS MARY E. SWITZER,
Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C.

DEAR MISS SWITZER: The American Nurses' Association herewith submits its objections to Interim Policies and Requirements pertaining to Standards for Payment for Skilled Nursing Home Care as published in the Federal Register, Volume 34, Number 120, dated June 24, 1969.

As you are undoubtedly aware, the ANA was an early supporter of the Historic Social Security Amendments of 1965 which provided new funds for health services for many aged and medically indigent people. The nursing profession has voiced its concern time and again with regard to the quality of care to be financed through the provisions of Title XVIII and Title XIX. We wish to restate and reemphasize ANA's concern regarding the quality of nursing services being financed by this legislation, with specific reference to the proposed interim policies and requirements for skilled nursing home care under Title XIX.

We believe it was the intent of Congress that the standards of health care be identical for both Title XVIII and Title XIX. We do not accept the premise that one standard of care be required for those covered by Medicare and a lower standard of care for those covered by the Medicaid program. Health care is a right, not a privilege. Federal funding should ensure equal standards of quality care for all health programs supported by public funds. These funds should not be used so as to institute or to perpetuate substandard care for any segment of the population.

When the Medicare Conditions of Participation for Extended Care Facilities were released, the American Nurses' Association, in commenting on the staffing of a nursing service department, stated that it considered the regulation regarding the charge nurse to be minimal. It was acceptable then only because it was a generally higher standard than prevailed in 1966 and it was hoped—and expected—it would have some impact on raising the quality of nursing care. We indicated then, and continue to maintain that the standard should be raised as quickly as possible to require that all charge nurse positions be filled with Registered Nurses. This standard should also apply to nurse staffing of skilled nursing homes.

As you know, the charge nurse bears responsibility for the quality of nursing care for a group of patients in the health care facility. This responsibility includes assessing, planning, directing, implementing, supervising and evaluating nursing care of these patients. In a nursing home, the charge nurse responsibilities may extend to the entire facility, not just a single patient unit. The ANA's position continues to be that only the registered nurse is prepared by education and experience to assume charge nurse responsibilities. The educational programs for the practical nurse are not designed to include content that would enable her to assume such functions.

In effect, under the proposed interim policies and requirements many Medicaid patients requiring "skilled nursing care" will actually receive custodial care. However, nursing homes will be reimbursed by the government for "skilled nursing care" at higher rates than rates allotted "custodial care" facilities. Under such conditions, not only is the patient deluded into expecting nursing care that is not available, but the taxpayer is subsidizing substandard care.

The American Nurses' Association is not protesting the employment of practical nurses licensed by waiver, or other nursing assistants. Although many conscientious practical nurses licensed by waiver are employed in nursing homes, the quality of nursing care for the public simply cannot be assured when those who may have had no formal educational preparation or testing of their acquired knowledge are placed in charge nurse positions which require a high level of knowledge and nursing judgment. The absence of any readily available super-

[1] See statement, p. 61.

vision by prepared health professionals during the evening and night hours in most nursing homes makes this matter of even graver concern to the nursing profession, and to the public.

It is indeed regrettable, in fact unthinkable, that the standards which now must be met, minimal as they are, are being lowered under the proposed policies and requirements, even for the interim period of one year. The proposed staffing pattern of the "skilled nursing home" does not, in our opinion, qualify the homes as providing skilled nursing care.

The present shortage of qualified nursing personnel is a hardship for many citizens, but the shortage will not be solved by diluting standards further. Sufficient qualified candidates will never be attracted to careers in nursing and to positions in nursing homes, if opportunities for truly satisfying and rewarding experiences cannot be found. The frustration of poor working conditions aggravated by the continuation of low standards and lack of recognition for sound academic preparation will only add to the present crisis by diverting qualified persons now engaged in nursing to more satisfying and rewarding positions outside the field of nursing.

In good conscience, the American Nurses' Association cannot condone any measure which would deny to the economically disadvantaged, the same quality of health care provided to other citizens. To do so seems a complete contradiction of the goals of so many other efforts designed to bring these people into the mainstream of American life. We stand firm in our opposition to such a dilution of standards as contrary to the welfare of people. Further, we deplore the use of Federal funds to perpetuate poor and unsafe nursing care.

In addition to lowering standards of nursing care for the poor, the new regulations will almost certainly greatly increase the cost of the Medicaid program by making eligible, nursing homes previously denied Medicaid funds because they did not meet the nursing regulations. Americans are therefore being required to finance poor quality care at higher and higher costs.

We hope you share our concern and will support efforts to improve rather than to repress the delivery of quality health care to millions of Americans.

It is our understanding that special provisions are being made for review comments received apropos the proposed interim policies and requirements dealing with the standards for payment for skilled nursing home care and that hearings may be held. In this event, the American Nurses' Association stands ready and would welcome the opportunity to present its views in person.

Sincerely yours,

Mrs. Judith G. Whitaker,
Executive Director.

ITEM 4: SUBMITTED BY REV. JOHN MASON,* DIRECTOR OF SERVICES TO AGING, AMERICAN LUTHERAN CHURCH

Exhibit A. Statistics of 95 Homes, Dec. 31, 1968

AMERICAN LUTHERAN CHURCH, DIVISION OF SOCIAL SERVICE, DEPARTMENT OF SERVICES TO THE AGING—STATISTICS OF 95 HOMES, AS OF DEC. 31, 1968

	Total	Male	Female	Percent
Resident's religious affiliation:				
American Lutheran Church	4,353	1,166	3,187	8.6
Lutheran Church in America	425	113	312	4.7
Lutheran Church-Missouri Synod	269	81.	188	3.0
Other Lutherans	278	83	195	3.1
Other Protestants	2,550	557	1,993	28.4
Catholics	493	149	344	5.5
Other faiths	215	33	182	2.4
No affiliation	385	167	218	4.3
Total	8,968	2,349	6,619	100.0
Percentage		26.2	73.8	

* See statement, p. 77.

AMERICAN LUTHERAN CHURCH, DIVISION OF SOCIAL SERVICE, DEPARTMENT OF SERVICES TO THE AGING—STATISTICS OF 95 HOMES, AS OF DEC. 31, 1968—Continued

	Total	Male	Female	Percent
Resident's age (average age 81.6):				
Number under 60	158	66	92	1.8
Number in their sixties	470	154	316	5.2
Number in their seventies	2,220	529	1,691	24.7
Number in their eighties	4,767	1,229	3,538	53.2
Number in their nineties	1,326	367	959	14.8
Number over 100	27	4	23	.3
Total	8,968	2,349	6,619	100.0
Accommodations:				
Number of residents Jan. 1, 1968	8,662	2,251	6,411	
Admissions during the year	3,558	1,197	2,361	
Number of persons accommodated	12,220	3,448	8,772	
Deaths during the year	1,764	600	1,164	
Departures during the years	1,488	499	989	
Number of residents Dec. 31, 1968	8,968	2,349	6,619	
Types of payments:				
Paying privately	5,803	1,561	4,242	64.7
Life contract	36	7	29	.4
Old-age assistance	3,129	781	2,348	34.9
Total	8,968	2,349	6,619	100.0
Types of services:				
Residential	3,366	904	2,462	37.5
Nursing	5,150	1,354	3,792	57.4
Extended-care facility	452	91	361	5.1
Total	8,968	2,349	6,619	100.0

EXHIBIT B. FIVE-YEAR COMPARISON—AMERICAN LUTHERAN CHURCH NATIONAL PROGRAM EXPENSE—AVERAGE PER RESIDENT PER DAY COST

	1964	1965	1966	1967	1968	Increase (decrease), 1964–68, percentage
Number of homes	71	93	93	93	95	------
Administration	$0.66	$0.71	$0.77	$0.91	$0.99	50.0
Dietary	1.39	1.53	1.68	1.85	1.96	41.0
Nursing	1.76	19.4	2.21	2.64	2.94	67.0
Chaplaincy	.05	.05	.06	.06	.07	40.0
Activities	.03	.04	.06	.07	.08	266.7
Rehabilitation	.01	.01	.02	.03	.03	300.0
Social work	.01	.01	.01	.01	.01	0
Other services	0	.01	.03	.04	.04	400.0
Housekeeping	.33	.33	.37	.41	.45	36.4
Laundry	.18	.19	.20	.23	.26	44.4
Plant operation and maintenance	.61	.64	.67	.72	.79	29.5
Property and related expense	.16	.17	.19	.03	.04	(75.0)
Total	5.19	5.63	6.27	7.00	7.66	47.6

Note: To these actual cost figures the individual home must add the per resident per day debt amortization costs. These costs may in many cases be offset by the gift income received by the home. If gift income is not used to lower monthly rates it is generally used to prepay debt or to set up an expansion building fund, or to buy equipment.

EXHIBIT C. AMERICAN LUTHERAN CHURCH NATIONAL AVERAGE—STAFF HOURS PER BED PER MONTH

	1967	1968
Number of homes	93	101
Administration	4.8	5.1
Dietary	18.1	17.7
Nursing	45.0	47.4
Chaplaincy	.5	.4
Activities	1.3	1.3
Rehabilitation	.3	.4
Social work	.1	.1
Other services	.1	.1
Housekeeping	7.2	7.4
Laundry	3.5	3.6
Plant operation and maintenance	3.2	3.1
Total	84.1	86.6
Ratio of residents to staff	2.9	2.8

Exhibit D. Position of the American Lutheran Church on Delivery of Health Service to Elderly People

A short paragraph in the July 14, 1969 issue of "The National Observer" found on page 5, column 1, "Medicaid Plan 'Badly Conceived'" prompts me to write this rather lengthy statement on the subject. May I introduce myself briefly by saying that for the past 15 years I have been the Director of the Department of Services to the Aging of The American Lutheran Church. Under the supervision of this Department are more than 100 retirement-nursing homes owned and operated either by the national church body or by nonprofit corporations made up of Lutheran congregations and operating within the policies of the Division of Social Service of The American Lutheran Church. In 1968 we cared for more than 12,000 persons in our homes.

The problem of an adequate and economically sound program for the delivery of health care to elderly people has long been the concern of the church. The American Lutheran Church has been active in this field for more than one hundred years in this country and the work goes back for hundreds of years in the lands from which our people emigrated.

The American Lutheran Church has its national office in Minneapolis, Minnesota. It is the responsibility of the Department of Services to the Aging to bring consultative service to the congregations of the church in the area of development of both institutional and non-institutional services to the elderly. This consultation provides guidance in the design, structure, finance and program of retirement-nursing homes sponsored by congregations of The American Lutheran Church and operated as community resources to help meet the needs of elderly people without discrimination on account of race, creed or national origin. These homes are designed and staffed to provide all of the social components of care, from simple board and room to the most intensive nursing care.

The consultation service of the department also assists congregations, homes and other social agencies of The American Lutheran Church in the development of non-institutional services such as, home visitors, meals-on-wheels, community centers, etc.

In addition to the services of consultants, which are provided without charge to the congregations, homes and agencies, the department also provides some special grant money to develop innovative services on a pilot project basis, or to assist in the establishment of services that are needed but cannot be budgeted for in a given year, such as the purchase of equipment for a physical therapy program, or providing part of the salary for a therapist, social worker, chaplain, activity director, etc. These grants usually run for three years on a diminishing basis with the understanding that the agency will assume the full cost when the grant program runs out. Our department also provides an in-service training program in rehabilitative nursing for nurses employed in our homes.

For many years we have conducted a resident training course for administrators of homes which are under our supervision.

Our programs serve on a nonprofit basis in a very real sense—each year the program income fails to cover the program cost. The deficit is met by the free flow of voluntary gifts from members of our congregations and the people of the communities which we serve. If it were not for these gifts, our program would be forced to charge recipients of service at a higher rate.

The capital cost for construction in 80% of the homes of The American Lutheran Church has been raised by gifts from the members of the congregations which have formed nonprofit corporations for the purpose of providing this service to older people, and from interested parties in the communities to be served. In the other 20%, the capital funds have come through a combination of contributions from the same source mentioned above and loans or guaranteed mortgages from state and federal agencies. This voluntary effort has kept the capital debt at a relatively low figure which has resulted in a corresponding lower cost to the person or family or government agency responsible for paying the necessary rates.

The typical long term skilled nursing care home of The American Lutheran Church has about 100 beds. It is designed so that the entire structure can be licensed to provide skilled nursing care. It provides care for old people at whatever level may be required—from residential to intensive nursing and terminal care.

About 20% of the residents require only boarding care, another 20% require personal care, 40% require nursing care, some of these are in need of intensive and terminal care, and about 20% of the total unit is certified as an ECF unit if the home has elected to participate in Medicare. Thus about 40% of the beds are required for people who need something less than skilled nursing care and 60% require nursing care at various levels.

It has been our policy to provide whatever level of care a person may require at a given time in his or her own room without forcing the person to move. We have found that a more efficient program can be developed by bringing the nursing care to the patient rather than the patient to the nurse. This helps to keep older people well longer, tends to minimize anxiety caused by moving old people about due to changes in health conditions and allows for a less costly staffing pattern.

The average per resident per day cost is lower in our homes than in many others while the quality of care is of the best. The statistics given below will indicate low average costs and the staff hour analysis will indicate that the average patient-to-staff ratio is good for the multilevel service that is offered.

When Medicare came into the picture, our homes had little difficulty in obtaining certification. A number of homes chose not to be certified and a number of homes certified are voluntarily dropping out of the ECF program each year because the program does not meet the real needs of the residents and has been a cause for a substantial increase in costs that are not, in our opinion, justified by an improvement in health care.

Staffing and other requirements for the ECF program go beyond that required for skilled nursing care. Our experience indicates that often the ECF certified patient needs less skilled nursing care than the noncovered long term care patient. This means that the cost of care for such a person is unnecessarily high. The following diagram may illustrate the problem.

THE TYPICAL ALC HOME

Pre-Medicare—100 beds—designed to provide whatever level of care a person may need—and so licensed—minimum of patient moving—efficient staffing patterns.

Under Medicare—Four separate and distinct parts—theory is that people should be moved from part to part as health needs change—inefficient staffing patterns—much patient anxiety—a high cost program.

Certified ECF beds about:	*Percent*
Retirement Care	20
Personal Care	20
Nursing Care	40
Intensive Nursing Care	20

The ECF unit usually has less than 50% of beds occupied by Medicare-covered patients. If the total unit cost is divided among these patients the daily per patient cost becomes very high. Our practice is to fill the other beds with patients needing skilled nursing care but as they must pay the same rate as the ECF patients, according to Medicare regulations, the per patient cost is higher than it ought to be while the cost for the ECF patient is lower than it would have been if we had not used the open beds in the ECF unit for nursing care patients.

Our position is that costs for skilled nursing home care in facilities which have the separate and distinct parts as called for in Medicare are substantially higher than would be the case if no distinct part of a facility were so designated. Such a facility should be licensed and staffed to provide skilled nursing care where needed and an efficient staffing pattern can then be developed. The doctors should certify such patients as were eligible for Medicare benefits and the charge would be based on the formula the home applies to all residents. The doctors would be required to recertify those patients needing longer periods of covered care in accord with regulations governing the allowable benefit periods.

Recommendations:

1. Eliminate the present policy requiring "separate and distinct parts" for Extended Care Units, Skilled Nursing Care Units, Intermediate Care Units and

Recommendations:

2. Eliminate the 60-day corridor provision that makes it impossible for aged persons to regenerate eligibility for a new spell of illness until after they have been discharged from any unit licensed for nursing care for 60 days.

3. Rely on the Departments of Health in the respective states to license and regulate skilled nursing homes and eliminate special surveys and resultant costs.
4. Rely on the annual audit of a regular CPA and eliminate cost of extra Medicare audits.
5. Simplify the Utilization Review Procedures to make them acceptable to physicians and nursing home staff.
6. Apply reimbursement policies on a cost per diem basis including depreciation and interest on capital debt. It would be good also to consider allowing a per diem item for capital expansion and replacement purposes.
7. Allow the physician to certify the patient eligibility with requirement for recertification of those patients needing longer periods of covered care in accord with regulations governing the allowable benefit periods.
8. Adopt one standard for skilled nursing care and eliminate the present differences between standards for Titles 18 and 19.
9. Adopt a uniform cost accounting system that will be mandatory for all groups participating in the program.
10. Require full fiscal disclosure on the part of all facilities receiving payment for services from public funds.
11. Arrange for special grants to institutions for program improvement—to be given on a diminishing basis over a short period of years.
12. Conduct annual conferences for administrators of health care facilities so that there may be a continuous up-grading of programs and services. These could be regional in one year and national in the alternate year. It could also be arranged that participation in these conferences could qualify as the "continuing education" aspect for the licensed administrators.

NOTES ON THE SUPPLEMENTAL SHEETS

Green Sheet—Vital Statistics for 1968

1. Average age of residents—81.6. If those under 70 were eliminated the average age would be much higher.
2. 34.9% of residents receive some form of governmental assistance.
3. Only 5.1% of residents were beneficiaries of Medicare.

Yellow Sheet—Staff Hour Analysis for November 1968

1. On a national basis our homes showed a 95.5% occupancy in November, 1968.
2. Note that the residential beds made up 35.5% of our total licensed beds and they were occupied at a rate of 97.4%, that the skilled nursing sections were licensed for 43.5% of our beds and were occupied 114.1%! This really means that the low occupancy of the ECF portion, 21% of total beds occupied only 53.7, allowed the placement of nursing care patients in the unoccupied ECF beds.
3. Our homes show a ratio of one staff person for each 2.8 residents.
4. Our cost in wages amounted to $5.09 per resident per day with $2.72 of this cost going to nursing care.

Pink Sheet—Revenue and Expense Analysis for 1968

1. For the 12 months of 1968 only 18% of our licensed beds were in the ECF category and of this 18% only 33.2% were occupied as of December 31, 1968.
2. Note that we show 125.1% occupancy of licensed skilled nursing home beds—possible only because the ECF units showed a 33.2% occupancy.
3. Operating Revenue—that is income from fees=$28,102,873. Program Expense plus interest, depreciation and other=$28,957,667. Our Program Deficit was $854,793.
4. The deficit was covered by voluntary gifts from our constituencies in the amount of $2,192,609 which left a net gain of $1,337,815 to be used to prepay debt, to expand facilities, etc.
5. Note that the gift amount dropped 31.3% as compared to 1967. We expect it to be up in 1969 according to our current monthly reports.
6. Note that our program cost averaged $7.66 per resident per day plus 1.31 for interest and depreciation for a total cost of $8.97.

It should also be noted that these are *averages*—some nursing patient costs were higher, others were lower.

This kind of program, we believe, can cut the total expenditures for health care because we can keep people well—or at least not in need of hospital care—longer and we tend to prevent anxiety-caused illness because people can live with a sense of security without fear of removal due to change in health, and we can develop more efficient staffing patterns when we do not use the "separate

and distinct part" concept. Likely one reason so many of our homes stay out of the Medicare program is the reluctance to accept the "separate and distinct part" philosophy.

White Sheet—Five Year Comparison—ALC National Program Expense

1. Program costs in past five years have increased 47.6%.
2. Administration, dietary and nursing costs account for the largest dollar increase.
3. Plant operation and maintenance costs have increased only moderately, which reflects better building construction.
4. Some of the rubrics tend to be a little misleading because, for instance, much rehabilitation is done in the nursing service and even in the dietary program. Social work is also done in these areas and in chaplaincy. Thus the figures need interpretation.
5. We have collected data for Staff Hour Analysis only since 1967 but even so the data is becoming significant.